



सत्यमेव जयते

Ministry of Ayush
Government of India

STANDARD TREATMENT GUIDELINES
ON
**MANAGEMENT OF
DERMATOLOGICAL DISORDERS**
IN
UNANI SYSTEM OF MEDICINE

AYUSH VERTICAL
DIRECTORATE GENERAL OF HEALTH SERVICES

Ministry of Health & Family Welfare
Government of India

STANDARD TREATMENT GUIDELINES
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UNANI SYSTEM OF MEDICINE

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आयुष मंत्रालय और
राज्य मंत्री
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
भारत सरकार



Minister of State
(Independent Charge) of
Ministry of Ayush and
Minister of State in
Ministry of Health and Family Welfare
Government of India

प्रतापराव जाधव
PRATAPRAO JADHAV



Message

India's rich heritage of traditional healthcare systems has long provided holistic, time-tested solutions for the prevention, management, and promotion of health. In recent years, there has been growing recognition of the significant role that Ayush systems can play in addressing the increasing burden of skin diseases through patient-centric, and integrative healthcare approaches.

The release of the Standard Treatment Guidelines (STGs) for Dermatological Disorders in the respective Ayurveda, Siddha, Unani, and Homeopathy (ASUH) systems, with the inclusion of Yoga, marks another important milestone in our collective efforts to strengthen the integration of Ayush systems into the national healthcare framework. Building upon the success of the previously released STGs, these guidelines reaffirm our commitment to harmonizing the wisdom of traditional medicine with contemporary scientific evidence, thereby enhancing the quality, safety, and accessibility of healthcare services.

These guidelines provide evidence-based recommendations for the prevention, diagnosis, and management of common dermatological disorders, including Psoriasis, Dermatitis, Vitiligo, Urticaria, and Dermatophytosis. By offering standardized and system-specific clinical guidance, they will support healthcare practitioners in delivering safe, effective, and holistic patient care while promoting rational and evidence-informed clinical practice.

I am confident that these STGs will contribute significantly to improving clinical outcomes, encouraging integrative models of healthcare, and strengthening the role of Ayush systems in Public health sector. They will also serve as valuable reference documents for clinicians, academicians, researchers, and policymakers, fostering greater uniformity and excellence in patient care across the country.

I wholeheartedly appreciate the dedicated efforts of Ayush Vertical under DGHS as well as all the experts, institutions, researchers, and stakeholders whose invaluable contributions have made the development of these comprehensive guidelines possible. I am confident that this initiative will further strengthen the vision of accessible, affordable, and quality healthcare for all through the Ayush systems of medicine.



(Prataprao Jadhav)

14th August 2026
New Delhi

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सत्यमेव जयते



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Foreword

Dermatological health is an integral part of overall well-being, as skin disorders can have significant physical, psychological and social impacts. The increasing burden of chronic and recurrent dermatological conditions highlights the need for comprehensive and patient-centred approaches that extend beyond symptom management to encompass prevention, long-term care, and improved quality of life. In this context, the Ayush systems offer a distinctive and comprehensive perspective on health, emphasizing the role of appropriate lifestyle practices, dietary measures, and individualized care. The integration of validated Ayush interventions with contemporary healthcare approaches can contribute towards strengthening accessible, inclusive, and holistic dermatological care.

I am pleased to note that the Ayush Vertical under the Directorate General of Health Services (DGHS), Ministry of Health & Family Welfare, in close collaboration with the Central Research Councils under the Ministry of Ayush and eminent experts from the respective systems, has developed these *Standard Treatment Guidelines (STGs) for Dermatological Disorders including psoriasis, dermatitis, vitiligo, urticaria, and dermatophytosis*. The guidelines are the outcome of a rigorous and systematic process involving extensive expert consultations, critical appraisal of classical texts, evaluation of contemporary scientific evidence, and consensus-based deliberations.

These guidelines provide practical recommendations for the prevention, diagnosis, treatment, follow-up and rehabilitation of common dermatological disorders while preserving the fundamental principles of each Ayush system. They are expected to promote greater uniformity in clinical practice, facilitate rational decision-making, and encourage appropriate integrative healthcare in public health sector. These STGs will also serve as a valuable reference for education, capacity building, research, and the generation of high-quality clinical evidence, thereby further strengthening the scientific foundation of Ayush healthcare.

The Government of India remains committed to evidence-based integration, quality assurance and standardisation across the Ayush sector. These guidelines are an important step towards strengthening Ayush's contribution to accessible, affordable and people-centric healthcare.

I congratulate the Ayush Vertical under DGHS and appreciate the contributions of the Central Research Councils, experts, clinicians, academicians, researchers and other stakeholders. I am confident that these guidelines will serve as a valuable resource for healthcare professionals and further strengthen the quality, credibility and global acceptance of Ayush systems of medicine.

(Rajesh Kotecha)

Date: 25th August. 2026

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भारत सरकार
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Government of India
Ministry of Health & Family Welfare
Directorate General of Health Services



Message

The growing global emphasis on holistic, preventive, and patient-centred healthcare has renewed interest in traditional systems of medicine and their potential contribution to contemporary health challenges. In India, the Ayush systems of medicine have long served as an integral component of healthcare delivery, offering comprehensive approaches to health promotion, disease prevention, and management through their time-tested principles and evidence-informed practices. As healthcare increasingly embraces integrative models of care, the role of Ayush in addressing both communicable and non-communicable diseases assumes even greater significance.

Dermatological disorders constitute a significant public health challenge, affecting individuals across all age groups and contributing substantially to morbidity, psychological distress, social stigma, and reduced quality of life. A wide spectrum of skin conditions such as dermatitis, dermatophytosis, psoriasis, urticaria, and vitiligo are frequently encountered in clinical practice and require safe, effective, and patient-centered management strategies. The Ayush systems of medicine offer holistic and individualized approaches to the management of dermatological disorders by addressing the underlying constitutional imbalances, promoting healthy dietary and lifestyle practices, and utilizing evidence-informed therapeutic interventions.

The Standard Treatment Guidelines (STGs) on Dermatological Disorders in Ayush Systems of Medicine have been developed under the aegis of the Ayush Vertical, Directorate General of Health Services. These guidelines represent a significant step towards promoting quality assurance, uniformity in clinical practice, and evidence-based healthcare delivery across the Ayush streams. Formulated through a rigorous consultative process involving experts from Ayurveda, Siddha, Unani, and Homoeopathy, along with specialists from modern medicine, the guidelines provide practical and clinically relevant recommendations for the management of common dermatological conditions.

I commend the Ayush Ministry, for bringing out this important document and express my sincere appreciation to the experts from the Research Councils and National Institutes under the Ministry of Ayush for their valuable contributions. I also acknowledge the support extended by the dermatology departments of Dr. Ram Manohar Lohia Hospital and Lady Hardinge Medical College.

By fostering greater collaboration among different systems of medicine and encouraging a multidisciplinary approach to healthcare, these guidelines exemplify our collective commitment to improving patient outcomes and strengthening integrative healthcare delivery in the country. I am confident that these Standard Treatment Guidelines will serve as a valuable reference for Ayush practitioners.

(Loveneesh G Krishna)

डॉ. रामराव दा. पाटील

उप महानिदेशक (आयुष)

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Ministry of Health and Family Welfare

Government of India

FOREWORD

The standardization of clinical practice is fundamental to ensuring quality, safety, and consistency across healthcare delivery systems. Recognizing this imperative, the Ayush Vertical, under the leadership and guidance of the Directorate General of Health Services (DGHS), initiated the systematic development of Standard Treatment Guidelines (STGs) for common clinical conditions across traditional systems of medicine. Building upon the successful publication of our earlier volumes on Musculoskeletal and Metabolic Disorders, I am pleased to present the third set in the series: **Standard Treatment Guidelines for Dermatological Disorders**.

This volume addresses five commonly encountered clinical entities—Psoriasis, Dermatitis, Vitiligo, Urticaria, and Dermatophytosis. These guidelines are designed to assist Ayush practitioners in delivering standardized, evidence-informed, and safe clinical care while preserving the foundational diagnostic and therapeutic principles of Ayurveda, Siddha, Unani, and Homeopathy. Beyond routine clinical application, this document aims to foster consistency in practice, enhance quality assurance, support capacity building, and provide a framework for future epidemiological and clinical research.

The preparation of these guidelines underscores the steadfast commitment of the Ayush Vertical to institutionalizing quality assurance within public health services. Developed through an extensive collaborative mechanism, this document brings together technical expertise from the Ayush Research Councils, senior academic specialists across all four traditional streams, and distinguished experts from modern medical specialties. This interdisciplinary approach ensures that the protocols remain deeply rooted in classical wisdom, scientifically robust, and aligned with modern public health standards.

A defining strength of this publication is its rigorous, field-level validation. To ensure operational feasibility in real-world clinical environments, the Ayush Vertical, in active collaboration with the Directorate of Ayush, Government of NCT of Delhi, conducted comprehensive field testing of the draft protocols. Medical Officers engaged in primary and secondary healthcare delivery tested the guidelines in their daily practice, providing critical operational feedback. Inclusion of their observations in the final publication has significantly enhanced its clinical relevance and practical utility.

I place on record my sincere gratitude to the members of the National Expert Committee, the Editorial Board, subject experts from the Ayush Research Councils, modern medicine specialists, the Directorate of Ayush (NCT of Delhi), and all participating Medical Officers. Their technical rigor, dedication, and spirit of collaboration have been crucial in bringing this project to fruition.

I am confident that the *Standard Treatment Guidelines for Dermatological Disorders* will serve as an authoritative reference for clinicians, academic faculties, researchers, and public health administrators. It is our earnest hope that this effort will further strengthen the delivery of accessible, safe, and quality-driven Ayush healthcare services to the nation.

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ABBREVIATIONS

AD	Atopic Dermatitis
ADSI	Atopic Dermatitis Severity Index
ANA	Antinuclear Antibody
ACE	Angiotensin-Converting Enzyme
AIDS	Acquired Immunodeficiency Syndrome
ASST	Autologous Serum Skin Test
BMI	Body Mass Index
BSA	Body Surface Area
CBC	Complete Blood Count
CDLQI	Children Dermatology Life Quality Index
CCRH	Central Council for Research in Homoeopathy
CT scan	Computed Tomography Scan
CHC	Community Health Centre
CRP	C-Reactive Protein
CSU	Chronic Spontaneous Urticaria
CIndU	Chronic Inducible Urticaria
CVD	Cardiovascular Disease
DALYs	Disability-Adjusted Life Year
DLQI	Dermatology Life quality Index
DSQL	The Dermatology-specific Quality of Life
DOPA	Levodopa
DVT	Deep Vein thrombosis
EASI	Eczema Area and Severity Index
ECHO	Echocardiography
ECG	Electrocardiogram
ESR	Erythrocyte Sedimentation Rate
FT3	Free Tri-iodothyronine
FT4	Free Thyroxine
FBS	Fasting Blood Sugar
HBA1C	Glycosylated Haemoglobin
HIV	Human Immunodeficiency Virus
HLA	Human Leukocyte Antigen
HSV	Herpes Simplex Virus
HAE	Hereditary Angioedema

IgE	Immunoglobulin E
ICD	International Classification of Diseases
IFN	Interferon
JAK/STAT	Janus Kinase/Signal Transducer and Activator of Transcription
KFT	Kidney Function Test
KOH	Potassium Hydroxide
LFT	Liver Function Test
MRI	Magnetic Resonance Imaging
NSV	Non-Segmental Vitiligo
NSAIDS	Non-Steroidal Anti-Inflammatory Drugs
PASI	Psoriasis Area Severity Index
PCR	Polymerase Chain Reaction
PHC	Primary Health Centre
PPD	Purified Protein Derivative
PPBS	Postprandial Blood Sugar
QOL	Quality of Life
RAST	Radioallergosorbent Test
RA Factor	Rheumatoid Factor
RO	Research Officer
SARDs	Systemic Autoimmune Rheumatic Disorders
SAPHO	Synovitis, Acne, Pustulosis, Hyperostosis, Osteitis
SASSAD	Six Area Six Sign Atopic Dermatitis
SCORAD	Scoring Atopic Dermatitis
SLE	Systemic Lupus Erythematosus
SV	Segmental Vitiligo
TSH	Thyroid-Stimulating Hormone
USG	Ultrasonography
UV	Ultraviolet
VASI	Vitiligo Area Scoring index
VES	Vitiligo Extent Score
VETF	Vitiligo European Task Force
VIDA	Vitiligo Disease Activity Score
VIS	Vitiligo Impact Scale
WHO	World Health Organisation

GLOSSARY

Sr. No.	Term	Term or Concept in English	Description
1.	<i>Ābla Dār</i>	Vesicular	Small fluid-filled eruption
2.	<i>Adwiya-i-Musakhkhina</i>	Calorific drugs	Drugs producing heat in the body
3.	<i>Aghdhiya Bāridā</i>	Food of cold temperament having ability to produce the humours which induce coldness in the body	Dietary substances which produce coldness in body.
4.	<i>Aghdhiya Ḥārā</i>	Diets having hot temperament	Dietary substances which produce heat in body
5.	<i>Aghdhiya Ḥirrīfa</i>	Spicy Pungent	Spicy (Pungent) foods that may produce heat in the body e.g. pepper.
6.	<i>Aghdhiya Latifa</i>	Food stuffs which are easy to digest but have little nutritional value, and produce such a sanguine which is normal in viscosity	Dietary substances which produce blood of thin consistency.
7.	<i>Aghdhiya Mubarrida</i>	Coldness producing diets	The food of cold temperament having ability to produce the humours which induce coldness in the body
8.	<i>Aghdhiya Muwallidat-i-Dam</i>	Haematopoietic/ blood producing diets	The foods which produce an excessive quantity of sanguine in the body e.g. grapes, pomegranate, egg yolk, fried meat, boiled meat, milk, dairy products, gram, etc.
9.	<i>Aghdhiya-i Muwallida-i Balgham</i>	Phlegm-producing diets	The foods which produce excessive quantity of phlegm in the body
10.	<i>Aghziya Ghalīza</i>	Dry and viscous foods	Dietary substances which produce blood of thick consistency.
11.	<i>Aghziya Mujaffifa-</i>	Foods causing desiccation of body fluid	The foods causing desiccation of body fluid
12.	<i>Aghziya Murattiba</i>	Foods of wet/moist temperament having ability to produce the humours which give rise to wetness in the body	Dietary substances which produce wetness in body

Sr. No.	Term	Term or Concept in English	Description
13.	<i>Aghziya Musakhkhina -</i>	Foods producing heat in the body	Dietary substances which increase heat in the body due to their hot temperament or heat-producing property.
14.	<i>Aghziya Muwallid-i Sawdā'</i>	Foods producing black bile	The foods which produce an excessive quantity of black bile in the body
15.	<i>Al-Ḥaraka wa'l Sukūn al-Nafsānī</i>	Psychic movement and repose	One of six essential factors for maintenance of health; psychic movement increases heat, while repose increases cold; a balance between the two ensures optimum health
16.	<i>Al-Hawā'</i>	Air	First of six essential factors for maintenance of health; basic source of oxygen through respiration Air free from pollutants play key role in preserving and maintaining health
17.	<i>Al-Iḥtibās wa'l Istifrāgh</i>	Retention and Evacuation	One of six essential factors for maintenance of health; <i>Iḥtibās</i> is necessary for digestion and metabolism as well as maintaining reserves of nutrients in body while <i>Istifrāgh</i> is necessary for removal of waste products/metabolites through defecation, micturition, menstruation etc.
18.	<i>Al-Ma'kūlāt wa'l Mashrūbāt</i>	Foods and Drinks	One of six essential factors for maintenance of Health It includes all dietary substances in the form of foods and drinks
19.	<i>Al-Nawm wa'l Yaqza</i>	Sleep and wakefulness	One of six essential factors for maintenance of Health
20.	<i>Asbāb Bādiya</i>	External factors	Causes that affect the body from outside (trauma, cold, heat), non-corporeal (outside the body) causes which produce corporeal states directly, e.g., blow, atmospheric heat, hot or cold food or psychological factors like anger or fear

Sr. No.	Term	Term or Concept in English	Description
21.	<i>Asbāb Sābiqa</i>	Internal factors	Causes that affect the body from within (repletion, starvation)
22.	<i>Asbāb Sitta Darūriyya</i>	Six essential factors	Six essential factors for maintaining physical, mental, social and spiritual health which include: air; foods and drinks; bodily movement and repose; mental activity and repose; sleep and wakefulness; retention and evacuation; these are essential for every person; and imbalance in any or all of these factors may lead to various disease conditions
23.	<i>Badraqa</i>	Vehicle	A drug or substance which helps main drug in absorption and reaching target; it may be an inert substance or of therapeutic value in potentiating effect of main drug.
24.	<i>Bakhūr / Dhūnī</i>	Incense/medicated fumes	Aromatic smoke; any medicated substance that is burnt for therapeutic purposes
25.	<i>Balgham Ghayr Ṭabīʿī</i>	Abnormal phlegm	Phlegm devoid of basic characters of normal phlegm.
26.	<i>Balgham Mālīḥ / Balgham Shor</i>	Saline phlegm	One of the abnormal types of phlegm, which is saline or alkaline in taste and inclined towards hotness and dryness
27.	<i>Baraṣ Abyaḍ</i>	The white form of vitiligo	Hypopigmented patches on skin with normal hair and easily reversible
28.	<i>Baraṣ Aswad</i>	A type of ichthyosis	Hyperpigmented patches on skin, with itching and shedding
29.	<i>Bārid Raṭb Mizāj</i>	Cold and moist temperament	Temperament in which the cold and moist properties dominate the other two qualities, i.e., hot and dry
30.	<i>Bukhārāt</i>	Vapours; gases	Vapours arising from boiling a liquid; gases produced from a substance during its metabolism

Sr. No.	Term	Term or Concept in English	Description
31.	<i>Burūdat</i>	Cold	One of the two active properties naturally associated with matter
32.	<i>Burūdat-al-Dam</i>	Coldness of blood	Predominance of coldness in the temperament of blood
33.	<i>Buthūr</i>	Eruptions	Appearance of lesions on skin, commonly associated with inflammation
34.	<i>Dalk</i>	Massage	Massage (regimen) with techniques ranging from light, moderate, and deep pressure; regimen involving manual manipulation of muscles.
35.	<i>Dam</i>	Sanguine; one of the four humours,	One of the four humours, which is characterized by hot and moist temperament, red colour, sweet taste and no odour; it is the best of all the four varieties of humours
36.	<i>Ḍimād/ Zimād</i>	Poultice	Semi-solid preparation of crude drugs meant for local application.
37.	<i>Ḍuʿf Quwwat Mughayyira</i>	Debility of transformative faculty	Debility of faculty which serves the function of growth and nutrition of the body tissues
38.	<i>Fasād al-Dam</i>	Vitiated blood/ abnormality of sanguine	A morbid condition of blood characterized by abnormal qualitative changes
39.	<i>Fasād-i-Ruṭūbat</i>	Vitiated body fluids / humours	A morbid condition characterized by abnormal qualitative changes in body fluids
40.	<i>Faṣd</i>	Venesection	Bloodletting through venesection (regimen) for complete evacuation of morbid matter, leading to moderation of all humours
41.	<i>Faṣd-i- Akḥal</i>	Bloodletting from median cubital vein	bloodletting through venesection from median cubital vein for complete evacuation of morbid matter
42.	<i>Faṣd-i-Bāsilīq</i>	Bloodletting from basilic vein	bloodletting through venesection from basilic vein for complete evacuation of morbid matter
43.	<i>Faṣd-i-Ṣāfin</i>	Bloodletting from saphenous vein	bloodletting through venesection from saphenous vein for complete evacuation of morbid matter

Sr. No.	Term	Term or Concept in English	Description
44.	<i>Ghalaba'-i-Balgham</i>	Predominance of phlegmatic humour	Qualitative imperfection or quantitative excess of phlegmatic humour in the body.
45.	<i>Ghalīẓ khilt</i>	Viscid humour	A humour with relatively thick consistency
46.	<i>Ghalīẓ Ruṭūbat</i>	Viscid body fluid	Body fluid having thick consistency
47.	<i>Ghalīẓ Sawdā'</i>	Viscid black bile	Black bile with relatively thick consistency
48.	<i>Ghidhā'</i>	Diet	Food(s) / nutritious item(s) consumed regularly; produce effect through their quality and replenish the body
49.	<i>Ghilza wa Lazūjat</i>	High viscosity and concentration	high viscosity of substance and its sticky nature
50.	<i>Ḥādd</i>	acute/acrid	Morbid conditions of acute or high intensity; Substance having acidity, irritability or sharpness
51.	<i>Ḥādd Ṣafrā'</i>	Acrid yellow bile	Yellow bile of increased acidity
52.	<i>Hammām</i>	Bathing	Turkish bath (regimen), constructed as per specific guidelines, where temperatures of different rooms are different for therapeutic purposes like cleansing, reducing viscosity of matter and elimination and diversion of morbid matter.
53.	<i>Harārat</i>	Internal heat	One of the two active properties naturally associated with matter.
54.	<i>Ḥiddat</i>	Acridity	Quality of acidity, irritability of a substance; sharpness or quick onset of a morbid condition
55.	<i>Ḥijāma</i>	Cupping	Mode of regimenal therapy in which horns (nowadays cups) are used with or without scarification for diversion and evacuation of morbid matter from blood.
56.	<i>Ḥijāma bilā Sharṭ</i>	Dry cupping	<i>Ḥijāma</i> (cupping therapy) without scarification; only application of cup with vacuum creation within it for diversion of morbid matter.

Sr. No.	Term	Term or Concept in English	Description
57.	<i>Hijāma bi'l-Sharṭ</i>	Wet cupping	<i>Hijāma</i> (cupping therapy) with scarification for bloodletting to achieve local evacuation of morbid matter.
58.	<i>Idrār-i Bawl</i>	Inducing diuresis	Process of increasing urination by some drugs/diets
59.	<i>Ilāj bi'l Dawā'</i>	Pharmacotherapy	Treatment of disease with help of medicines/drugs
60.	<i>Ilāj bi'l Ghidhā'</i>	Dieto-therapy	Treatment of diseases by manipulating and maintaining the dietary pattern depending upon requirement of treatment of diseases
61.	<i>Ilāj bi'l Tadbīr</i>	Regimenal Therapy	Regimenal therapy is modification in <i>Asbāb Sitta</i> <i>Ḍarūriyya</i> (six essential factors) and application of regimens for maintenance of health as well as for management of diseases
62.	<i>Inkibāb</i>	Vapour bath	Inhalation of steam particularly or exposure of a part of body or whole body to vapours obtained from decoction of drugs or boiled simple water
63.	<i>Ishāl</i>	Inducing purgation	Evacuation of morbid matter from body through intestines as a regimen
64.	<i>Islāh-i-Aghdhiya</i>	Dietary modification	Manipulation in dietary contents; pattern to mitigate its unwanted effects
65.	<i>Iṭfā'-i-Abkhira</i>	Stopping production of gases	Stopping production of gases accumulated in an organ or body part
66.	<i>Izāla'-i-Sabab</i>	Removal of Cause	Removal of cause of disease or treatment of cause
67.	<i>Jadhb-i-Mawād</i>	Absorbing morbid matter	Attracting morbid matter from affected site to another site, one of the objectives of <i>Imāla</i>
68.	<i>Jālī</i>	Detergent	Drug which cleanses surface of organs

Sr. No.	Term	Term or Concept in English	Description
69.	<i>Jazibat-i Dam</i>	Drugs that increase local blood circulation	Drugs/regimens that increase circulation of blood to a particular site/organ
70.	<i>Judhām</i>	Leprosy	A chronic infectious disease which causes deformity and loss and ulceration of organs
71.	<i>Jullāb</i>	Preparation of rose water and sugar	Liquid preparation for oral administration consisting of rose water and honey/sugar, along with other suitable drugs
72.	<i>Kalaf</i>	Melasma	Dark hyperpigmented patches on skin without roughness or itching
73.	<i>Khilt̤ Ghalīz</i>	Viscid humour	A humour with relatively thick consistency
74.	<i>Khilt̤ Ḥādd or Raqīq</i>	Acrid or thin humour	A humour with acrid/irritant nature or thin consistency
75.	<i>Khilt̤ Radī</i>	Morbid humour	The kind of humour which is incapable of becoming part of an organ
76.	<i>Khilt̤ Sawdāwī Ghaliz</i>	Thick black bile	One of the four humours, which is black in colour, cold and dry in temperament with relatively thick consistency
77.	<i>Laṭīf</i>	Highly diffusible	A substance that is easily disintegrated and absorbed by body in a shorter duration
78.	<i>Mā' al-Jubn</i>	Whey	Goat milk is boiled and a sour substance is added to it, so that the suspended albumins are clotted and separated from the liquid component. It is then filtered and whey is obtained
79.	<i>Mā' al-Fawākih</i>	Fruit juice	It is a liquid preparation of expressed fruit juice. A fresh juice is prepared when it is intended to be used.
80.	<i>Mā' al-Sha'īr</i>	Barley water	Liquid preparation obtained by boiling dehusked barley in water; the water is then drained and used

Sr. No.	Term	Term or Concept in English	Description
81.	<i>Mirra Sawdā'</i>	Black bile	One of the four humours, which is black in colour, cold and dry in temperament
82.	<i>Mizāj</i>	Temperament	Uniform quality of a compound present in its all particles in equal proportion, developed due to the interaction of opposite qualities of the four primary components in such a manner that most of the particles of each of the primary components/elements may come into contact with most of the others.
83.	<i>Mizāj Ḥārr</i>	Hot temperament	Temperament in which the hot quality dominates the other qualities
84.	<i>Mizāj Mu'tadil</i>	Equable temperament	Temperament wherein the qualities and quantities of all the participating primary components in a compound are not equal but perfectly balanced as per the required properties and functions of that compound
85.	<i>Mu'affināt</i>	Putrefactive agents	Drugs that putrefy morbid matter to make it easy to expel from body
86.	<i>Mu'addilāt</i>	Alterative	Drugs which normalize body humours in case of any qualitative or quantitative change
87.	<i>Musaffiyat-i-Dam</i>	Blood purifiers	Substances that eliminate toxic, putrefied and waste products from blood through urine, stool and sweat
88.	<i>Muawallid-i- Sawdā' Tadābīr</i>	Black bile producing regimens	Regimens that promote production of excess black bile
89.	<i>Mubarridāt</i>	Cooling agents / refrigerants	Agents/substances or procedures which reduce body temperature from normal limits
90.	<i>Muḥallilāt</i>	Resolvents	Drugs which resolve morbid matter

Sr. No.	Term	Term or Concept in English	Description
91.	<i>Muhallilāt-i Balāghim</i>	Phlegm resolvents	Drugs which induce dispersion of disease-causing phlegm accumulated in an organ or body part
92.	<i>Muḥammirāt</i>	Rubefacients	Drugs which produce redness of surface after local application by causing dilatation of capillaries and an increase in local blood circulation
93.	<i>Munaffitāt</i>	Vesicants	Drugs which produce blisters on surface of skin
94.	<i>Mundij</i>	Concoctive	Drug which modifies and prepares morbid humours for evacuation from body
95.	<i>Mundij-o-Mushil</i> therapy	Concoctive and Purgative therapy	Sequential therapy involving concoction (maturation of morbid matter) followed by its evacuation.
96.	<i>Mundij-i-Balgham</i>	Concoctive of phlegm	Drug which modifies and prepares phlegm for evacuation from body
97.	<i>Murattibāt</i>	Humidifying drug	Drugs that generates wetness due to its excessive moisture
98.	<i>Mushil-i-Balgham</i>	Purgative of phlegm	Drug which causes evacuation of phlegm
99.	<i>Mutaqayyih</i>	Suppurative	Agent which produces or causes production of pus
100.	<i>Muzmin</i>	Chronic	Diseases which have a slow onset, longer duration and lesser severity and reach their peak after a long time
101.	<i>Naṭūl</i>	Douche	Medicinal liquid preparation poured on affected part with force
102.	<i>Nudj</i>	Concoction	Process by which morbid matter/ humour matures and is made easily evacuable from body; drugs for concoction or the duration of concoction are specific to humoral morbidity
103.	<i>Nudj-o-Tanqiya-i Balgham</i>	Concoction and evacuation of phlegm	Process of maturation of phlegm and its subsequent evacuation from the body

Sr. No.	Term	Term or Concept in English	Description
104.	<i>Qabḍ</i>	Constipation	Difficulty in emptying bowels due to decreased functionality of large intestine
105.	<i>Qābiḍāt</i>	Astringents	Drug that causes contraction of body tissues and lumen
106.	<i>Qay'</i>	Inducing emesis	To induce vomiting as a regimen in order to evacuate gastric contents
107.	<i>Qūbā Damawī</i>	Sanguineous type of dermatophytosis	Type of dermatophytosis caused due to sanguineous predominance
108.	<i>Qūbā Ghayr Mutaqashshir</i>	Non-scaly type of dermatophytosis	Type of dermatophytosis characterized by non-scaling of affected part
109.	<i>Qūbā Hadīth</i>	Acute/recent onset of dermatophytosis	Type of dermatophytosis of recent onset
110.	<i>Qūbā Mutaqashshir</i>	Scaly/desquamating type of dermatophytosis	Type of dermatophytosis characterized by scaling/desquamating of affected part
111.	<i>Qūbā Radī</i>	Severe/unfavourable type of dermatophytosis	Type of dermatophytosis which responds to the treatment very slowly/non-responsive dermatophytosis
112.	<i>Qūbā Ratb Damawī</i>	Moist sanguineous type of dermatophytosis	Type of dermatophytosis caused due to sanguineous predominance, characterized by mild oozing
113.	<i>Qūbā Ruṭūbī</i>	Moist type of dermatophytosis	Type of dermatophytosis characterized by oozing
114.	<i>Qūbā Sā'ī</i>	Spreading/progressive type of dermatophytosis	Type of dermatophytosis which progresses rapidly affecting adjacent parts
115.	<i>Qūbā Sawdāwī</i>	Black biliary type of dermatophytosis	Type of dermatophytosis caused due to predominance of black bile
116.	<i>Qūbā Wāqif</i>	Stationary/localized type of dermatophytosis	Type of dermatophytosis which confines to its original site
117.	<i>Qūbā Yābis</i>	Dry type of dermatophytosis	Non-oozing type of dermatophytosis characterized by dryness of the lesion

Sr. No.	Term	Term or Concept in English	Description
118.	<i>Quwwat Dāfi'a</i>	Expulsive power	The mechanism by which tissues eliminate metabolic waste, directing it into the bloodstream for systemic removal.
119.	<i>Quwwat Jādhiba</i>	Absorptive power	The ability of tissues to absorb nutrients effectively from the surrounding environment.
120.	<i>Quwwat Māsika</i>	Retentive power	The capacity of tissues to retain absorbed nutrients long enough to enable proper assimilation.
121.	<i>Quwwat Mughayyira</i>	Transformative faculty	The transformative faculty found in all cells and tissues of the body, responsible for anabolic & catabolic activities
122.	<i>Quwwat Mughayyira wa Mushabbiha</i>	Transformative and assimilative power	The faculty responsible for transforming and structurally adapting nutrients to form tissue components.
123.	<i>Quwwat Tabī'iyya</i>	Natural faculties	Faculty serving the functions of nutrition, growth, reproduction and evacuation of waste products from the body for the preservation of the individual as well as the species
124.	<i>Rag-e Ba'saleeqe</i>	Basilic vein	A large superficial vein of the upper limb that originates on the medial (ulnar) side of the dorsal venous network of the hand and travels up the base of the forearm. The basilic vein terminates by uniting with the brachial veins to form the axillary vein
125.	<i>Riyāḍat</i>	Exercise	Activity involving physical effort, to maintain or improve health
126.	<i>Ruṭūbat</i>	Moistness/wetness	One of the two passive physical properties naturally associated with matter; Body fluids or humours
127.	<i>Ruṭūbat Radī</i>	Morbid fluid	Body fluids or humours that lack their natural qualities or balance and cause harm to the body

Sr. No.	Term	Term or Concept in English	Description
128.	<i>Ruṭūbat-i- Fāsida</i>	Putrefied humours	Putrefied body fluids or humours that cause harm to the body
129.	<i>Sāda</i>	Simple	Morbid condition in which only change in four physical properties without any organic cause
130.	<i>Sakūb</i>	Irrigation	Medicated liquid preparation poured slowly over an affected part from a distance
131.	<i>Sawdā'</i>	Black bile	One of the four humours, which is black in colour and has cold and dry temperament
132.	<i>Sawdā' Ghayr Ṭabī'ī</i>	Abnormal melancholic humour	Black bile produced either by combustion of black bile itself or combustion of any of the other three humours, i.e., sanguine, phlegm, yellow bile.
133.	<i>Sawdā' Muḥṭariqa</i>	Burnt black bile	A type of abnormal black bile which is formed by the burning of melancholic humour.
134.	<i>Sharā Balghamī</i>	Phlegmatic urticaria	Red itchy rashes appearing suddenly due to phlegmatic predominance
135.	<i>Sharā Damawī</i>	Sanguineous urticaria	Red itchy rashes appearing suddenly due to sanguineous predominance
136.	<i>Sharā Sawdāwī</i>	Melancholic urticaria	Blackish red itchy rashes appearing suddenly due to melancholic predominance
137.	<i>Shiqāqī</i>	Cracks	Breaks in continuity of a body part/skin surface
138.	<i>Sū' al-Haḍm</i>	Dyspepsia	Indigestion; a morbid state characterized by foul-smelling eructus, burning sensation in epigastrium, nausea and foul-smelling stools
139.	<i>Sū'-i-Mizāj</i>	Morbid temperament	Derangement or imbalance of temperament either in terms of four physical properties or qualitative or quantitative predominance of humours

Sr. No.	Term	Term or Concept in English	Description
140.	<i>Sū'-i-Mizāj Bārid</i>	Morbid cold temperament	When cold dominates abnormally in the body
141.	<i>Sū'-i-Mizāj Bārid Raṭb</i>	Morbid cold and moist temperament	When cold and moist qualities dominate abnormally in the body
142.	<i>Sū'-i-Mizāj Bārid Raṭb Uḍwi</i>	Morbid cold and moist temperament of an organ	When cold and moist qualities dominate abnormally in a specific part of the body
143.	<i>Ṣulb</i>	Hard	Hard in texture, usually having cold and dry temperament
144.	<i>Surkh/Tā'ūsī Khutūt</i>	Red/ peacock green coloured lines)	Red/ peacock green coloured lines noted in <i>Nār Fārsī</i> (Eczema)
145.	<i>Ta'dīl-i Mizāj</i>	Moderation of abnormal temperament	Moderation of temperament or bringing abnormal temperament to normal/balanced condition.
146.	<i>Ta'dīl-i-Dam</i>	Moderation/ attempreing of blood	To bring morbid blood to normal/ balanced condition
147.	<i>Ta'dīl-i-Khilt</i>	Moderation of humour	To bring back morbid humour to its normal/ balanced condition
148.	<i>Ta'liq al-'Alaq</i>	Leech therapy	Leech application as a regimen is one of the methods of evacuation; it is especially useful at a site where venesection or <i>Hijāma</i> is not done properly
149.	<i>Ta'rīq</i>	Diaphoresis	Sweating as a regimen done to remove morbid matter through skin
150.	<i>Tabrīd- i Badan</i>	Genesis of coolness in the body	A method of treatment in which coldness is produced/ generated or heat is reduced in body by drugs or regimen.
151.	<i>Tadhīn</i>	Oiling	(1) Lubricating a drug in moderately hot oil; (2) application of hot or cold oil on body part
152.	<i>Ṭafshīl</i>	De-husked lentil cooked with vinegar	A dish prepared from meat and de-husked lentil in vinegar used to soothe irritation in the body
153.	<i>Taftīh-i-Masām</i>	Inducing de-obstruction of pores	Inducing de-obstruction of skin pores by means of heat to induce sweating

Sr. No.	Term	Term or Concept in English	Description
154.	<i>Taḥlīl-i-Abkhira</i>	Dispersion of gases	Dispersion of gases accumulated in an organ or body part
155.	<i>Taḥlīl-i-Awrām</i>	Resolution of swelling	Process of resolving swellings
156.	<i>Takhshin</i>	Roughening of skin surface	Toughening of skin surface to increase local circulation
157.	<i>Talyīn-o-Ishāl</i>	To induce laxation and purgation	To induce loosening of stool and its evacuation from the intestines
158.	<i>Tamrīkh</i>	Embrocation/anoointing	Act of moistening and rubbing a part of body with a liniment or lotion.
159.	<i>Tanfiṭ</i>	Blistering/vesication	Process to induce blister formation by hot fluid or some drugs to increase blood supply of a particular organ
160.	<i>Tanqiya/Tanqiya'-i-Badan</i>	Evacuation of morbid matter	Induced elimination of morbid material from the body, usually done after proper concoction
161.	<i>Taqwiyat-i-Mi'da</i>	Toning up of stomach	Process which strengthens stomach and improves its function
162.	<i>Tarqīq-o-Tartīb-i-Dam</i>	To make sanguine thinner and increase its liquidity	To make sanguine thinner and increase its liquidity through use of drugs or certain regimens
163.	<i>Tartīb-i'Umūmī-wa-Maqāmī</i>	Generalized and localized moisturization	To moisturize the whole body or an specific organ through use of drugs or certain regimens
164.	<i>Taṣfiya al-Dam / Tanqiya'-i-Khūn</i>	Blood purification	Purification/cleansing of blood; elimination of anything which is an addition in quantity or quality to physiological composition of blood and considered as an impurity, by drug or regimen
165.	<i>Taskīn-i-Jild</i>	To soothe irritated skin	To soothe irritation of skin by applying certain drugs locally or regimen
166.	<i>Tawabil-i- Harra</i>	Spices and condiments having hot temperament	Spices and condiments having hot temperament
167.	<i>Ṭilā</i>	Liniment	A kind of medicated oil or a thin medicinal preparation applied locally

Sr. No.	Term	Term or Concept in English	Description
168.	<i>Ufūnat</i>	Infection	An abnormal change occurring in the humours/ body fluids caused by extrinsic or intrinsic factors; in extrinsic factors there may be morbid bodies, which come from dead bodies and stagnant waters that may be interpreted as microorganisms; due to this change the physiological functions of the humours alter; the other causes are stagnation in blood vessels or obstruction in viscera and irregular diet which is very prone to become septic
169.	<i>Yubūsat</i>	Dryness	One of the two passive physical properties naturally associated with matter

CHAPTER

(Nār Fārsī)

DERMATITIS

(*Nār Fārsī*)

- Dermatitis (Eczema) **Nār Fārsī** (National Unani Morbidity Code M-22)¹

ICD-11 for mortality and morbidity statistics²:

- **SN43** Eczema disorder (TM2)
- **EA80** Atopic Dermatitis
- **EA82** Nummular Dermatitis
- **EA85.0** Dyshidrotic eczema
- **EK00** Allergic contact Dermatitis

CASE DEFINITION^{3,4}

Dermatitis refers to inflammation of the skin resulting in erythema, itching, edema, and vesiculation, often followed by crusting and scaling. It includes a broad spectrum of disorders such as atopic dermatitis, contact dermatitis (irritant/allergic), seborrheic dermatitis, nummular dermatitis and dyshidrotic dermatitis.

INTRODUCTION (*Incidence/Prevalence, Morbidity/Mortality/Risk Factors*)³⁻¹²

- Atopic dermatitis affects up to 20% of children and around 10% of adults globally, with increasing prevalence in industrialized nations.
- Contact dermatitis accounts for nearly 70% of occupational skin diseases worldwide.
- Seborrheic dermatitis is estimated to affect 1–5% of the general population but may exceed 85% in HIV-infected individuals.
- Nummular dermatitis represents approximately 0.2–0.5% of dermatology cases, while dyshidrotic dermatitis constitutes 5–20% of hand eczema cases globally.
- In India, similar prevalence patterns are observed, with a significant burden of atopic and contact dermatitis, particularly among industrial workers and urban populations.
- Morbidity includes chronic pruritus, secondary infections, sleep disturbances, and psychological impact, although mortality is exceedingly rare.
- Key risk factors across these types of dermatitis include genetic predisposition, atopic background, impaired epidermal barrier, exposure to irritants or allergens, microbial dysbiosis, emotional stress, and environmental factors.
- A dermatitis may be entirely endogenous (constitutional) or be entirely exogenous (contact). The latter consists of irritant and allergic contact reactions. Commonly, dermatitis has a multifactorial aetiology and may be aggravated by the presence of pathogens (*staphylococcus aureus*). Assessment of the relative importance (contribution) of the possible factors may be difficult and subjective.

Unani medicine's perspective (Etiology, Pathology and Classification)

Nār Fārsī is a dermatological condition characterized by “appearance of fluid-filled eruptions associated with intense itching and burning. The surrounding area becomes painful, and the eruptions quickly form crusts. Reddish-green streaks often appear at the site before the eruptions develop”.¹³

Etiology

It is caused by *Ṣafrā'* (yellow bile) mixed with small quantity of *Sawdā'* (black bile) or *Ḥādd Ṣafrā'* (acid yellow bile) mixed with *Dam* (sanguine)^{13,14}.

Predisposing factors

- General debility¹⁵
- Nerve debility¹⁵
- Gout¹⁵
- Arthritis¹⁵
- Exposure to extreme cold or hot weather condition¹⁵
- Worm infestation in children¹⁵
- Long-term intake of garlic and mustard¹³
- Decreased evacuation of morbid matter from the body¹³

Pathology

- *Nār Fārsī* develops from bilious humour mixed with a bit of melancholic humour¹⁶ or *Ḥādd Ṣafrā'* (acid yellow bile) mixed with *Dam* (sanguine)¹⁴. It initiates with appearance of *Surkh/Tā'ūsī Khutūt* (Red/ peacock green colored lines) followed by rapidly spreading *Buthūr* (eruptions), which are filled with watery fluid. There is severe burning sensation and itching with immediate crusting. These *Buthūr* (eruptions) are encircled with a large number of smaller eruptions.¹⁶

Classification^{15,17,18}

According to the chronicity, *Nār Fārsī* is of two types:

- *Ḥādd* (acute)
- *Muzmin* (chronic)

According to the colour and shape of blisters, *Nār Fārsī* has following types:

- *Sāda* (simple)
- *Surkhī Mā'il* (reddish)
- *Ābla Dār* (vesicular)
- *Mutaqayyih* (suppurative)
- *Ṣulb* (hard)
- *Shiqāqī* (cracked)

CLINICAL PRESENTATION³⁻⁹

Table 1: Clinical features of different types of dermatitis

Type of Dermatitis	Clinical Features	Investigations	Appearance
Atopic Dermatitis	• Chronic, relapsing pruritic eczematous lesions, often involving flexural areas (elbows, knees, neck), with lichenification, xerosis • Intense itching, red, scaly or oozing, crusting, cracked and thickened skin lesions, sometimes bleeding on scratching • Commonly affects children below the age of five years • Dennie-Morgan folds under eyes (Dennie-Morgan folds, also known as Dennie-Morgan lines or infraorbital folds, are horizontal creases or folds that appear under the eyes). White dermatographism is a skin response in which gentle pressure from a blunt object—such as a fingernail or tongue depressor—produces a pale or whitish streak on the skin, rather than the typical red mark seen in normal reactions.; • Personal/family history of asthma, allergic rhinitis common.	• Serum IgE level (often elevated) • Absolute eosinophil count • Skin swab test • Patch test if contact allergy suspected • Skin biopsy in atypical cases	 Fig1¹⁹
Irritant Contact Dermatitis	• Localized erythema, scaling, rough, inflamed skin often with burning, fissuring at site of repeated chemical or physical insult (soaps, detergents, occupational irritants); • Often painful more than itchy, without spreading beyond contact area.	• Mainly clinical diagnosis • Skin swab test for secondary infection • Patch test (negative, helps exclude allergic dermatitis) • Skin biopsy if diagnosis uncertain	 Fig 2¹⁹

Type of Dermatitis	Clinical Features	Investigations	Appearance
Allergic Contact Dermatitis	- Erythema, vesicles, intense pruritus, often spreading beyond direct contact zone due to delayed type IV hypersensitivity; - Chronic cases show lichenification.	- Patch Test - Skin swab test - Skin biopsy	 Fig 3¹⁹
Parthenium Dermatitis	Parthenium dermatitis is a widespread and distressing dermatoses in rural and urban India caused by the air borne allergen of the Compositae weed Parthenium hysterophorus. Parthenium dermatitis has been thought to be mediated solely by type IV hypersensitivity, but recently a combined immediate (type I) and delayed (type IV) hypersensitivity mechanism has been postulated in the initiation and perpetuation of parthenium dermatitis, especially in sensitized subjects with an atopic diathesis.	- Patch test with parthenium antigen - Skin swab test in cases of secondary infection - Serum Ig levels - Skin biopsy if required	 Fig 4⁴²
Seborrheic Dermatitis	- Erythematous plaques with greasy, white or yellowish scales or crust on scalp (dandruff), eyebrows, beard, retro-auricular area, sternum; - May cause mild pruritus. - Exacerbates in cold weather, stress, common in Parkinsonism and HIV patients.	- Usually clinical diagnosis - KOH examination - Skin swab test - Skin biopsy if atypical	 Fig 4¹⁹
Nummular Dermatitis	- Well-demarcated, round to oval "coin-shaped" eczematous plaques, often exudative or crusted, primarily on legs and arms; - Intense pruritus; - Commonly in middle-aged to elderly men; - Winter aggravation.	- KOH examination - Skin swab test - Patch test - Skin biopsy	 Fig 5²⁰

Type of Dermatitis	Clinical Features	Investigations	Appearance
Stasis Dermatitis	- Develops in the lower legs due to poor circulation from conditions like varicose veins leading to skin discolouration, thickening & leg swelling. - Reddish, brownish or grayish skin discolouration with itching, oozing, crusting or thickening. - Signs of chronic leg swelling	- Venous Doppler ultrasound of lower limb (to assess venous insufficiency) - Skin swab test if ulcer or infection - Skin biopsy	 Fig 6²¹
Neurodermatitis (Lichen Simplex Chronicus)	Localized, itchy skin condition characterized by thickened, leathery, and scaly skin caused by a habitual itch-and-scratch cycle.	- Clinical diagnosis - Skin swab test - Patch test - Skin biopsy	 Fig 7²²
Dyshidrotic Dermatitis (Pompholyx)	- Sudden onset of deep-seated tapioca-like vesicles on lateral aspects of fingers, palms, sometimes soles; - Associated with burning, itching; may fissure; - Often triggered by stress or hot weather, frequent recurrences. - Also known as 'Pompholyx'.	- KOH examination to rule out fungal infection - Skin swab test - Patch test - Skin biopsy	 Fig 8¹⁹

Clinical Presentation: (Unani medicine's perspective)

The affected area of skin becomes red, with small, clear blisters appearing in clusters. They cause pain, burning, and severe itching. On the third or fourth day, their fluid becomes thicker, and the blisters begin to rupture. Subsequently, the fluid dries to form a scab with yellowish, whitish, or greenish tinges, beneath which pus and yellow fluid may begin to leak¹⁵.

CLINICAL EXAMINATION²³

A detailed patient's history should be taken and focus on the following:

- Onset and distribution of lesions
- Inspection to identify skin rashes, redness, dryness, scaling, crusting, discolouration, thickening and other signs of irritation.
- The severity of pruritus (e.g., keeping patient awake at night)
- Family and/or personal history of the atopic triad (Atopic triad refers to the genetic predisposition to develop allergic conditions such as atopic dermatitis, allergic asthma, allergic rhinitis and other allergies like conjunctivitis)

- Presence of contact allergens
- The presence of triggers including allergens (e.g., dust mites, animal dander), hot showers/sweating, soaps, fragrances, food hypersensitivities, and synthetic fabrics such as polyester.

Classic physical examination findings of Atopic Dermatitis (depending on the age group)

- Infants develop oedematous papules and plaques that may have vesicles or crust on the scalp, face, and extensor extremities.
- Infants rarely have atopic dermatitis lesions affecting the diaper area but may be susceptible to other causes of diaper dermatitis such as candida or seborrheic dermatitis.
- Atopic dermatitis children classically have fewer exudative patches and plaques on antecubital and popliteal fossae; adults have chronic lichenified (enhanced skin markings) lesions that have a predilection for hands.
- Individual lesions may also be further classified into acute (oedematous, erythematous papules and plaques and/or vesicles/crusting), subacute (erythema, scale, variable crusting), or chronic (thick plaques with lichenification and scale) stages.

Unani Perspective:-

A comprehensive approach—including the patient’s clinical, family, medical, and personal history, along with a general physical examination and a complete evaluation of the integumentary system—is essential for diagnosing eczema.

A. Acute Eczema²⁴

Acute eczema manifests as red, erythematous, and oedematous plaques. These plaques are often poorly defined and might be accompanied by tiny papules and vesicles. When these blisters rupture, the lesion may appear moist and oozy. The oozing fluid then dries and forms crusts, resulting in a scaly appearance.

B. Chronic Eczema²⁴

In chronic condition, there may be less exudation, with prominent scaling, lichenification (a triad of hyperpigmentation, skin thickening and increased skin markings), and fissuring in flexural lesions.

Table 2: DIFFERENTIAL DIAGNOSIS^{5,6}

The following diseases must be considered in differential diagnosis of Dermatitis:

Condition	Differential Features	Investigations
Psoriasis	• Chronic plaques with sharply demarcated edge, • Thick silvery scales typically on extensor elbows, knees, scalp; • Auspitz sign (pinpoint bleeding when scale removed) positive, nail pitting, possible arthritis;.	• Skin biopsy showing acanthosis, parakeratosis, • Munro micro abscesses.

Condition	Differential Features	Investigations
Scabies	- Intense nocturnal pruritus with small erythematous papules, vesicles, burrows (thin wavy lines), often on finger webs, wrists, waist, genitalia; - Excoriations, secondary impetiginization; - Family members frequently affected.	Skin scraping with KOH or mineral oil showing mites, eggs, or feces.
Tinea corporis	- Annular erythematous plaques with raised scaly advancing margins and central clearing, possible vesicles at periphery; - Worse in humid weather - Usually asymmetrical; - History of pets or communal sports.	KOH mount positive for septate branching hyphae.
Drug eruptions	- Rapid onset of widespread symmetric erythematous macules, papules, commonly starting on trunk, with recent drug exposure; - May involve mucosa if severe.	- Clinical history; - skin biopsy shows superficial perivascular lymphocytic infiltrate.
Lichen planus	- Pruritic, purple, polygonal, planar papules with Wickham striae (white lacy lines), - Commonly on flexor wrists, lumbar area, ankles; - Oral lesions appear as reticulate white patches; - May have nail thinning or longitudinal ridging.	Biopsy reveals saw toothed hypergranulosis, basal cell vacuolisation, with band like lymphocytic infiltrate at the epidermal junction and civatte bodies.
Insect Bite/ Insect bite hypersensitivity/ Bed bug infestations	- Common in children, chronic hypersensitivity to bites - Localized reactions: - Itchy, erythematous papules or wheals - Central punctum may be present - May progress to vesicles or bullae - Itchy erythematous papules, often in lines or clusters - May have central punctum or sometimes contain a clear fluid	--
Dermatophytid reaction	- Symmetric itchy papules or vesicles on hands or feet secondary to fungal infection elsewhere on body (e.g., tinea pedis); - Often bilateral or symmetrical; - lesions themselves are KOH negative, - improve after primary fungal infection is treated.	- KOH negative at eruption site, - Positive at primary infection site.

Condition	Differential Features	Investigations
Pityriasis rosea	- Begins with single large herald patch on trunk followed by multiple smaller oval salmon-colored lesions along cleavage lines (Christmas tree pattern); - mild itching, self-limiting.	Clinical diagnosis; biopsy rarely performed.
Impetigo	- Honey-yellow crusted erosions often around mouth and nose in children, sometimes with bullae (bullous impetigo); - spreads by scratching.	Bacterial culture positive for <i>Staphylococcus aureus</i> or <i>Streptococcus pyogenes</i>.
Eczema herpeticum	- Clusters of uniform punched-out erosions on eczematous skin, often painful, associated with fever, lymphadenopathy; - may progress rapidly.	Tzanck smear showing multinucleated giant cells or HSV PCR positive.

Table 3: SUPPORTIVE INVESTIGATIONS ^{3,7,8,9,19,25,26,27}

Test	Comment
Essential	
Detailed history and Physical examination	
Complete haemogram (If systemic symptoms persist)	- Complete haemogram may show eosinophilia or other abnormalities of white blood cells. to exclude immune deficiencies, and IgE levels can be helpful to confirm an atopic pattern. - Immunoglobulin profile may be helpful to evaluate immunodeficiency or show raised IgE levels.
C-Reactive Protein	Inflammation is also characterized by an increased blood concentration of inflammatory markers, of which CRP is the most commonly used in clinical studies, being a strong marker of non-specific inflammation. C - reactive protein levels are influenced by many factors like age, BMI and smoking.
Skin scraping with KOH	This is a direct microscopic examination of the skin specimen to detect fungal spores or hyphae.
Skin swab test	To identify bacterial or viral infections that may superinfect the skin
Advanced	
Patch Test	- Patch tests are very useful in finding the cause of allergic but not irritant dermatitis, i.e., they detect allergens responsible for type IV allergy. - Depending on the degree of inflammation, the reaction is graded from 0 to 3+

Test	Comment
Serum IgE Levels	- Total serum IgE levels and IgE antibodies specific to certain antigens (measured using radioallergosorbent test or RAST) may be useful in diagnosis in atopic states. - More than 80% of patients with AD have elevated IgE levels of >200 IU/mL. - RAST may sometimes help to identify specific (dietary and environmental) allergens which may be perpetuating dermatitis in an atopic patient. - May help in advising patients on role of dietary and environmental allergens in perpetuating dermatitis.
Skin Biopsy	Skin biopsy is an important and not commonly performed diagnostic procedure that may assist in making or confirming a diagnosis. The intent is to characterize the nature of skin growth or eruption and assist in the histopathologic evaluation of a tissue sample.
Doppler Ultrasound	- To differentiate dermatitis from other vascular or infectious conditions or to evaluate for cellulitis, venous insufficiency, or vasculitis, which may mimic or coexist with dermatitis - Doppler USG is useful to assess venous insufficiency, reflux, or deep vein thrombosis (DVT), which may underlie or worsen Stasis dermatitis.

DIAGNOSTIC CRITERIA^{3,4,6,28,29,30}

The diagnosis of dermatitis is primarily clinical and made after a complete medical history and physical examination. Dermatitis has varied diagnostic criteria in different types of dermatitis which are stated below:

Table 4: Diagnostic Criteria for each type of Dermatitis

Type of Dermatitis	Diagnostic Criteria	
Atopic Dermatitis	Diagnostic criteria proposed by the United Kingdom Working Party: These consist of one mandatory and five major criteria, it is easy to use and do not require any laboratory testing.	
	Mandatory criterion (must be positive)	An itchy skin lesion or parental report of scratching or rubbing of skin
	Major criteria (at least three of the five should be positive)	Onset below 2 years of age (not used if the child is less than 4 years of old)
		History of skin crease involvement (including cheeks in children under 10 years)
		History of generally dry skin

Type of Dermatitis	Diagnostic Criteria	
		Personal history of other atopic disease (or history of any atopic disease in a first-degree relative of children under 4 years)
		Visible flexural dermatitis (or dermatitis of cheeks, forehead, or outer limbs in children below 4 years)
Irritant Contact Dermatitis	• Diagnosis by exclusion: history of repeated irritant exposure, lesions confined to contact area, immediate burning more than itching, improves on avoidance; • No positive patch test.	
Allergic Contact Dermatitis	• Requires positive patch test (type IV hypersensitivity); • Pruritic eczematous lesions often extending beyond contact site, delayed onset (24–72h after exposure).	
Seborrheic Dermatitis	• Clinical diagnosis: chronic erythematous patches with greasy yellow scales on seborrheic areas (scalp, eyebrows, nasolabial folds, chest); • Recurs with stress or winter.	
Nummular Dermatitis	• Circular or oval pruritic eczematous plaques on extremities, frequently oozing; • Diagnosis supported by negative KOH to rule out tinea.	
Dyshidrotic Dermatitis	• Characteristic presentation of recurrent deep-seated vesicles on sides of fingers, palms, soles, intensely pruritic, often triggered by stress or seasonal factors.	

Evaluation and Assessment^{31,32,33}

The most used tools for assessing dermatitis severity in adult patients are presented and compared. It's an inflammatory condition that requires accurate severity assessment for effective management.

Table 5: Various assessment tools used for the evaluation of dermatitis are as follows:

Tool	Comments
Scoring Atopic Dermatitis (SCORAD)	Assesses disease extent, severity of 6 clinical signs on a 4-point scale, and patient-reported pruritus and sleep loss, to a maximum score of 103
Atopic Dermatitis Severity Index (ADSI)	The sum of 5 items rated on a 4-point scale (0-3): erythema, excoriation, exudation, lichenification, and pruritus
Six Sign Atopic Dermatitis (SASSAD)	Six clinical signs are scored from 0 to 3 at each of 6 sites on the body

Tool	Comments
Dermatology Life Quality Index (DLQI)	10-item questionnaire assessing impact on daily activities and overall quality of life
Eczema area and severity index	The EASI is a widely used tool to assess the severity of atopic dermatitis (eczema). It evaluates two main components: 1. Area: The percentage of body surface area affected by eczema. 2. Severity: The intensity of eczema symptoms

PRINCIPLES OF MANAGEMENT^{13,14,15,34}

Red Flag signs:⁹

These signs should be assessed before initiating treatment to identify cases requiring management/consultation through modern medicine.

- Secondary bacterial or viral infection (pus, fever)
- Generalized erythroderma
- Growth delay in children with Atopic Dermatitis
- Severe psychological distress

Unani medicine's perspective

- *Tanqiya* (evacuation of morbid matter)^{13,34}
- *Talyīn-o-Ishāl* (laxation and purgation)¹⁵
- *Taṣfiya'-i-Dam* (purification of blood)¹⁵
- *Taskīn-i-Jild* (to soothe irritated skin)¹⁵
- *Ta'dīl-i-Khilt* (normalization of causative humour) with *Mubarridāt* (coolants) and *Murattibāt* (humectants)
- *Tarqīq-o-Tartīb-i-Dam* (to make sanguine thinner and increase its liquidity)^{13,14}
- *Islāh-i-Aghdhiya* (dietary modification)¹³

In Unani medicine, '*Ilāj bi'l Tadbīr*' (regimenal therapy) [IUMT-7.2.0] and '*Ilāj bi'l Dawā*' (pharmacotherapy) [IUMT-7.1.10] are considered the core mode of treatment in cases of *Nār Fārsī*. '*Ilāj bi'l Tadbīr*' (Regimenal therapy) [IUMT-7.2.0], includes *Hijāma* (cupping) [IUMT-7.2.30]¹³, *Ta'līq al-'Alaq* (leech therapy) [IUMT-7.2.68]³⁵, *Faṣd* (venesection) [IUMT-7.2.6]³⁶, *Munḍij-o-Mushil* therapy [MM Therapy] (concoctive and purgative therapy) [IUMT-6.1.134] & [IUMT- 6.1.146]¹³, *Ṭilā'* (liniment) [IUMT-6.2.53]¹³, and *Ḍimād* (poultice) [IUMT-6.2.52]¹³, etc.

(A) Prevention Management

Nār Fārsī can be prevented by avoiding the following factors that make an individual more susceptible to it:

- General debility¹⁵
- Nerve debility¹⁵
- Exposure to extreme cold or hot weather condition¹⁵
- Decreased evacuation of morbid matter from the body¹³

Table 6: Dos and Don'ts

Dos	Don'ts
• <i>Aghdhiya Mubarrida</i> (coldness producing dietary items)¹⁴ • <i>Mā' al-Sha'ir</i> (barley water)^{14,37} • <i>Āb-l Anārayn</i> (pomegranate juice)¹⁴ • Expressed juice of cucumber¹⁵ • Expressed juice of watermelon¹⁵ • Milk³⁷ • <i>Kadū</i> (pumpkin)³⁷ • <i>Tindā</i> (round melon)³⁷ • <i>Lavkī</i> (bottle gourd)³⁷ • <i>Pālak</i> (spinach)³⁷ • <i>Khurfa</i> (common purslane)³⁷ • Keep the affected area dry	• Intake of <i>Aghdhiya Hirrifa</i> (food having pungent taste)¹⁴ • Diets having hot temperament³⁷ • Intake of meat¹⁴ • Intake of <i>Halwahjāt</i> (sweet dishes)¹⁴ • Prolonged use of garlic and <i>Khardal</i> (<i>Brassica nigra</i> L.)¹⁴ • Intake of spicy and seasoned food¹⁴ • Intake of sour food³⁷ • Intake of wine¹³ • Local application of <i>Mu'affināt</i> (things causing putrefaction), highly potent <i>Mubarridāt</i> (coolants), highly potent <i>Qābiḍāt</i> (astringents), highly potent <i>Muḥallilāt</i> (resolvents), soap and warm water¹⁴ • Exposure to sunlight¹⁴ • Exposure to extreme climates¹⁴

Yoga:³⁸ Dermatitis is a multifactorial condition influenced by immune dysregulation and psychosocial stress, where stress aggravates inflammation, elevates pro-inflammatory cytokines (e.g., IL-6, TNF-α), and delays skin healing. From a yogic standpoint, it reflects an imbalance at both physiological and psychological levels. Yoga offers a holistic, evidence-based approach by reducing stress and modulating neuroendocrine function through practices like *Dhyana* and *Yoga Nidra*, which help lower cortisol levels. *Pranayama* techniques such as *Nadi Shodhana* and *Bhramari* improve autonomic balance and reduce systemic inflammation. Additionally, *Asanas* like *Tadasana*, *Trikonasana*, *Padahastana*, *Ardachakrasana*, *Bhujangasana*, *Setu Bandhasana* enhance circulation and support skin repair. Collectively, yoga exerts anti-inflammatory and immunomodulatory effects, while improving psychological well-being and quality of life. Thus, it serves as an effective complementary therapy alongside conventional medical management of dermatitis.

(B) Interventions

At Level 1: - (Where the Optimal standard of treatment in a situation where technology and resources are limited e.g. Solo Physician clinic/Community wellness centres/PHC)

Clinical Diagnosis:

The diagnosis of Dermatitis is primarily based on clinical signs and symptoms, however, the following investigations may be done to assess severity of inflammation or exclude other diagnosis:^{3,6,9}

- ✓ Complete Haemogram
- ✓ Skin scraping with KOH

- ✓ Assessment of severity by different assessment tools such as SCORAD, ADSI, SASSAD, DLQI.

Unani Medicine's Perspective

Management:

OPD level management – If the patient shows mild features of *Nār Fārsī*, two or more of the following medications may be given along with diet restriction:

Table 7: Single drugs/Compound formulations for internal use

S.No.	Drug	Dosage form	Dose (perday)	Time of administration	Duration and Frequency	Badraqa (vehicle)	Precaution/ Contraindication
1.	<i>Shāhitra</i> (<i>Fumaria parviflora</i> Lam.) ^{17, 40}	Decoction	100 ml	As directed by the physician	As directed by the physician	-	NS
2.	' <i>Unnāb</i> (<i>Ziziphus jujuba</i> Mill.) ¹⁷	Decoction	100 ml	As directed by the physician	7 - 15 days	Nil	NS
3.	<i>Tamar Hindī</i> (<i>Tamarindus indica</i> L.) ¹⁴	Decanted water of pulp	60 to 80 ml in two divided doses	As directed by the physician	7 - 15 days	Nil	NS
4.	<i>Biṭṭikh Hindī</i> (<i>Citrullus lanatus</i> (Thunb.) Matsum. & Nakai) ¹⁴	Juice	60 to 80 ml. in two divided doses	As directed by the physician	7 - 15 days	Nil	NS
5.	<i>Khayār</i> (<i>Cucumis sativus</i> L.) ¹⁴	Juice	60 to 80 ml. in two divided doses	As directed by the physician	7 - 15 days	Nil	NS
6.	<i>Sharbat-i-Chobchīn</i> ³⁹	Liquid	24-48 ml	As directed by the physician	As directed by the physician	-	Diabetes Mellitus
7.	<i>Ma'jūn-i-'Ushba</i> ⁴⁰	Semisolid	10 g in the morning	As directed by the physician	As directed by the physician	' <i>Araq-i-'Ushba</i> 72 ml	Diabetes Mellitus
8.	<i>Ḥabb Muṣaffī-i-Khūn</i> ⁴¹	Pills	500 mg-1 g in the morning	As directed by the physician	As directed by the physician	Water	NS

Table 8: Single drugs/Compound formulations for external use

Sr. No.	Drug	Dosageform	Dose (perday)	Time of administration	Duration and Frequency
1.	<i>Gil Armanī</i> (Armenian earth) mixed with vinegar and water ¹⁴	Paste	q. s. / for external use	As directed by the physician	7 - 15 days
2.	<i>Lu'āb-i-Bazr-i Qaṭūnā</i> (Mucilage of seed of <i>Plantago ovata</i> Forssk.) ¹⁴	Mucilage obtained after soaking in water	q. s. / for external use	As directed by the physician	7 - 15 days
3.	<i>Lu'āb-i-Bārtang</i> (Mucilage of <i>Plantago major</i> L.) ¹⁴	Mucilage	q. s. / for external use	As directed by the physician	7 - 15 days

Note: Out of the drugs mentioned above, any one or a combination of two or more may be prescribed by the physician. '*Ilāj bi'l Tadbīr* (Regimenal therapy) described under principles of management may be recommended as per assessment of physician about the condition of the patient and stage of disease. The duration of the treatment may vary from patient to patient. The physician should decide the dosage and duration of the therapy based on the clinical findings and response to the therapy.

Recommended and restricted diet & lifestyle: Same as described under preventive management

Follow up (with duration)- 1st Follow-up on 7th day followed by 2nd follow-up on the 15th day.

Reviews should include:^{3,4,6,8}

During follow-up of patients with dermatitis, these key areas should be systematically assessed:

- Monitor lesion count, sleep quality, and mental well-being
- **Symptom control:** Intensity and frequency of pruritus, changes in extent or severity of lesions.
- **Lesion morphology:** Any reduction in erythema, scaling, oozing, or lichenification, or appearance of new lesions.
- **Signs of infection:** Presence of crusting, pustules, warmth, or lymphadenopathy suggesting secondary bacterial infection.
- **Impact on quality of life:** Sleep disturbances due to itching, limitations in daily activities, emotional or psychological stress.

- **Adherence to avoidance measures and skin care:** Proper moisturization, avoidance of known triggers or allergens.
- **Need for adjusting treatment:** Whether acute flares need new medicine.

Referral Criteria:

- Lack of clinical improvement after 4-6 weeks of individualized treatment
- Extensive skin involvement (>30% BSA), especially in children or elderly.
- Severe pruritus leading to sleep disturbance or psychological distress.
- Severe pain with burning or stinging sensation.
- Secondary infection suspected due to oozing, crusting, fever, or lymphadenopathy.
- Diagnostic uncertainty (e.g., differential diagnosis from psoriasis, seborrheic dermatitis, scabies).
- Evidence of an increase in severity/complications.
- Coexisting systemic diseases (diabetes, hypothyroidism, renal impairment) affecting skin healing.
- Recurrent relapses despite compliance with therapy.
- Suspected allergic etiology needing patch testing or further evaluation.
- Substantial impact on their quality of life and activities of daily living

At Level 2: [CHC/SHCO (10-20 bedded hospital) with basic facilities and routine investigations]

Clinical Diagnosis: Same as level 1. The case referred from Level 1, or a fresh case must be evaluated thoroughly for any complications. Some investigations which may be necessary to investigate complications or exclude other differential diagnoses are as follows:^{3,6,9}

- Serum IgE

Management: Same as level 1 and/or treatments mentioned at this level. At this level, the patient may preferably be treated in indoor department.

Note: Treatment at this level may be started with *Hijāma* (cupping)¹³/*Faşd* (venesection)¹³ followed by oral administration of two formulations (*Nuqū'-i-Shāhitra* and *Maṭbūkh-i-Halayla*) given in Table 11 as per the following instructions:

- (A) oral administration of *Nuqū'-i-Shāhitra*³⁹ for a few days (as decided by the physician after assessment of the severity and chronicity of the morbid condition)¹⁵ followed by *Tanqiya* (evacuation of morbid matter) by *Matbukh-i-Halayla*.¹³

Table 9: Single drugs and compound formulations for internal use

Sr. No.	Single herb/ Compound Drugs	Dosage form	Dose per day	Time	Duration & Frequency	<i>Badraqa</i> (vehicle)	Precaution/ Contraindication
1.	<i>Sarphuka</i> (<i>Tephrosia</i> <i>purpurea</i> (L.) Pers.) ¹⁷	Decoction	100 ml	As directed by the physician	7 - 15 days	Nil	NS
2.	<i>Chirā'ita</i> (<i>Swertia</i> <i>chirayita</i> (Roxb.) H. Karst. ^{17, 40}	Decoction	100 ml	As directed by the physician	As directed by the physician	-	NS

Sr. No.	Single herb/ Compound Drugs	Dosage form	Dose per day	Time	Duration & Frequency	Badraqa (vehicle)	Precaution/ Contraindication
3.	<i>Gul-i-Mundī</i> (<i>Sphaeranthus indicus</i> L.) ¹⁷	Decoction	100 ml	As directed by the physician	As directed by the physician	-	NS
4.	<i>Sharbat-i-'Unnāb</i> ⁴¹	Liquid	48 ml in the morning	As directed by the physician	As directed by the physician	Water	Diabetes Mellitus
5.	<i>'Araq-i-Shāhitra</i> ⁴¹	Liquid	60-144 ml	As directed by the physician	As directed by the physician	-	NS
6.	<i>Sharbat Murakkab Muşaffī-i-Khūn</i> ⁴¹	Liquid	48 ml in the morning	As directed by the physician	As directed by the physician	Water	Diabetes Mellitus
7.	<i>'Araq-i-Shāhitra Murakkab</i> ³⁹	Liquid	72 ml	Morning at empty stomach	40 days	-	NS
8.	<i>'Araq-i-Mundī</i> ⁴¹	Liquid	72 ml in the morning	As directed by the physician	As directed by the physician	<i>Sharbat-i-'Unnāb</i> 24 ml	Diabetes Mellitus

Table 10: Single drugs/Compound formulations for external use

Sr. No.	Formulation	Dosage form	Dose per day	Time	Duration & Frequency	Precaution/ Contraindication
1.	<i>Kamīla</i> (<i>Mallotus philippensis</i> (Lam.) Muell. Arg.) 3g, <i>Murdār Sang</i> (Litharge) 3 g, <i>Kāfūr</i> (camphor) 3 g, <i>Şandal</i> (<i>Santalum album</i> L.) 3 g, Mixed with 24 ml of rose water ³⁷ .	paste	q. s. / for external use	As directed by the physician	As directed by the physician	NS
2.	<i>Isfīdāj</i> (Zinc oxide), <i>Murdār Sang</i> (Litharge), <i>Şandal Safaid</i> (<i>Santalum album</i> L.) and <i>Kāfūr</i> (Camphor) mixed with rose water ¹³ .	Paste	q. s. / for external use	As directed by the physician	As directed by the physician	NS
3.	<i>Rasavt</i> (<i>Berberis aristata</i> DC), <i>Kāfūr</i> (camphor), <i>Zard Chob</i> (turmeric) mixed with expressed juice of chicory plant ¹³ .	Liniment	q. s. / for external use	Morning and night	As directed by the physician	NS

Table 11 : Management with *Mundij wa Mushil* therapy [MM Therapy] (concoctive and purgative therapy)

Sr. No.	Formulation	Dosage form	Dose	Time	Duration	Badarqa (vehicle)	Precaution/Contraindication
1.	<i>Nuqū'-i-Shāhitra</i> ³⁹ • <i>Shāhitra</i> (<i>Fumaria parviflora</i> Lam.) 7 g, • <i>Chirayita</i> (Roxb.) H. Karst. 7 g, • <i>Sarphuka</i> (<i>Tephrosia purpurea</i> (L.) Pers.) 7 g, • <i>Mundī</i> (<i>Sphaeranthus indicus</i> L.) 7 g, • 'Unnāb (<i>Ziziphus jujuba</i> Mill.) 5 No., • <i>Halayla Siyāh</i> (<i>Terminalia chebula</i> Retz.) 7 g, • <i>Şandal Surkh</i> (<i>Pterocarpus santalinus</i> L.f.).	Concoction [The drugs are soaked in hot water for overnight. In the morning, it is filtered and the liquid thus separated is taken orally with 48 ml of <i>Sharbat-i-'Unnāb</i> .]	100 ml	Morning before meal	14 days	<i>Sharbat-i-'Unnāb</i>	Pregnancy, Diabetes Mellitus
2	<i>Maṭbūkh-i-Halayla</i> ¹⁴ • <i>Post-i-Halayla Kābulī</i> (<i>Terminalia chebula</i> Retz., fruit rind) 36 g, • <i>Shāhitra</i> (<i>Fumaria parviflora</i> Lam.) 24 g, • <i>Tukhm-i-Kasūs</i> (<i>Cuscuta reflexa</i> Roxb. seed) 10 g, • <i>Tukhm-i-Kāsnī</i> (<i>Cichorium intybus</i> L. seed) 10 g, • <i>Post-i-Bekh-i-Bādiyān</i> (<i>Foeniculum vulgare</i> Mill., root bark) 7 g, • <i>Ālū Bukhāra</i> (<i>Prunus domestica</i> L. fruit) 20 pieces and • 'Unnāb (<i>Ziziphus jujuba</i> Mill., fruit) 20 pieces	Decoction mixed with <i>Maghz-i-Amaltās</i> (Fruit pulp of <i>Cassia fistula</i> L.) 54 gm.	100 ml	Morning before meal	2-3 days	Water	Pregnancy

Note: Out of the drugs mentioned above, any one or a combination of two or more may be prescribed by the physician. *'Ilāj bi'l Tadbīr* (Regimenal therapy) described under principles of management may be recommended as per assessment of physician about the condition of the patient and stage of disease. The duration of the treatment may vary from patient to patient. The physician should decide the dosage and duration of the therapy based on the clinical findings and response to the therapy.

Recommended and restricted diet & lifestyle: Same as described under preventive management

Follow-up (with duration):

The follow-up may be done once a week. The patients who are responding well may be treated for at least 3 months or as per clinical requirement.

Referral criteria:

The following cases may be referred:

- Same as mentioned earlier at level 1, plus
- Non-response to treatment after 4–6 weeks of individualized therapy.
- Complicated or severe forms (e.g., eczema herpeticum, generalized erythroderma)
- Presence of psychological disturbance (e.g., anxiety, depression due to disfigurement)
- Immunocompromised states (e.g., HIV, chemotherapy) complicating presentation.
- Referral if lesions are widespread, unresponsive, or infected.
- Autoimmune disorders with cutaneous overlap (e.g., SLE, celiac disease).
- Need for multi-disciplinary care (e.g., dermatology, allergology, psychiatry).
- Any other complications that threaten the life of the patient.

At Level 3: (Ayush hospitals attached with teaching institutions/ Ayush research institutions having indoor facility/ District level/ state level Ayush hospitals/ Tertiary care Allopathic hospitals having Ayush facilities)

Clinical Diagnosis^{3,9,11}: Same as levels 1 & 2. Confirm diagnosis and severity with the help of investigations such as

- Detailed evaluation: Skin biopsy
- Peripheral blood eosinophil count
- Patch test (for allergic contact dermatitis)

Management: Same as level 2 and/or treatments mentioned at this level. At this level, the patient may preferably be treated in indoor department.

Note: Similar to level 2, treatment at level 3 may begin with *Hijāma* (cupping)¹³/*Faşd* (venesection)¹³ followed by oral administration of two formulations (*Nuqū'-i-Shāhitra* and *Maṭbūkh-i-Halayla*) given under Table 11 as per the following instructions:

- (A) oral administration of *Nuqū'-i-Shāhitra*³⁹ for a few days (as decided by the physician after assessment of the severity and chronicity of the morbid condition)¹⁵ followed by *Tanqiya* (evacuation of morbid matter) by *Matbukh-i-Halayla*.¹³

Detail of *Munḍij-o-Mushil* therapy [MM Therapy] (concoctive and purgative therapy) through *Nuqū'-i-Shāhitra* and *Maṭbūkh-i-Halayla* has been provided at level 2 under Table No. 11.

Table No. 12 : Unani formulations for internal use

Sr. No.	Single herb/ Compound Drugs	Dosage form	Dose per day	Time	Duration & Frequency	Badraqa (vehicle)	Precaution/ Contraindication
1	<i>Ma'jūn-i-Chobchīnī</i> ³⁷	Semisolid	7 g	Morning	As directed by the physician	<i>Sharbat-i-'Unnāb</i> 24 ml and <i>'Araq-i-'Ushba</i> 144 ml	Diabetes Mellitus
	<i>Itṛīfal-i-Shāhītra</i> ³⁷	Semisolid	7 g	Night	As directed by the physician	<i>'Araq-i-Chobchīnī</i> 144 ml	
2	<i>'Araq-i-'Ushba</i> ⁴¹	Liquid	60-120 ml	As directed by the physician	As directed by the physician	<i>Sharbat-i-'Unnāb</i> 48 ml	Diabetes Mellitus
3	<i>'Araq-i-'Unnāb</i> ⁴¹	Liquid	60-144 ml	As directed by the physician	As directed by the physician	-	NS
4	<i>Araq Murakkab Muṣaffī-i-Khūn ba Nuskha Kalān</i> ⁴¹	Liquid	144 ml (morning)	As directed by the physician	As directed by the physician	<i>Sharbat-i-'Unnāb</i> 48 ml	Diabetes Mellitus
5	<i>'Araq-i-Chobchīnī</i> ⁷⁴¹	Liquid	144 ml	As directed by the physician	As directed by the physician	-	NS

Table No. 13 : Single drugs/Compound formulations for external use

Sr. No.	Formulation	Dosage form	Dose per day	Time	Duration & Frequency	Precaution/ Contraindication
1	<i>Gil Armanī</i> (Armenian earth) mixed with water and vinegar ¹³	Liniment	q. s. / for external use	As directed by physician	As directed by physician	NS
2	<i>Māzū</i> (<i>Quercus infectoria</i> G. Olivier) mixed with vinegar ¹⁵	Paste	q. s. / for external use	As directed by physician	As directed by physician	NS
3	<i>Rasavt</i> (<i>Berberis aristata</i> DC.) 1 part, <i>Kāfūr</i> (camphor) 1 part, mixed with <i>Lu'āb-l Bazr-l Qaṭūnā</i> (Mucilage of seed of <i>Plantago ovata</i> Forssk.) and <i>Lu'āb-i Bārtang</i> (Mucilage of <i>Plantago major</i> L.) ¹⁵	Liniment	q. s. / for external use. Note: It may be used as <i>Kimād</i> (fomentation); a piece of cloth is soaked with this liniment and kept over the affected part repeatedly	As directed by physician	As directed by physician	NS

Sr. No.	Formulation	Dosage form	Dose per day	Time	Duration & Frequency	Precaution/Contraindication
4	<i>Marham Safayda Kāfūrī</i> ³⁷	Semisolid	q. s. / for external use	As directed by physician	As directed by physician	NS
5	<i>Marham-i-Isfīdāj</i> ¹³	Semisolid	q. s. / for external use	As directed by physician	As directed by physician	NS

Table 14: Research Formulations of CCRUM for oral and local administration in Dermatitis

Sr. No.	Drug	Dosage form	Dose (per day)	Time of administration	Duration / Adjuvant Frequency		Precautions/ contraindications
1	UNIM-401	Infusion (prepared by soaking in water overnight) for oral use	17gm	Morning on empty stomach	OD	Nil	Nothing specific (NS)
	UNIM-402	Oil for local application	as required			-	
2	UNIM-401	Infusion (prepared by soaking in water overnight) for oral use	17gm	Morning on empty stomach	OD	Nil	NS
	UNIM-403	Oil for local application	as required			-	

Note: Out of the drugs mentioned above, any one or a combination of two or more may be prescribed by the physician. *'Ilāj bi'l Tadbīr* (Regimenal therapy) described under principles of management may be recommended as per assessment of physician about the condition of the patient and stage of disease. The duration of the treatment may vary from patient to patient. The physician should decide the dosage and duration of the therapy based on the clinical findings and response to the therapy.

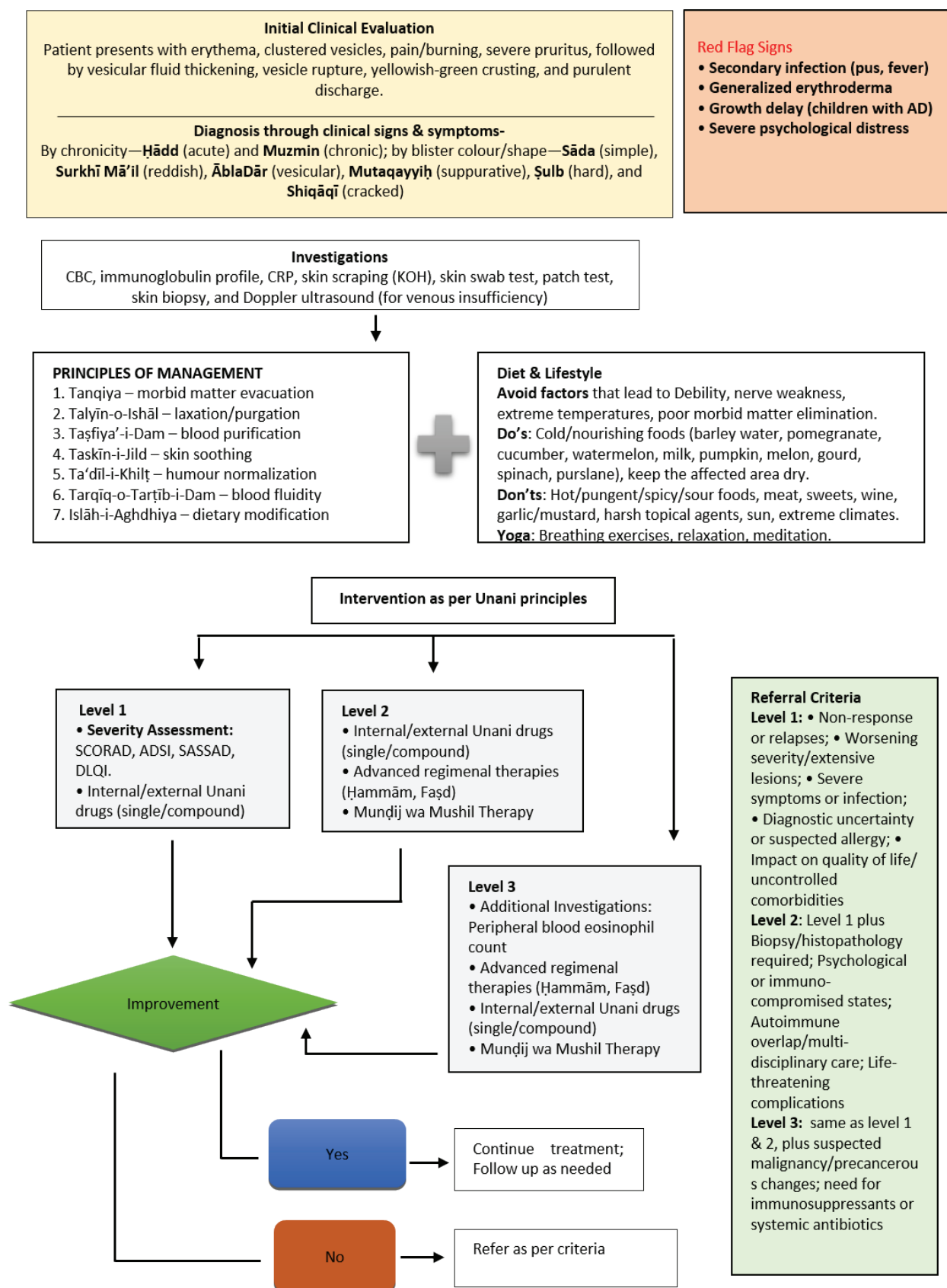
Recommended and restricted diet & lifestyle: Same as described under preventive management.

Follow-up (with duration):

The follow-up may be done once a week. The patients, who are responding well, may be treated for at least 3 months or as per clinical requirement.

Referral criteria:

- Same as mentioned earlier at level 2, plus
- Life-threatening complications, e.g., sepsis from superimposed infection.
- Treatment-refractory cases unresponsive to Unani and supportive therapy.
- Severe psychological morbidity needing inpatient psychiatric care.
- Integrated approach for cases with psychiatric distress or systemic complications.
- Uncontrolled immunosuppressive complications such as infections like *Staphylococcus aureus*, eczema herpeticum (HSV), and molluscum, ocular complications such as cataracts and keratoconus, telangiectasia, and acneiform eruptions, hypertension and nephrotoxicity, etc.
- Suspicion of malignancy or precancerous skin changes (e.g., cutaneous T-cell lymphoma)
- Requirement of immunosuppressants or systemic antibiotics.
- Other modalities can be considered depending on the case.

ALGORITHM FOR CLINICAL ASSESSMENT AND MANAGEMENT OF DERMATITIS (*NĀR FĀRSĪ*)

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02

DERMATOPHYTOSIS (*Qūbā*)



DERMATOPHYTOSIS

Qūbā

(ICD-11: 1F28)¹

Qūbā (Ring worm / Dermatophytosis) (**NUMC:** J-54)²

CASE DEFINITION

Superficial infection caused by a dermatophyte is known as dermatophytosis or ringworm. This term is a misnomer because worms are not involved³. "Dermatophytosis", the Latin name for worm, describes the serpentine appearance of the skin lesions⁴.

Unani medicine's perspective:

According to Unani medicine, "Qūbā (also referred to as *Dād*) is described as a cutaneous condition marked by dryness of the skin, which may clinically manifest as either hyperpigmented or erythematous patches. The underlying pathogenesis is attributed to the pathological admixture of *Ghalīz Sawdā'* (viscid black bile) with *Dam* (sanguine) that is both excessively *Hādd* (acid) and *Laṭīf* (highly diffusible). In some cases, the condition is linked to the presence of *Balgham Shor* (saline phlegm) and burnt *Ghalīz khilt* (viscid humour) circulating within the vessels".^{5,6}

INTRODUCTION (*Incidence/Prevalence /morbidity/mortality/risk factors*)

- Dermatophytes (keratinophilic fungi) are the most common cutaneous fungal infections seen in humans affecting skin, hairs and nails with a considerable morbidity.⁷
- According to World Health Organization (WHO), the prevalence rate of superficial mycotic infection worldwide has been found to be 20-25%.
- Its prevalence varies in different countries. It is more prevalent in tropical and subtropical countries like India where the heat and humidity are high for most part of the year.^{8,9} Community - based surveys and dermatology outpatient data show 20-30% prevalence, especially in humid regions. In some areas, up to 50-60% of dermatology OPD cases are due to dermatophytosis.
- An epidemic of recalcitrant dermatophyte infection has engulfed India and many parts of the world and the species that is dominant has been controversially named as *Trichophyton indotinae*.¹⁰ This is resistant to many front-line drugs. This has led to an alteration in the immunity.¹¹ A National Task force was formed which details the cause of recalcitrant infection as below. Notably steroid abuse has led to varied forms of dermatophytosis classically *Tinea incognito* and *Majocchi* variant which do not respond to conventional agents.

Factors implicated in recalcitrant dermatophytosis¹²

Clinical type of dermatophytosis

Fungal species- *Trichophyton Indotinae*

Host Immunity Resistance

- The new species *Trichophyton indotinae* has unique mechanisms of resistance and is fast becoming the most dominant variety of dermatophytosis in India
- Chronic and recurrent cases have increased significantly in the last 5-10 years due to overuse of topical steroids and antifungal creams which have made them resistant to common antifungal drugs.
- Dermatophytosis is not life threatening, but it causes severe itching and discomfort, social embarrassment and stigma, sleep disturbances, work absenteeism and reduced productivity.
- Study using DLQI (Dermatology Life Quality Index) shows moderate to severe impact on quality of life in 40-60% of chronic / recurrent cases. Psychological stress, anxiety and low self-esteem are common.^{13,14}

Unani Medicine's perspective: (Classification, Etiology and Pathology)

Classification

Qūbā is classified according to the dominant deranged humour involved in its pathogenesis.

- *Qūbā Damawī* (Sanguineous type): *Qūbā Damawī* attributed to *Fasād al-Dam* (Vitiated blood) and *Ruṭūbat-i- Fāsida* (Putrefied humours), and presents with erythematous lesions.
- *Qūbā Sawdāwī* (Black biliary type): results from the pathological burning of humours into black bile (*Sawdā'*), typically manifesting as hyperpigmented skin changes.

Qūbā Ruṭūbī (Moist type): *Qūbā Ruṭūbī* arises from disturbances in fluid metabolism, increased *Harārat* (internal heat), and associated *Ufūnat* (infection), and appears as hypopigmented patches.^{15,16}

Based on causative factors, clinical pattern, and appearance, *Qūbā* is classified into the following types:

- ***Qūbā Ratb Damawī***: Itching with slight oozing; easily curable.
- ***Qūbā Yābis***: Caused by *Sawdā'* resulting from the metabolism of *Balgham Shor* and *Ihtirāq* (combustion) of *Balgham Māliḥ* (saline phlegm).
- ***Qūbā Mutaqashshir***: Resembles *Baraṣ Aswad*; marked by excessive dryness and scaling.
- ***Qūbā Ghayr Mutaqashshir***: Does not involve scaling.
- ***Qūbā Sā'i***: Spreading type; not easily curable.
- ***Qūbā Wāqif***: Always remains localized.
- ***Qūbā Hadīth***: Acute condition with short duration; easily curable.
- ***Qūbā Radī***: Has a poor prognosis.¹⁷

Etiology

- *Khilṭ Radī* (Morbid humour) is considered the primary cause of *Qūbā*.
- Morbid humour is of two types: *Khilṭ Ḥādd* or *Raqīq* (acrid or thin) and *Khilṭ Ghalīz* or *Sawdāwī* (thick or melancholic)

- An excess of *Khilt Sawdāwī* (black bile) in the blood, often due to the transformation of blood into black bile.
- A mixture of *Khilt Sawdāwī Ghaliz* (thick black bile) and *Balgham Māliḥ* (saline phlegm) is also believed to contribute to the development of *Qūbā*^{17,18,19}

Pathology

Qūbā is characterized as a superficial dermatological condition exhibiting centrifugal spread over the skin surface. It is caused due to *Fasād-i-Ruṭūbat* (Vitiated body fluids / humours) and due to increased *Hiddat* (acridity) of *Khilt Sawdā'* (black bile). This derangement is believed to impair the normal metabolism of blood, allowing pathological substances to accumulate and penetrate the smaller cutaneous vessels. The natural faculty, known as *Quwwat Ṭabī' iyya*, safeguards the vital organs by diverting harmful humours toward the surface of the skin, thereby leading to the manifestation of *Qūbā*.

Following the rupture of local fine vessels, the pathological matter extravasates onto the skin surface, giving rise to annular lesions. The annular configuration is attributed to the continuous leakage of the causative humour from the ruptured vessels, a process exacerbated by the *Ghilza wa Lazūjat* (high viscosity and concentration) of the substance.

Clinically, the lesion initially presents as a small dot and expands in a centrifugal manner, preferentially affecting smooth skin areas. When blood metabolism is disrupted by *Ghalīẓ Ruṭūbat* (viscid humour), which is excessively hot and irritant in nature, it results in intense pruritus. Additionally, if *Burūdat* (coldness) is associated the same humour, the pathognomonic lesions of *Qūbā* are formed.^{17,18,19,20}

CLINICAL PRESENTATION^{21,22,23}

a) Typical Lesion-

- A typical lesion of dermatophytosis is an annular or arcuate plaque which spreads centrifugally (away from the centre).
- The edge is active, showing papulo-vesiculation, pustulation and scaling, while the centre is usually relatively clear.
- In chronic lesion there may be nodules, hyperpigmentation and even lichenification (thickening, hyperpigmentation and increased skin markings) in the centre.
- In India due to steroid abuse altered morphologies including *Tinea incognito* and *Majocchi Granuloma* are seen. Fig 1



Figure 1: Follicular papules in a lesion of tinea corporis seen in Majocchi Granuloma

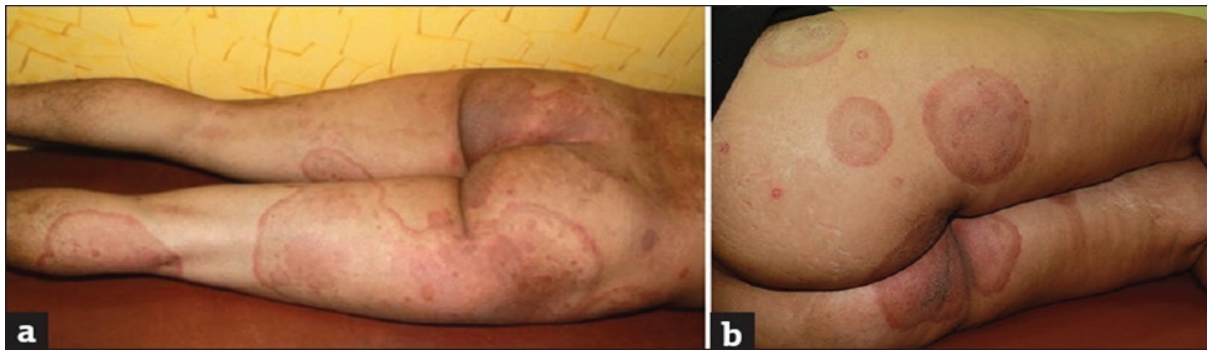


Figure 2:(a & b) Large sized, erythematous patches with active border over the gluteal regions and legs. (Figure 1 & 2: Courtesy: Verma et al. Indian J Dermatol 2017; 62:227-36)

- b) As *T. indotinae* has become a dominant cause of dermatophytosis Tinea corporis. Specific features of this variant are now well described and are listed in the Table below.
- c) **Asymptomatic dermatophytosis carrier**- are defined as individuals in which dermatophytes are identified, even though no clinical signs are observed. Anthropophilic species adapt more easily to the host and induce a weaker immune response.
- d) **Sites of Infection**- on the basis of site of infection, can present as Tinea corporis (body); Tinea cruris (groin); Tinea capitis (scalp); Tinea pedis (feet); Tinea manuum (hands); Tinea unguium (nails); Tinea barbae (bearded area)

CLINICAL EXAMINATION ¹⁴

A thorough clinical examination helps to diagnose, classify and differentiate from other dermatoses.

1. **General Inspection includes** Observation of site(s) of infection, number, size and distribution of lesion. Common sites include groin, axillae, trunk, face, feet, hands, nails, scalp. Ask about onset, progression, recurrence, family history and steroid/antifungal use.
2. **Local Examination (Table 1)**

Features	Description
Shape	Annular (ring like), circular/oval.
Border	Well defined, raised, erythematous, active margin.
Colour	Redness.
Distribution	Examine the location and extent of lesions
Centre	May appear normal or hypopigmented.
Scaling	Present especially at margin.
Itching	Usually intense pruritus, especially at night.
Coalescence	Lesion may merge into each other in long standing cases.
Lichenification	In chronic steroid modified cases.
Inflammation	Degree of inflammation (redness, swelling)

3. Region Specific Examination (Table 2)

Type	Clinical Sign
Tinea corporis (body)	Ringworm lesion on trunk/limbs, raised scaly borders, presents as circumscribed lesions with a wide variety of appearances, including scales, vesicles, and pustules.
Tinea cruris (groin)	Red itchy rash in groin/thighs, often bilateral.
Tinea capitis (scalp)	Patchy hair loss, inflammation, black dots, scaling, boggy swellings (kerion), broken hair.
Tinea pedis (feet)	Scaling, fissures between toes, moccasin – type dryness, cracked skin between toes (itching and inflammation).
Tinea manuum (hands)	Typically involves one hand, dry scaling, hyperkeratosis or blistering.
Tinea unguium (nails)	Thickened, brittle, discoloured nails, onycholysis.
Tinea faciei (face)	Erythematous plaques, often aggravated by sun or steroids.
Tinea barbae (bearded area)	Dermatophytosis of the bearded area, appears as a pustular folliculitis.

Table 3: DIFFERENTIAL DIAGNOSIS ^{24,25}

Differential diagnosis	Distinguishing features
Tinea corporis (annular lesions with well-defined, scaly, often reddish margins; commonly pruritic)	
Annular psoriasis	Gray or silver scale; nail pitting; 5-10% of affected individuals have family history of psoriasis ⁴
Atopic dermatitis	Personal or family history of atopy; less likely to have active border with central clearing; lesions may be lichenified.
Erythema multiforme	Target lesions; acute onset; no scale; may have oral lesions.
Fixed drug eruption	Dusky; erythematous; usually single, non-scaly lesion; most often triggered by sulfa, acetaminophen, ibuprofen, or antibiotic use.
Granuloma annulare	No scale, vesicles, or pustules; nonpruritic; smooth; commonly on dorsum of hands or feet.
Lupus erythematosus (sub-acute cutaneous)	Sun-exposed areas; multiple annular atrophied lesions; female-to-male ratio 3:1 ²
Nummular eczema	More confluent scale; less likely to have central clearing. Mostly situated on the extensor surface of extremities.
Pityriasis rosea herald patch	Typically, an adolescent with a single lesion on neck, trunk, or proximal extremity; pruritus of herald patch is less common; progression to generalized rash in one to three weeks.
Seborrheic dermatitis	Greasy scale on erythematous base with typical distribution involving nasolabial folds, hairline, eyebrows, postauricular folds, chest; annular lesions less common.

Differential diagnosis	Distinguishing features
Secondary syphilis	It may present with annular lesions, but also involves other areas like palms, soles and mucous membranes.
Tinea cruris (usually occurs in male adolescents and young men; spares scrotum and penis)	
Candidal intertrigo	Involves scrotum; satellite lesions; uniformly red without central clearing.
Erythrasma	It is a bacterial infection presenting as red-brown patches without an active border, showing coral-red fluorescence under Wood's lamp examination.
Inverse psoriasis	Red and sharply demarcated; may have other signs of psoriasis such as nail pitting.
Seborrheic dermatitis	Greasy scale on erythematous base with typical distribution involving nasolabial folds, hairline, eyebrows, postauricular folds, chest; annular lesions less common.
Lichen simplex chronicus	Thickened itchy skin due to chronic scratching.
Contact dermatitis	It can cause similar itching and redness in the groin area.
Tinea pedis (Erythema, scale, fissures, maceration; itching between toes extending to sole, borders, and occasionally dorsum of foot; may be accompanied by dermatophytosis manuum ["one-hand, two-feet" involvement] or onychomycosis)	
Contact dermatitis	Distribution may match footwear; usually spares interdigital skin.
Dyshidrotic eczema	"Tapioca pudding" vesicles on lateral aspects of digits; often involves hands.
Foot eczema	May have atopic history; usually spares interdigital skin.
Juvenile plantar dermatosis	Shiny taut skin involving great toe, ball of foot, and heel; usually spares interdigital skin.
Psoriasis	Involvement of other sites; grey or silver scale; nail pitting; 5-10% of affected children have family history of psoriasis ⁴ .
Tinea capitis (one or more patches of alopecia, scale, erythema, pustules, tenderness, pruritus, with cervical and suboccipital lymphadenopathy)	
Alopecia areata	Discrete patches of hair loss with no epidermal changes (i.e., no scale); total loss of hair or fine miniature hair growth; exclamation point hairs; no crusting; no inflammation; possible nail pitting.
Systemic lupus erythematosus (SLE)	It can affect the scalp causing hair loss and inflammation.
Atopic dermatitis	Personal history or family history of atopy; less often annular; lymphadenopathy uncommon; alopecia less common.
Bacterial scalp abscess	Alopecia less likely; hair pluck is painful.
Psoriasis	Gray or silver scale; nail pitting; 70% of affected children have family history of psoriasis ⁴ ; involvement of other sites.

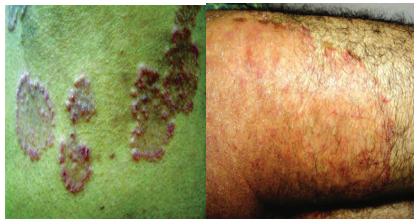
Differential diagnosis	Distinguishing features
Seborrheic dermatitis	Alopecia uncommon; lymphadenopathy uncommon; greasy scale; typical distribution involving nasolabial folds, hairline, eyebrows, postauricular folds, chest.
Trichotillomania	No scale; commonly involves eyelashes and eyebrows; hairs of varying lengths.
Tinea unguium (Onychomycosis) (discoloured [white, yellow, brown], thickened nail with subungual keratinous debris and possible nail detachment; often starting with great toe but can involve any nail)	
Other nail dystrophies, most commonly associated with repeated low-grade trauma, psoriasis, or lichen planus	Appearance can be indistinguishable from onychomycosis; may have other manifestations of alternate diagnosis
Pityriasis versicolor, is a frequent, benign, superficial fungal infection of the skin. It belongs to Malassezia-related diseases. Clinical features of pityriasis versicolor include either hyperpigmented or hypopigmented finely scaly macules. The most frequently affected sites are the trunk, neck, and proximal extremities²⁶	

Table 4: SUPPORTIVE INVESTIGATIONS^{27,28}

Test	Description
Essential	
Potassium hydroxide (KOH) Scraping- Simple, inexpensive, quick and sensitive test.	a) Interpretation of KOH mount.
	T. capitis Branching hyphae. Spores within or around the hair.
	T. cruris Branching hyphae.
	T. corporis Branching hyphae.
Advanced	
Cultures	Cultures need to be done when clinical suspicion is strong and KOH mount is negative or when it is necessary to identify the fungal species, Sabouraud dextrose agar medium is used. Microscopic morphology of microconidia & macroconidia, along with surface topography & pigmentation.
Wood's Light	It is useful method of screening outbreaks of T. Capitis in schools. Wood's light fluoresces infected scalp hair in Tinea capitis caused by certain species, not in all, but infected skin does not show fluorescence.
Dermatophyte test medium	Scales from the advancing border, subungual debris or affected hair embedded in the medium.
Histopathology special stains	Periodic acid-Schiff & Grocott's methenamine silver are used. Tissue by skin or nail biopsy are obtained.
Biopsy or Polymerase Chain Reaction (PCR)	They are used to confirm the types and extent of infection.

Table 5: DIAGNOSTIC CRITERIA^{24,28,29}

The diagnosis of dermatophytosis is based on mostly clinical examination.

Type	Description	Image
Tinea corporis/ cruris	Annular or arcuate lesion with periphery showing papulo-vesiculation with itching and scaling.	
Tinea capitis	Pink, scaling itchy patches on the scalp skin and areas of hair loss due to the breakage of hair shafts, round scaling area of alopecia.	
Tinea unguium	Yellowish discolouration of nail plate which may show crumbling or is thickened. Asymmetrical involvement of few nails.	
Tinea pedis	Vesicular, with itchy vesicles occurring on the sides of the feet on a background of erythema., interdigital maceration.	
Tinea manuum	Dull red with silvery scales in the palmar creases.	

(Figures-Courtesy: Khanna N. Illustrated synopsis of dermatology and sexually transmitted diseases. 4th edition; 2011)

Evaluation and Assessment

The Dermatology Life Quality Index (DLQI) is a practical 10-question tool assessing the impact of skin disease on patients' lives, scored from 0 to 30, with higher scores indicating greater impairment.³⁰

The Dermatology-specific Quality of Life (DSQL) instrument measures physical, psychological, and social limitations through 36 items, focusing on disease-specific impacts.³¹

Skindex-16 is a validated 16-item questionnaire scored on a 0–6 Likert scale, evaluating the effects of skin diseases on quality of life, with lower scores indicating better QoL.³²

PRINCIPLES OF MANAGEMENT

Red Flags

These signs should be assessed before initiating treatment to identify cases requiring management/consultation through modern medicine.

- Secondary bacterial infection.
- Intractable alopecia cases causing permanent hair loss in *Tinea capitis*
- Uncontrolled Diabetes-mellitus
- Lower extremity cellulitis in cases of *Tinea pedis*.
- Underlying severe immunodeficiency due to HIV/AIDS.
- Severe wide spread infection causing significant pain or inflammation or eczematization irrespective of treatment.

(A) Preventive Management

Life Style

- Maintaining personal hygiene is essential to prevent the onset and spread of dermatophytosis, especially in warm and humid climates.
- After bathing, patients should thoroughly dry the entire body, paying special attention to skin folds and spaces between the toes.
- Clothing and bedding should be washed in hot water at or above 60°C, followed by sun drying, to effectively eliminate *Trichophyton rubrum* and reduce fungal load.
- Ironing garments post-wash provides an added measure of fungal decontamination.
- Items such as wristbands, threads, cords, straps, and rings should be avoided, as they may harbour fungal spores and contribute to recurrent infections.
- Sharing of personal items—such as clothes, towels, bed linen, and soaps—should be strictly avoided.
- Clothes belonging to infected individuals should be washed and stored separately to prevent cross-contamination.
- Environmental hygiene, including regular mopping and surface cleaning, is necessary to minimize fungal presence in the surroundings.
- Patients should avoid wearing tight-fitting or synthetic garments, as these can trap heat and moisture, promoting fungal proliferation.
- Loose-fitting, breathable cotton clothing is recommended to maintain skin dryness and reduce infection risk.
- Contact with pets should be minimized, as animals can serve as reservoirs of dermatophyte infection.
- Topical or systemic corticosteroids should be avoided, as they may mask symptoms, complicate diagnosis, and result in treatment failure.
- Comorbid conditions can increase susceptibility to chronic or treatment-resistant infections; such cases may require tailored interventions.
- Weight reduction is recommended for obese patients, particularly to prevent recurrent infections in intertriginous areas.

- Regular bathing aids in reducing fungal load by removing infected scales; thorough drying of intertriginous zones post-bath is essential.
- Clothes should be turned inside out and sun-dried to further lower the risk of reinfection.
- Concurrent treatment of infected household members and close contacts is vital to prevent re-exposure and recurrence.^{32,33,34,35}

Yoga^{33,34} practice plays a supportive role by:

- Boosting immunity
- Reducing stress. (which can worsen fungal infection)
- Enhancing blood circulation to the skin.
- Supportive detoxification and hormonal balance.

Yoga can play a supportive role in prevention by enhancing overall immunity and promoting skin health. Regular practice of asanas like *Shavasana*, *Padmasana*, *Sidhasana*, *Makarasana*, and *Suryanamaskara* improves blood circulation and detoxification, helping to maintain healthy skin. *Pranayama* and meditation reduce stress, which is known to lower immunity and increase susceptibility to infections. *Shat kriya* and *yoga nidra* helps in deep relaxation for immune system repair.

Unani Medicine's Perspective

Dietary modification constitutes a significant therapeutic component in Unani medicine. In the management of *Qūbā*, a light and easily digestible diet is recommended.

Foods known to promote the production of *Sawdā'* (black bile) - such as brinjal, lentils, cabbage, colocasia, sour food items, and pungent spices are advised to be strictly avoided.^{15,36}

Table 6: Do's & Don'ts (disease aggravating factors)

Dos	Don'ts (disease aggravating factors)
• Take easily digestible, non-spicy food. • Maintain personal hygiene • Clothing and bedding should be washed in hot water at or above 60°C • Ironing of garments • Environmental hygiene to minimize fungal presence in the surroundings • Regular bathing and thorough drying of intertriginous areas post-bath	• <i>Muawallid-i- Sawdā' Tadābīr</i> (Black bile producing regimens) to be avoided • Avoid intake of spicy, oily food. • Avoid exposure to excess dryness and heat • Avoid sharing of personal items

(B) Interventions

Unani System of Medicine adopts a holistic approach in the treatment of *Qūbā*. *Qūbā* is considered a humoral disorder caused primarily by a derangement in *Khilṭ-e-Sawdā'* (melancholic humour). The general line of treatment as mentioned in classics is as follows:

- *Tanqiya'-i-Badan* (cleansing of morbid matter/humour from body): Treatment begins with the removal of harmful substances from the body using *Mundij Mushil* Therapy. This includes the administration of *Mundij* (concoctive) and *Mushil* (purgative) drugs followed by '*Tabrīd*' therapy

- *Ta'liq al-'Alaq* (leech therapy) may be performed before applying any topical medication.
- Use of *Hammām* (bathing), *Faşd* (venesection), and *Hijāma bi'l-Sharṭ* (wet cupping), is suggested depending on the type of *Qübā*.
- Combined approaches using different therapeutic classes or modalities are also considered.^{6, 17,37,38,39}

At Level 1- Solo Physician Clinic/Health Clinic/PHC (optimal standard of treatment where technology and resources are limited)

Clinical Diagnosis: The diagnosis of Dermatophytosis is primarily clinical and made after physical dermatological examination. However, some investigations, like a complete hemogram, and KOH mount may be done. Assessment according to Dermatology Life Quality Index (DLQI), Dermatology-specific Quality of Life (DSQL), SKINDEX-16.

Management:

Table 7: Single drugs and Compound Unani formulations for internal/external use

Sr. No.	Drug	Dosage form	Dose (per day)	Time of administration	Duration and Frequency	Badraqa (vehicle)	Contraindication
A.	Compound Formulations (Oral)						
1.	<i>Ḥabb-e-Kibreeth sagheer</i> ⁴⁰	Pills	250-500 mg	After meal	7-15 days	Water	Pregnancy
2.	<i>Araq Murakkab Muṣaffī-i-Khūn</i> ⁴¹	Liquid	60-120 ml	After meal	15-30 days	Water	NS
3.	<i>Itṛīfal-i-Shāhitra</i> ^{41,42}	Semisolid	5-10 g	After meal	15-30 days	Water	Diabetes Mellitus
4.	<i>Ma'jūn Chob Chini Ba Nuskha Kalan</i> ⁴³	Semisolid	5-10 g	After meal	15-30 days	Water	Diabetes Mellitus
B.	Compound formulations for local application						
1.	<i>Ḍimād -i-Dād</i> ³⁷	Semisolid	Q.S. for external use	Morning and night	15-30 days		NS
2.	<i>Ḥabb-e- Qübā</i> ⁴⁴	Tablet	Q.S. for external use	Morning and night	15-30 days		NS
3.	<i>Marham-i-Qübā</i> ^{42,43}	Semisolid	Q.S. for external use	Morning and night	15-30 days		NS
4.	<i>Marham-i-Dād</i> ^{15,37}	Semisolid	Q.S. for external use	Morning and night	15-30 days		NS
5.	<i>Rogan-i-Narjeel</i> ⁴⁵	Oil	Q.S. for external use	Morning and night	15-30 days		NS

Sr. No.	Drug	Dosage form	Dose (per day)	Time of administration	Duration and Frequency	Badraqa (vehicle)	Contraindication
C.	Mufrad (single) drugs for oral use						
1.	<i>Kalonji (Nigella sativa L.)</i> ⁴⁶	Seeds Powder	1-2 g	After meal	15-30 days	water	NS
2.	<i>Post-Injeer Dashti (Ficus hispida L.f.)</i> ⁴⁷	Powder	4-6 g	After meal	15-30 days	water	NS
3.	<i>Mundi (Sphaeranthus indicus L.)</i> ⁴²	Decoction	15-20 g	After meal	15-30 days	water	NS

Note: Out of the drugs mentioned above, any one oral combination of two or more may be prescribed by the physician. 'Ilāj bi'l Tadbīr (Regimenal Therapy) described under principles of management may be recommended as per assessment of physician about the condition of the patient and stage of disease. The duration of the treatment may vary from patient to patient. The physician should decide the dosage (per dose) and duration of the therapy based on the clinical findings and response to the therapy.

Other Formulations for local application:

The following drug combinations in suitable forms may be advised:

- *Kharpaza (Cucumis melo L.)*, *Ushna (Dolichousnea longissima (Ach.) Articus)*, *Ārad Bāqlā* (Powder of *Vicia faba L.*) and *Ārad Nakhūd* (Powder of *Cicer arietinum L.*) in the form of paste is applied over the affected area.^{15,38,48}
- Wax, fat of duck and oil are applied topically in the form of *Ṭilā'*.¹⁵
- *Ṭilā'* of *Mazu (Quercus infectoria G. Olivier.)* and vinegar.
- *Ispand (Peganum harmala L.)*, *Kundush (Centipeda minima (L.) A. Braun & Asch.)* and *Turbud (Operculina turpethum (L.) Silva Manso)* are ground and mixed with vinegar.¹⁵
- Local application of paste of *Murdar Sang* (Litharge), *Roghan-i Gul* and vinegar.
- Local application of paste of *Gandhak* (Sulphur), *Behroza (Pinus roxburghii Sarg.)* and vinegar.¹⁶

Recommended and restricted diet & lifestyle—Same as described under preventive management.

Follow up (With duration) –1st follow-up after 15 days, followed by 2nd follow-up on the 30th day

Reviews should include:

- Monitoring the person's symptoms and the ongoing impact of the condition on their everyday activities and quality of life.
- Discussing the person's knowledge of the condition, any concerns they have, their personal preferences, and their ability to access services.
- Reviewing the patient with poor adherence to treatment, reinfection from close contact, drug resistance, misdiagnosis, and infection with uncommon species.

- Reviewing the co-morbidities associated with dermatophytosis.

Referral criteria:

- No response at all within 2-3 weeks of treatment done.
- Uncontrolled comorbidities like diabetes mellitus, hypertension etc.
- Evidence of an increase in severity/complications
- Diagnostic uncertainty.
- Substantial impact on their quality of life and activities of daily living.

At Level 2: [CHC/SHCO (10-20 bedded hospital) with basic facilities and routine investigations

Clinical Diagnosis: Same as Level 1. Any fresh case or referred case from Level 1 shall be evaluated thoroughly for confirmation of diagnosis and complications.

Investigations: The diagnosis would be primarily clinical. However some investigations may be necessary to investigate complications or exclude other differential diagnoses as follows:

- Renal function test.
- Fasting lipids, glucose, and thyroid functions.

Management: Patients referred from Level- 1, may be continued with the same treatment, if appropriate for the presenting complaints. For new patients at this level, the management described in Level- 1, may also be considered while giving prescriptions.

Table 8: Single drugs and compound Unani formulations for internal/external use

Sr. No.	Drug	Dosage form	Dose (per day)	Time of administration	Duration and Frequency	Badraqa (vehicle)	Contraindication
A. Compound Formulations (Oral)							
1.	<i>Iṭrīfal Mundj</i> ^{44,49}	Semisolid	10-20 g	After meal	15-30 days	Water	Diabetes Mellitus
2.	<i>Jawārish Jalinoos</i> ⁵⁰	Semisolid	5-15 g	After meal	15-30 days	Water	Diabetes Mellitus
3.	<i>Ma'jūn Ushba</i> ^{41,42}	Semisolid	5-10 g	After meal	15-30 days	Water	Diabetes Mellitus
4.	<i>Qurş Asfar</i> ⁴²	Tablet	750 mg-1.5 g	After meal	15-30 days	Water	NS
B. Compound formulation for local application							
1.	<i>Zimad-e- Bars</i> ⁴⁰	Semisolid	Q.S. for external use	Morning and evening	15-30 days	-	NS
2.	<i>Marham Hina</i> ⁴⁷	Semisolid	Q.S. for external use	Morning and evening	15-30 days	-	NS
3.	<i>Marham Kafoor</i> ⁴⁹	Semisolid	Q.S. for external use	Morning and evening	15-30 days	-	NS

Sr. No.	Drug	Dosage form	Dose (per day)	Time of administration	Duration and Frequency	Badraqa (vehicle)	Contraindication
4.	<i>Marham Khārish</i> ⁴³	Semisolid	Q.S. for external use	Morning and evening	15-30 days	-	NS
5.	<i>Roghan Narjeel</i> ⁴⁵	Oil	Q.S. for external use	Morning and night	15-30 days	-	NS
6.	<i>Roghan Qooba</i> ⁵¹	Oil	Q.S. for external use	Morning and evening	15-30 days	-	NS
C. Mufrad (single) drugs							
1.	<i>Aftimoon (Cuscuta reflexa Roxb.)</i> ^{16,46}	Decoction	3-5 g	After meal	Up to 3 Months	Water	Pregnancy
2.	<i>Mundi (Sphaeranthus indicus L.)</i> ⁴²	Decoction	15-20 g	After meal	15-30 days	water	NS
3.	<i>Babchi (Cullen corylifolium (L.) Medik.)</i> ^{42,49}	Powder	3-5 g	After meal	15-30 days	water	NS
4.	<i>Shahtara (Fumaria parviflora Lam.)</i> ^{46,49}	Decoction	5-10 g	After meal	15-30 days	water	NS
5.	<i>Unnab (Ziziphus jujuba Mill.)</i> ^{49,52}	Decoction	15- 20 No.	After meal	15-30 days	water	NS
6.	<i>Ushba (Smilax aristolochiifolia Mill.)</i> ^{49,52}	Decoction	9 g	After meal	15-30 days	water	NS

Note: Out of the drugs mentioned above, any one oral combination of two or more may be prescribed by the physician.

Table 9: Management with *Mundij wa Mushil* therapy [MM Therapy] (Concoctive and Purgative therapy): ^{6,15,18,40}

In case of *Qūbā Sawdāwī* (black biliary type) or *Qūbā Radī* which has a poor prognosis, *Mundij-wa-Mushil* therapy (Concoctive and Purgative therapy) will be used for evacuation of morbid black bile.

Sr. No.	Formulation	Dosage form	Dose	Time	Duration	Badraqa (vehicle)	Precaution/ Contraindication
1.	<i>Halayla Siyāh (Terminalia chebula Retz.),</i> <i>Halayla Kābulī (Terminalia chebula Retz.),</i>	decoction	100ml	Morning before meals	15-20 days	-	Pregnancy

Sr. No.	Formulation	Dosage form	Dose	Time	Duration	Badraqa (vehicle)	Precaution/ Contraindication
	• <i>Halayla Zard</i> (<i>Terminalia chebula</i> Retz.), • <i>Āmla</i> (<i>Phyllanthus emblica</i> L.) 17 ½gm. each, • <i>Gāozabān</i> (<i>Borago officinalis</i> L.), • <i>Bisfā'ij</i> (<i>Polypodium vulgare</i> L.), • <i>Bādranjboya</i> (<i>Melissa axillaris</i> (Benth.) Bakh.f.), • <i>Ustukhudūs</i> (<i>Lavandula steochas</i> L.) 14 gm. each, • <i>Turbud</i> (<i>Operculina turpethum</i> (L.) Silva Manso) 7 gm., • <i>Shāhtra</i> (<i>Fumaria parviflora</i> Lam.) 24 ½ gm., • <i>Ālū Bukhāra</i> (<i>Prunus domestica</i> L.) 20 Numbers, • <i>Mawīz Munaqqā</i> (<i>Vitis vinefera</i> L.) are soaked and boiled in 1600 ml of water till 600 ml. of liquid is left. • Thirty five grams of <i>Aftīmūn</i> (<i>Cuscuta reflexa</i> Roxb.) is added to it and boiled again till it is reduced to 400 ml. The boiled material is filtered and 52 ½ gm. of <i>Maghz-i Falūs-i Khiyār Shambar</i> (Fruit pulp of <i>Cassia fistula</i> L.), 3 gm. of <i>Ghārīqūn</i> (<i>Laricifomes officinalis</i> (Vill.) Kotl. & Pouzar) and honey are added to the filtrate.						
Note: After completion of course of above <i>Mundij</i> and appearance of signs of <i>Nudj</i> in urine, following purgative drug has to be added to the above formulation used for <i>Nudj</i>							
2.	<i>Habb-i-Aftimun</i>	pills	5-10 gm	Early morning before meal	2-3 days (after <i>Nudj</i>)	water	Pregnancy

Other Formulations:

In *Qūbā Radī*, the infected matter of *Qūbā* is penetrated deep into the skin, therefore relatively more potent drugs are used such as *Ushaq* (*Ferula ammoniacum* (D. Don) Spalik) mixed with vinegar is applied locally after leeching.

Topical application of *Roghan Katan* (oil of *Linum usitatissimum* L.), *Roghan-e-gandum* (oil of *Triticum aestivum* L.), *Roghan-e-badam talkh* (oil of *Prunus amygdalus* var. *amara* Batsch.), *Roghan-e-Narjeel* (oil of *Cocos nucifera* L.), ghee and butter are recommended in cases of *Qūbā Hād*.^{15,16,11,12}

Ṭilā' (Liniment):

- Vinegar, *Roghan-i-Gandum* (oil of *Triticum aestivum* L.), *Zarāwand Mudahraj* (*Aristolochia rotunda* L.), *Zarnikh* (Arsenic), *Ushaq* (*Ferula ammoniacum* (D. Don) Spalik), *Muqil* (*Commiphora mukul* Engl.), *Zāj* (Alum).⁵³
- Honey, *Sudāb* (*Ruta graveolens* L.), water, garlic (*Allium sativum* L.), *Chuqandar* (*Beta vulgaris* L.).
- Sulphur, *Kath Safaid* (*Vachellia leucophloea* (Roxb.) Maslin, Seigler & Ebinger), sugar, *Afyūn* (*Papaver somniferum* L.).³⁷

‘Ilāj bi’l Tadbīr (Regimenal therapy):

Ta’līq al-‘Alaq (Leech therapy): Evacuate morbid humours from the affected part using leeches before applying any topical medication.¹⁷

Faşd (Venesection): Employ *Faşd* (Venesection) in case of predominance of sanguineous humour in the whole body. It is performed at the site closest to the lesion.^{15,18,19, 48}

Hijāma bi’l Sharṭ (Wet Cupping):

Evacuate the morbid humours by *Hijāma bi’l Sharṭ* (Wet cupping).^{19,48}

Recommended and restricted diet & Lifestyle: Same as described under preventive management.

Follow-up (with duration): The follow-up may be done once a fortnight. The patients who are responding well may be treated as per the assessment of physician.-

Referral criteria:

- Same as mentioned earlier at level 1, plus,
- Nail/scalp involvement, kerion.
- No response to 4-6 weeks of treatment.
- Any other complications that threaten the life of the patient.
- Patients with weak immune system such as those suffering from HIV/AIDS

At Level 3: (Ayush hospitals attached with teaching institutions/ Ayush research institutions having indoor facility/ District level/ state level Ayush hospitals/ Tertiary care Allopathic hospitals having Ayush facilities)

Clinical Diagnosis:

Same as levels 1 and 2. Confirm diagnosis and severity with the help of investigations such as follows:

- Specimen culture
- Wood light examination
- Dermatophyte test medium
- Histopathology special stains

Investigations: Same as Levels 1 and 2.

Management: Patients referred from Level 1 or 2, may continue the same treatment, if appropriate for the presenting complaints. For new patients at this level, the management described at Level-1 and Level-2, may also be considered while giving prescriptions.

Table 10: Single drugs and compound Unani formulations for internal/external use

Sr. No.	Drug	Dosage form	Dose (per day)	Time of administration	Duration and Frequency	Badraqa (vehicle)	Contraindication
A.	Compound Formulations (Oral)						
1.	<i>Habb-e-Shahtra</i> ⁵⁴	Pills	7-9 g	After meal	15-30 days	Water	NS
2.	<i>Habb-e-Kibrit</i> ⁵⁰	Pills	4.5 g	After meal	7-15days	Water	NS
3.	<i>Jawārish Jalinoos</i> ⁵⁰	Semisolid	5-15 g	After meal	15-30 days	Water	Diabetes Mellitus
4.	<i>Ma'jūn Ushba</i> ⁴¹	Semisolid	5-10 g	After meal	15-30 days	Water	Diabetes Mellitus
5.	<i>Ayārij-i- Fayqrā</i> 2-3 days (after <i>Mundij</i>) ¹⁷	Powder	3-5 g	Early morning before the meal	2-3 days	Water	Pregnancy
6.	<i>Ayarij Arkaghanees</i> ⁵⁰	Powder	14g	After meal	15-30 days	<i>Joshanda Shāhitra</i>	Pregnancy
7.	<i>Sharbat Unnab</i> ⁴¹	Liquid	20-60 ml	After meal	15-30 days	Water	Diabetes Mellitus
8.	<i>Sharbat Ushba</i> ²⁰	Liquid	40 ml	After meal	15-30 days	Water	Diabetes Mellitus
9.	<i>Sharbat Musaffi Khoon</i> ²⁰	Liquid	50 -60 ml	After meal	15-30 days	Water	Diabetes Mellitus
10.	<i>Araq Murakkab Muṣaffī-i-Khūn</i> ⁴¹	Liquid	60-120 ml	After meal	15-30 days	Water	NS
B.	Compound formulation for local application						
1.	<i>Marham Hina</i> ⁴⁷	Semisolid	Q.S. for external use	Morning and night	15-30 days	-	NS
2.	<i>Marham Zarareeh</i> ¹⁶	Semisolid	Q.S. for external use	Morning and night	15-30 days	-	NS

Sr. No.	Drug	Dosage form	Dose (per day)	Time of administration	Duration and Frequency	Badraqa (vehicle)	Contraindication
3.	Roghan-e-Qooba ⁵¹	Oil	Q.S. for external use	Morning and night	1-3 months	-	NS
C.	Mufrad (single) drugs						
1.	Aftimoon (<i>Cuscuta reflexa</i> Roxb.) ⁴⁶	Decoction	3-5 g	After meal	15-30 days	Water	pregnancy
2.	Ushaq (<i>Ferula ammoniacum</i> (D. Don) Spalik)	Powder	2.5 to 7 g	After meal	15 days to 30 days	Water	NS
3.	Mundi (<i>Sphaeranthus indicus</i> L.) ⁴²	Decoction	15-20 g	After meal	15-30 days	water	NS
4.	Babchi (<i>Cullen corylifolium</i> (L.) Medik.) ^{42, 49}	Powder	3-5 g	After meal	15-30 days	water	NS

Note: Out of the drugs mentioned above, any one oral combination of two or more drugs may be prescribed by the physician.

Table 11: Management with *Mundij wa Mushil* therapy [MM Therapy] (Concoctive and Purgative therapy): ^{6,15,18,50}

In case of chronic *Qūbā Sawdāwī* (black biliary type) or *Qūbā Radī* which has a poor prognosis, *Mundij wa Mushil* therapy (Concoctive and Purgative therapy) will be used for evacuation of morbid black bile.

S. No.	Formulation	Dosage form	Dose	Time	Duration	Badraqa (vehicle)	Precaution/Contraindication
1.	• <i>Halayla Siyāh</i> (<i>Terminalia chebula</i> Retz.), • <i>Halayla Kābulī</i> (<i>Terminalia chebula</i> Retz.), • <i>Halayla Zard</i> (<i>Terminalia chebula</i> Retz.), • <i>Āmla</i> (<i>Phyllanthus emblica</i> L.) 17 ½ gm. each, • <i>Gāozabān</i> (<i>Borago officinalis</i> L.), • <i>Bisfā'ij</i> (<i>Polypodium vulgare</i> L.), • <i>Bādranjboya</i> (<i>Melissa axillaris</i> (Benth.) Bakh.f.), • <i>Ustukhudūs</i> (<i>Lavandula steochas</i> L.) 14 gm. each,	decoction	100 ml	Morning before meals	15-20 days	-	Pregnancy

S. No.	Formulation	Dosage form	Dose	Time	Duration	Badraqa (vehicle)	Precaution/ Contraindication
	• <i>Turbud</i> (<i>Operculina turpethum</i> (L.) Silva Manso) 7 gm., • <i>Shāhtra</i> (<i>Fumaria parviflora</i> Lam.) 24 ½ gm., • <i>Ālū Bukhāra</i> (<i>Prunus domestica</i> L.) 20 Numbers, • <i>Mawīz Munaqqā</i> (<i>Vitis vinefera</i> L.) are soaked and boiled in 1600 ml of water till 600 ml. of liquid is left. • Thirty five grams of <i>Aftīmūn</i> (<i>Cuscuta reflexa</i> Roxb.) is added to it and boiled again till it is reduced to 400 ml. The boiled material is filtered and 52 ½ gm. of <i>Maghz-i Falūs-i Khiyār Shambar</i> (Fruit pulp of <i>Cassia fistula</i> L.), 3 gm. of <i>Ghārīqūn</i> (<i>Laricifomes officinalis</i> (Vill.) Kotl. & Pouzar.) and honey are added to the filtrate.						
Note: After completion of course of above <i>Mundij</i> and appearance of signs of <i>Nuḍj</i> in urine, following purgative drug has to be added to the above formulation used for <i>Nuḍj</i>							
2.	<i>Ayarj Loughazia</i>	Semisolid	14g	Early morning before meal	2-3 days (after <i>Nuḍj</i>)	water	Pregnancy

Other Formulations:

Oral use of decanted water of *Nagand Babri* (*Vitex negundo* L.) 12 g with *Filfil Siyah* (*Piper nigrum* L.) 7 no., followed by a local application of a paste of *Afyun* (*Papaver somniferum* L.) 1 g, *Arad Singhada* (Powder of *Trapa natans* L. powder) 6 g mixed in *Arqe Leemu Kaghzi* (Lemon juice).³⁶

Local application:

- The *Ṭilā'* prepared with grounded asafoetida root mixed with vinegar, can be massaged over the affected area¹⁵.
- *Iqlimiya Dhahabi* and *Hartāl* (*Arsenic*) ground with *Gulnār* (*Punica granatum* L.) and *Gul Surkh* (*Rosa damascena* Mill.), mixed with vinegar used locally.¹⁵
- *Tukhm-i-Panwār* (*Arivela viscosa* (L.) Raf.), mercury.⁵⁵
- *Samagh 'Arabī'* (*Vachellia nilotica* (L.) P.J.H. Hurter & Mabb.), *Ushaq* (*Ferula ammoniacum* (D. Don) Spalik), vinegar, make a paste and apply over the affected area.

- *Roghan-i-Gandum* (oil of *Triticum sativum* Lam.) apply over the affected area^{15, 18}

'Ilāj bi'l Tadbīr (Regimenal therapy):

Management with 'Ilāj bi'l Tadbīr (Regimenal therapy): as described under principles of management as per assessment of physician about the condition of the patient and stage of disease.

Ta'līq al-'Alaq (Leech therapy): Evacuate morbid humours from the affected part using leeches before applying any topical medication.¹⁷

Faṣḍ (Venesection): Employ Faṣḍ (venesection) in case of predominance of sanguineous humour in the whole body. It is performed at the site closest to the lesion.^{15,18,19,48}

Hijāma bi'l Sharṭ (Wet cupping):

It is advised to evacuate the morbid humours using wet cupping.^{19,48}

Ḥammām (Turkish bath): It is indicated in the treatment of *Qūbā*.¹⁷

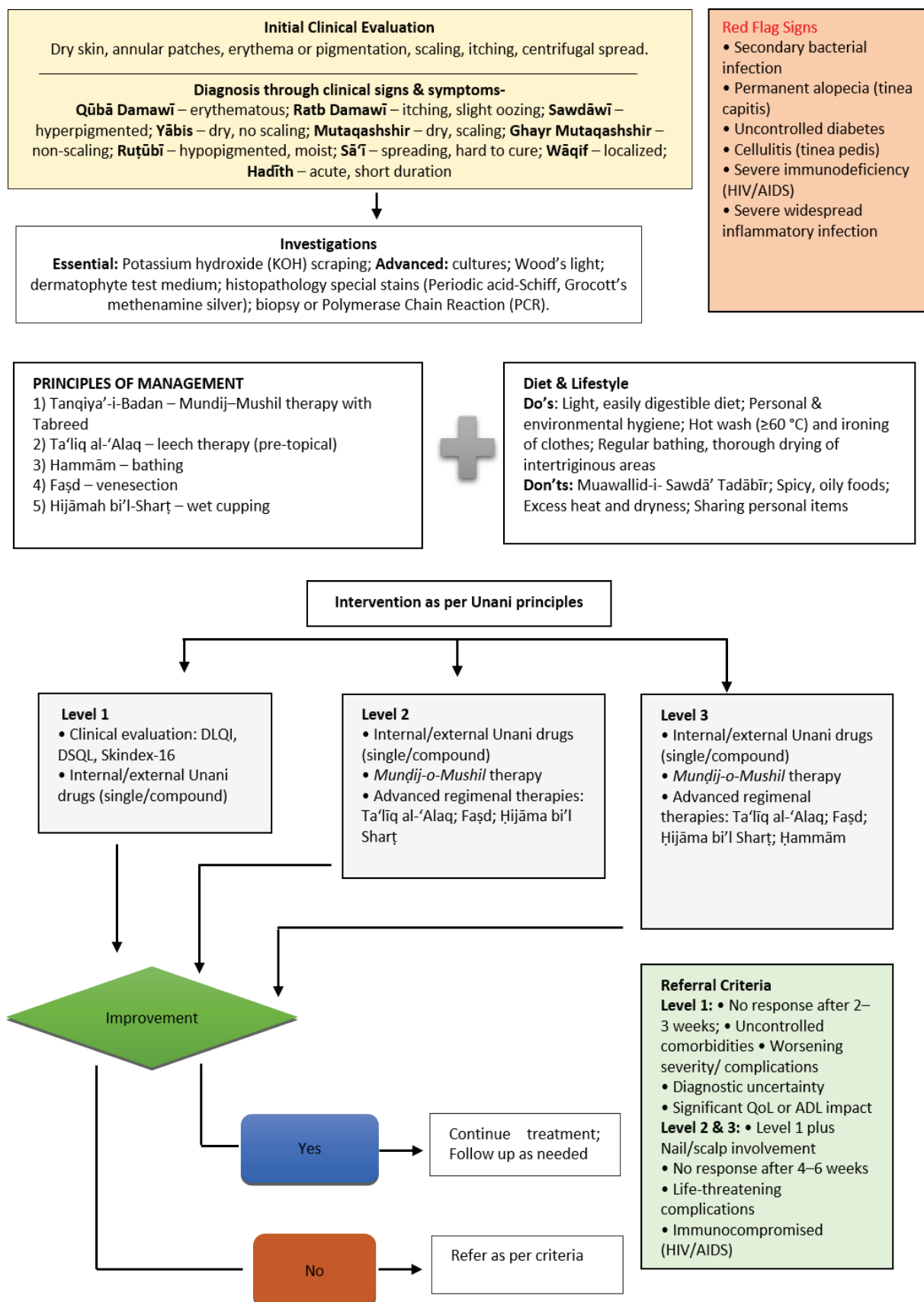
Recommended and restricted diet & Lifestyle: Same as described under preventive management.

Follow-up (with duration): The follow-up may be done once a fortnight. The patients who are responding well may be treated as per the assessment of physician.

Referral criteria:

- Same as mentioned earlier at level 2.
- Other modalities can be considered depending on the case.

ALGORITHM FOR CLINICAL ASSESSMENT AND MANAGEMENT OF DERMATOPHYTOSIS (QŪBĀ)



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PSORIASIS

(*Taqashshur al-Jild*)

Taqashshur al-Jild (National Unani Morbidity Code: J-14)¹

Psoriasis (ICD-11 for mortality and morbidity statistics: EA90)²

Psoriasis disorder (ICD-11 for mortality and morbidity statistics: SN4A)²

CASE DEFINITION^{3,4}

Psoriasis is a common, chronic, inflammatory and proliferative condition of the skin, may be associated with systemic manifestations in many organ systems. The most characteristic lesions are red, scaly, sharply demarcated, indurated plaques, particularly over the extensor surfaces and scalp. It can cause itching, irritation, burning and stinging, and the extent and severity vary enormously over time and between individuals

Unani Perspective:-

Taqashshur al-Jild (Psoriasis) is a chronic clinical condition characterized by scaling, roughness, and increased thickness of skin due to *Sawdā' Ghayr Ṭabī'ī* (abnormal melancholic humor).⁵ The scales are developed of different size and colour.¹ But scales are generally round shaped and silvery white resembling fish scales. The skin remains dry with peeling of scales and itching over the lesions.⁵

INTRODUCTION (*incidence/prevalence, morbidity/mortality/risk factors*)^{3,6-12}

- Psoriasis vulgaris is a chronic, non-communicable, disfiguring, and disabling disease with negative impact of varied degree on a patient's quality of life (QoL).
- It affects males and females equally. About 2–3% of the population have psoriasis and 10% of these individuals will develop psoriatic arthritis. Of this group, in 3–5% of them, it is severe⁸
- According to the World Health Organization, approximately 0.09% - 11.43% (incidence, 46,22,594, prevalence 4,08,05,386) of the global population suffers from psoriasis.
- In India, the prevalence of this illness varies from 0.44 to 2.8%; both sexes affected equally with few studies showing male predominance and most of the patients are in their third or fourth decade at the time of presentation.
- The lifetime risk of developing the disease is strongly associated with a family history; if no parent has psoriasis, the risk is 4%; if one parent has psoriasis, the risk is 14-28% and if both parents have psoriasis, the risk is 40-65%.

PATHOGENESIS AND ITS THERAPUETIC IMPLICATIONS⁸

1. Genetics:

There are two peaks of onset of psoriasis (Fig. 1). Type I has onset in the second and third decades and a more common family history of psoriasis. Type II has onset in late adulthood in patients without obvious family history.

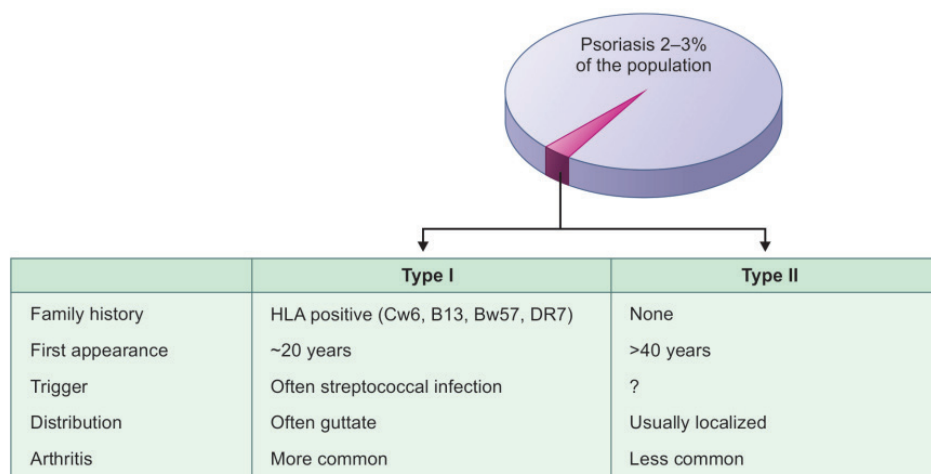


Fig.1 Onset of psoriasis

2. Hyperproliferation

The growth fraction of the upper layer of skin known as the epidermis is increased with the basal cell being increased 7x compared with normal skin. The cell turnover time decreases from 30 to 5 days, similarly the cell cycle time reduces from 311 to 36 hours.

3. Inflammation

Psoriasis is now known to be an autoimmune disorder with an important role of CD4T cells with Th 17 and Th 12 cells playing an important role.¹¹ Notably these cells are determined by cytokines that are the target of novel drugs known as biologic which have changed the therapeutics of psoriasis.¹² (Fig. 2) Psoriatic keratinocytes contain high levels of antimicrobial peptides which may account for the surprisingly low incidence of bacterial skin infection.

4. Psoriasis is also now appreciated to be an intimate part of the metabolic syndrome, associated with hypertension, diabetes mellitus, and coronary artery disease.

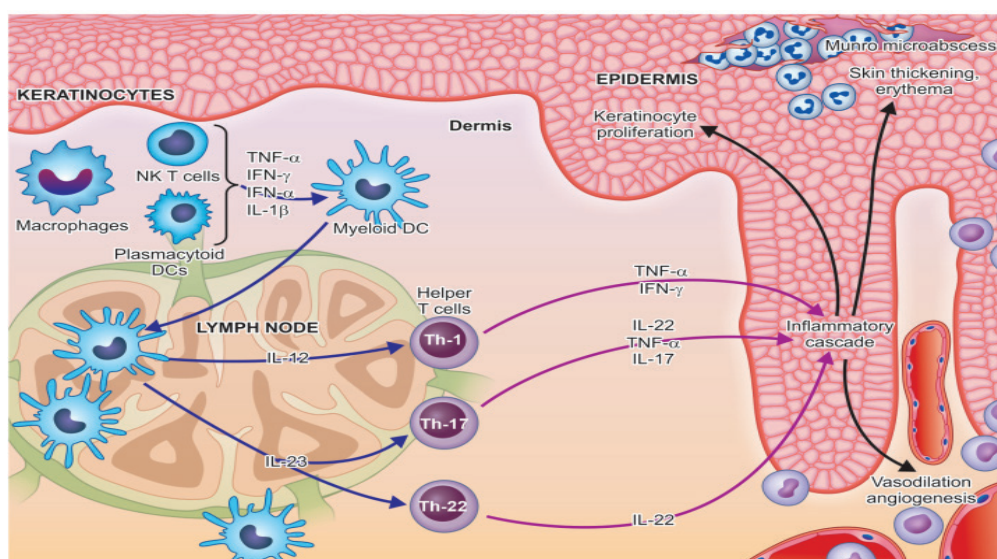


Fig.2 A depiction of the major T cell subtypes and cytokines that determine Psoriasis. Drugs that inhibit these cytokines are available and are known as Biologics

Unani medicine’s perspective: (Etiology and Pathology)

• Etiology

Taqashshur al-Jild (Psoriasis) is a multifactorial disease. Asbāb Bādiya (external factors) and Asbāb Sābiqa (internal factors) alone or in combination are the predisposing factors for the development of this disease. These factors include Mirra Sawdā’ (Bilious black bile); Harārat (Heat), Burūdat (Cold), or Yubūsat (Dryness) of the Khilṭ (Humor) involved; Sawdā’ Muḥtariqa (Burnt black bile) and Balgham Shor (Saline phlegm).^{5,13}

• Pathology

Taqashshur al-Jild (Psoriasis) is caused by humoural imbalance. Excessive accumulation of Khilṭ Sawdā’ (black bile) under the skin hinders nutrition and causes loss of normal skin function. As a result, skin is unable to excrete this Sawdā’ Ghayr Ṭabī’ī (abnormal melancholic humour), leads to the formation and shedding of scales from the skin. This represents a derangement in the quality or quantity of body humours, associated with Ruṭūbat Radī (morbid fluid) and weakness of skin causing scaling/sloughing of the skin.^{5,13}

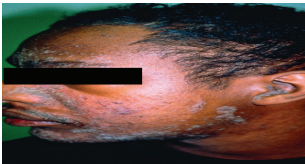
CLINICAL PRESENTATION^{3, 14-19}

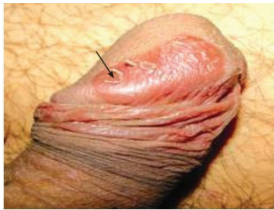
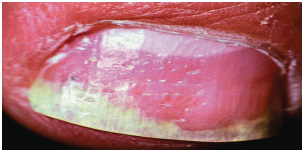
Psoriasis has several clinical variants that differ in severity, location, longevity, shape, cause and pattern. The course of the disease is marked by exacerbations and remissions usually gets worse in winters. Patients may experience more than one type of Psoriasis at the same time. The different types of psoriasis are fairly distinct and are listed below.

Table 1: Types of Psoriasis

Types of Psoriasis	Description	Figure
Clinical forms of psoriasis (based on morphology or natural history)		
Plaque Psoriasis	• The most common form of Psoriasis. • The most common sites are the scalp, trunk, buttocks and • extensor surfaces of the limbs. • It presents as well-defined, with silvery white scales varying in size from 1cm to several centimetres. • In the active phase of disease, the skin lesions develop along the lines of scratch or sites of trauma (Koebner’s phenomenon)	
Guttate psoriasis	• Sudden onset of a shower of small lesions from 2 or 3mm to 1cm in diameter, round or slightly oval, appearing diffusely over the body. • Most commonly seen in children and young adults, it frequently follows several weeks after pharyngitis caused by group A beta-hemolytic streptococci	

Types of Psoriasis	Description	Figure
Unstable psoriasis (Active psoriasis, eruptive inflammatory psoriasis)	- There is marked activity in the form of enlargement of plaques and an increase in erythematous areas and development of many new, smaller plaques with complaints of severe pain or pruritus. - The precipitating factors are systemic or potent topical corticosteroid withdrawal	
Erythrodermic psoriasis	- It is uncommon only in 1-2 % of patients are affected involving more than 90% of body surface area by psoriasis lesions with febrile, dependent oedema, severe itching, and redness with varying degrees of scales. - Environmental or therapeutic triggers, including systemic illness, alcoholism, antimalarials, irritating topical treatments, UV radiation or withdrawal of systemic corticosteroids, cyclosporine, often precipitate the acute form.	
Pustular psoriasis	- The acute generalized pustular psoriasis (von Zumbusch) presented with recurrent episodes of fever with general malaise, multiple isolated sterile pustules, laboratory abnormalities (leucocytosis, elevated ESR or C-reactive protein, confirmed by Kogoj's spongiform pustules on histopathology). - Palmoplantar pustulosis presents one or more well-defined plaques symmetrically on palms and soles, with dusky red, scaly and fissured. Numerous pustules are present within plaques, usually 2-5 mm in diameter	
Atypical forms of psoriasis¹⁸	- Rupoid psoriasis is presented as limpet-like, cone-shaped lesions. - Elephantine psoriasis has unusual presentations, such as persistent, thick scaling, large plaques on the back, limbs, hips, or elsewhere. - Ostraceous psoriasis is a ring-like hyperkeratotic lesion with a concave surface resembling an oyster shell.	
Other specified forms of psoriasis (based on age or precipitants)		
Linear and segmental psoriasis	The linear or segmented psoriasis lesions are unilateral or Blaschko linear, and an extremely unusual presentation is seen at a young age.	

Types of Psoriasis	Description	Figure
Psoriasis in childhood and old age	- It is common in children with a cumulative prevalence of up to 18 years, mostly associated with obesity and diabetes. - Under the age of 2 years, Napkin psoriasis is the most common presentation, characterised by well-defined erythema devoid of scales. - In old age groups after the age of 65 years, plaque psoriasis is commonly seen on the scalp.	
Drug-induced or exacerbated Psoriasis	Drugs such as commonly beta blockers, lithium, synthetic antimalarials, non-steroidal anti-inflammatory drugs (NSAIDs), Tetracycline, less commonly ACE inhibitors, interferon and antifungals may induce or exacerbate the psoriasis.	
Photo-aggravated psoriasis	Especially in women, exposure to sunlight may exacerbate psoriasis in sun-exposed areas.	
HIV- induced or exacerbated psoriasis	- Psoriasis may be the first presentation of HIV infection, as may the deterioration in a previously stable disease. Furthermore, there is a strong association between severe psoriasis, psoriatic arthropathy and HIV infection. - The most common variety is the Plaque psoriasis; sebopsoriasis, rupiod psoriasis and erythrodermic psoriasis are less common.	
Psoriasis affecting specific sites		
Scalp psoriasis	- The commonest area affected by plaque psoriasis is often the site first affected, and multiple discrete plaques of varying sizes diffusely involve the whole scalp. - Presented as dandruff-like flaking and silvery-white scale, with severe itching leading to burning sensation or soreness and bleeding.	
Sebopsoriasis¹⁹	Plaques of thin, sharply demarcated erythema with variable scales may occur in the typical areas of seborrhoea, like paranasal areas, external ears, medial eyebrows, hairline, preternal, and interscapular chest wall.	
Flexural psoriasis (Inverse psoriasis)	- Flexor psoriasis is often seen in individuals with plaque psoriasis elsewhere on the skin - Most common sites- axilla, submammary folds, umbilicus, inguinal creases, and other body folds- are commonly seen in older adults and are associated with obesity	

Types of Psoriasis	Description	Figure
Genital psoriasis	- In males, the most commonly seen in the glans penis, followed by scrotal skin and penile shaft, associated with inverse or plaque psoriasis. - In females, most commonly seen vulval involvement presented with symmetrical, erythematous, non-scaly, well-demarcated thin plaques affecting the labia majora with severe itching.	
Nail psoriasis (psoriatic onychodystrophy)	- Nail dystrophy may be seen in all types of psoriasis or occasionally as an isolated feature presented in 40 % of cases at any time, and the lifetime prevalence is significantly higher. - Nail changes includes pitting, separation of nail plate from nail bed appearing as yellowish discoloured nails (onycholysis) and thickened, irregular, brownish nails (onychodystrophy)	
Mucosal lesions	Mucosal involvement is infrequent but presents as a geographical tongue (benign migratory glossitis) and fissured tongue.	
Non-pustular palmoplantar psoriasis	Commonly seen on palms and soles, presented as typical scaly patches with fine silvery scales, can be evoked on scratching. However, on the wrist, forearm or palm, there is a clear edge without vesiculation	
Ocular lesions	- Psoriasis may affect ocular structure directly or indirectly and is associated with immunological phenomena. - Directly affected by blepharitis, chronic nonspecific conjunctivitis, xerosis, and rarely keratitis. - Immunologically affected uveitis is associated with extensive psoriasis and psoriatic arthritis.	
Extra-Cutaneous Manifestations		
Psoriatic arthritis	- There can be involvement of joints of hands and feet especially distal interphalangeal joints. - In some cases , spondylitis or sacroiliitis can also be seen. The arthritis can be deforming at times.	

Unani medicine's perspective: (Clinical Presentation)

Taqashshur al-Jild (Psoriasis) presents as well-defined erythematous plaques covered with silvery scales commonly over the scalp, and extensors of extremity, particularly over knees, elbows, and lumbosacral region.

Taqashshur al-Jild (Psoriasis) can present with different morphology in the form of plaque, guttate, rupioid, erythrodermic, pustular, inverse, elephantine, and psoriatic arthritis. Nail changes in *Taqashshur al-Jild* (Psoriasis) are seen as pitting, oil spots, subungual hyperkeratosis, nail dystrophy, and anchylosis.¹³

CLINICAL EXAMINATION ¹⁹

Psoriasis is mostly diagnosed on the basis of clinical examination of the skin, scalp, and nails along with review of patients smoking history, medical history and family history. The characteristic skin lesions are sharply demarcated, scaly, erythematous raised plaques, either painful or itching red patches covered with silvery scales. The lesions vary in shape and may be ovoid, round, or irregular and are often symmetrically distributed. Common areas of involvement include extensor surface of body, elbows, knees, scalp, trunk, lumbosacral region and nails. A skin biopsy needed in some cases to confirm the diagnosis and to rule out other diseases.

Table 2: DIFFERENTIAL DIAGNOSIS ^{3, 19-22}

Psoriasis Subtype	Differential Diagnosis	Characteristic and Diagnostic Features
Plaque psoriasis		Well-defined, sharply demarcated, erythematous plaques with a thin, silvery-white scale; tend to be symmetrically distributed over the body. There is predilection for extensor surfaces of the body like elbows, knees, scalp, back, buttocks, etc.
	Eczema	Erythematous papules/plaques lacking a silvery scale; can be vesicular or weeping; chronic lesions can be lichenified/hyperkeratotic. Predilection for flexural surfaces; more pruritic than psoriasis; does not koebnerize; personal or family history of asthma, hay fever, allergies.
	Dermatophyte infection	Solitary/many erythematous lesions with central clearing and peripheral scale; Potassium hydroxide preparation, fungal culture, and rarely, skin biopsy confirm diagnosis.
	Subacute cutaneous lupus erythematosus	Photo-distributed psoriasiform lesions. Skin biopsy and laboratory tests confirm the diagnosis.
	Lichen planus	Typically, pruritic, violaceous papules with frequent mucosal involvement.
	Atopic dermatitis	Three distinct patterns of AD, depending on the age of the patient. Intensely itchy, lichenified plaques.
Guttate psoriasis		Small “droplet” lesions of short duration (weeks to months); palms and soles spared. Occurs in <2% of patients with psoriasis, usually affects those aged younger than 30 years; may have an antecedent upper respiratory infection

Psoriasis Subtype	Differential Diagnosis	Characteristic and Diagnostic Features
	Secondary syphilis	Generalized erythematous psoriasiform papules with collarette scale; palms and soles affected; associated with nonscarring alopecia, lymphadenopathy, systemic symptoms (malaise, fever, headache, myalgias). Chancre may still be evident in early stages of secondary syphilis; rapid plasma reagin confirms diagnosis.
	Pityriasis rosea	1–2 weeks after a vague “viral” episode. A single patch appears on the trunk, followed by smaller lesions along skin cleavage lines. Usually self-limiting and does not usually recur; associated with Herpesvirus 6; epidemics occur in spring and fall.
Erythrodermic psoriasis		Severely disabling Diffuse erythema >75% body surface area with or without exfoliation; superficial desquamation, hair loss, nail dystrophy.
	Pityriasis rubra pilaris	Orange-red plaques start on the head and spread caudally; small areas of spared skin is frequently present; yellowish thickening of palms and soles; nail changes similar to psoriasis. Skin biopsy confirms diagnosis
	Drug eruptions	Generalized erythroderma develops approximately 7–10 days after the initiation of a new drug. Skin biopsy confirms diagnosis; eosinophilia is suggestive of a drug eruption.
Pustular psoriasis		Individual/coalescing sterile pustules that occur either in an acute, generalized fashion or are localized to palms and soles. Usually affects aged >65 y; >25% of patients have a positive family history.
	Irritant dermatitis	Irritant dermatitis is most frequently caused by occupational exposure, either as an industrial contact or as a household contact. Clinical features, ranging from a little dryness, redness or chapping to various types of eczematous dermatitis to an acute caustic burn.
	Folliculitis	Dome-shaped follicular pustules. Pseudofolliculitis seen in the beard area (after shaving), thighs, and arms (after epilation by waxing).
	Allergic contact dermatitis	Develops due to involvement of immunological pathway, being a type IV (delayed hypersensitivity) reaction to exogenous contact antigens. Progresses from erythema to edema to papulovesiculation.
Inverse psoriasis		Well-demarcated, erythematous lesions with minimal scaling. Affects intertriginous Areas.

Psoriasis Subtype	Differential Diagnosis	Characteristic and Diagnostic Features
	Intertrigo	Moist, erythematous lesions of intertriginous areas, caused by mechanical factors or secondary infection; difficult to distinguish from inverse psoriasis
	Cutaneous T-cell lymphoma	Erythematous patches/plaques of intertriginous areas. Skin biopsy of the thickest, untreated .A lesion with minimal sun exposure confirms the diagnosis
	Tinea cruris (Jock itch)	Caused by dermatophytes, presented with severe itching, red, well-defined scales and cracked rash in groin folds, inner thigh and rarely around the anus, less often with musty or yeasty odour from the area. The KoH test* and culture will confirm the diagnosis.
	Tinea corporis	Annular/arcuate lesions with relative clearing in the center and an active periphery. Infection of the glabrous skin anywhere on the body, except palms, soles, and groins.
	Candidiasis	Resembles like psoriasis with glistening deep red colour lesions, particularly in flexor areas, but scaling tends to be confined to the edge, and small satellite pustules and papules are usually evident outside the main area. The culture test will confirm the diagnosis.
	Seborrheic dermatitis	The lesions are lighter in colour, less well-defined and covered with a dull or branny scale. The most common sites are on the scalp, lateral sides of eyebrows, ear, nasolabial folds, and the upper part of the chest and back.
	Nummular dermatitis	History: of atopic diathesis, Morphology: discoid plaques, Common site: acral parts.

* to rule out Tinea in Psoriasis

SUPPORTIVE INVESTIGATIONS³

- Diagnosing psoriasis is typically based on clinical presentation
- A skin biopsy will be helpful in atypical cases.
- In generalized pustular psoriasis, high sensitivity C-reactive protein may be mildly elevated, but higher levels are seen in psoriatic arthritis.
- Blood tests like CBC (Complete Blood Count), KFT (Kidney Function Test), LFT (Liver Function Test), HLA B27 (Human Leukocyte Antigen B27), Uric acid levels, Human Immunodeficiency Virus, Rheumatoid factor, X-ray and Antinuclear antibodies, tests for specific infections like streptococcal and staphylococcal antibodies can help differentiate psoriasis from other conditions with similar symptoms.
- KOH preparation should be done to rule out fungal infection (tinea etc.) in cases of psoriasis of hands, feet, and nails.

Table 3: Tests for diagnosis ^{19,20}

TEST	DESCRIPTION
1) Bedside tests	Two simple bedside tests were done to confirm the diagnosis.
a) Grattage test	This is positive when scales are accentuated by grating lesions with a glass slide.
b) Auspitz sign	When gently scraping off all the scales from lesions with a glass slide, a glistening white adherent membrane (Berkley's membrane) appears. Once this membrane is removed, punctate bleeding points become visible. (positive Auspitz sign).
2) Skin biopsy	Skin biopsy (done in doubtful cases) shows epidermis and dermal changes. Epidermal changes include parakeratosis, absent granular layer, regular acanthosis, suprapapillary thinning, elongation of rete ridges and collection of neutrophils in the epidermis (spongiform pustule of Kogoj and Munro's microabscess). Dermal changes: dilatation and tortuosity of capillary loops in dermal papillae, and lymphocyte infiltrates in the upper dermis.

Classification of severity and prognostic assessment

- **Psoriasis Area Severity Index (PASI) score** ²³
The PASI is a widely used instrument in psoriasis trials that assesses and grades the severity of psoriatic lesions and the patient's response to treatment. It produces a numeric score ranging from 0 to 72. A 75% reduction in the PASI score (PASI 75) is the current benchmark for most clinical trials in psoriasis.
- **Nail psoriasis Severity index.** ²⁴
This scale is used to evaluate the severity of nail bed psoriasis and nail matrix psoriasis by area of involvement in the nail unit. The NAPS I will be useful during clinical trials for evaluating response to treatment of psoriatic nails.

PRINCIPLES OF MANAGEMENT

Red flag signs ^{17, 25, 26}

These signs should be assessed before initiating treatment to identify cases requiring management through modern medicine.

- Patients with generalized pustular psoriasis or erythrodermic psoriasis with high grade fever.
- Psoriatic arthritis significantly impacting a person's physical, psychological or social well-being.
- Psoriasis with co-morbid disorders

A. Prevention Management

- Advice to avoid smoking, excessive alcohol intake, maintain a healthy weight and regular practice of Yoga.
- Advice on the benefits of sun exposure, as the beneficial effects of dietary vitamin D intake have shown a correlation with improvement in psoriasis.
- Advice to apply moisturizing creams or olive/coconut oil, as and when required, for dryness, itching, scaling.

- If possible, encourage the patients to identify any avoidable trigger factors and avoid the same if possible and develop coping strategies for flare-ups like Immediate use of prescribed topical treatments, Cold compresses to soothe itching, Temporary lifestyle adjustments (e.g., wearing loose cotton clothing, avoiding hot showers)
- A substitute salt to be considered in consultation with concerned physician in cases where a drug/medication is identified to be a trigger or exacerbating factor

Yoga:²⁷ Various yoga practices may be helpful in the management of psoriasis, such as *Shavasana* (Corpse Pose), *Bhujangasana* (Cobra pose), *Setu Bandhasana* (Bridge Pose), *Trikonasana* (Triangle Pose), *Balasana* (Child's Pose). Certain *Pranayam* and Meditation techniques like *Anulom Vilom* (Alternate Nostril Breathing), *Bhramari* (Humming Bee Breath), and *Kapalbhati* (Skull Shining Breath) will also help in reducing anxiety, emotional stress, cellular healing, reducing stress-related inflammation and promoting a positive mental state.

Unani medicine's perspective:^{5,13}

The general line of treatment as mentioned in classics:

- *Tanqiya'-i-Badan* (Cleansing of morbid matter/ humour from body)
- *Taṣfiya al-Dam* (Blood purification)
- *Ta'dīl-i Mizāj* (Normalization of temperament)
- *Taḥlīl-i-Awrām* (Resolution of swelling)
- *Tabrīd- i Badan* (Genesis of coolness in the body)
- *Tartīb-i'Umūmī-wa-Maqāmī* (General and local moisturization) and the use of *Jālī* (Detergent) drugs.

The main line of treatment is '*Ilāj bi'l Dawā'* (Pharmacological Treatment) [IUMT-7.1.10] and '*Ilāj bi'l Tadbīr* (Regimenal Therapy) [IUMT-7.2.0]. '*Ilāj bi'l Tadbīr* (Regimenal Therapy) includes application of *Ḍimad* (Poultice) [IUMT-6.2.52], *Ḥijāma* (Cupping) [IUMT-7.2.30]¹³, *Faṣd* (Venesection) [IUMT-7.2.6]¹³, *Ḥammām* (Turkish bath) [IUMT-7.2.70]^{28,29}, *Tadhīn* (Oiling) [IUMT-6.2.116]¹³, *Ta'rīq* (Diaphoresis) [IUMT-7.2.69]³⁰, *Ta'līq al-'Alaq* (Leeching) [IUMT-7.2.68]³⁰, etc.

For prevention of progression:

Diet & Lifestyle:

Asbāb Sitta Ḍarūriyya (six essential factors):^{13,30,31}

According to Unani medicine, health is preserved, and disease is prevented by maintaining balance in the *Asbāb Sitta Ḍarūriyya* (the six essential factors). These foundational factors guide holistic lifestyle interventions and are especially important in managing chronic disorders such as *Taqashshur al-Jild* (Psoriasis). The focus is on preventing humoral imbalance, correcting temperament (*Mizāj*), and supporting the body's natural healing mechanisms.

1. Al-Hawā' / (Air):

Refrain from exposure to excessive cold, heat and dryness, as these can worsen the melancholic temperament associated with *Taqashshur al-Jild* (Psoriasis). Stay in a clean, moderate climate and avoid dusty, polluted, or smoke-filled environments.

2. *Al-Ma'kūlāt wa'l Mashrūbāt* (Foods and Drinks):

Use *Aghziya latifa*, *Aghziya Murattiba* and refrain from *Aghziya Ghalīza*, *Aghziya Muwallid-i Sawdā'* and *Aghziya Hirrifa*.

3. *Al-Ḥaraka wa'l Sukūn al-Badanī* (Bodily movement and repose):

- Engage in moderate physical activity regularly to enhance blood circulation, support digestion, and maintain internal warmth.
- Avoid completely sedentary lifestyle, as it may contribute to humour accumulation (particularly *Sawdā'*).
- Ensure adequate rest and relaxation to avoid overexertion, which may weaken natural faculties (*Quwwat Tabī'iyya*).

4. *Al-Ḥaraka wa'l Sukūn al-Nafsānī* (Psychic movement and repose):

Maintain psychological calmness, as individuals affected by *Taqashshur al-Jild* (Psoriasis) exhibit a markedly increased risk of developing clinical depression or experience depressive symptoms.

5. *Al-Nawm wa'l Yaqza* (Sleep and wakefulness):

Establish a consistent sleep-wake cycle. Sleep problems may play a role in the development or worsening of *Taqashshur al-Jild* (Psoriasis) due to their effects on the immune system as sleep supports immune regulation.

6. *Al-Ihtibās wa'l Istifrāgh* (Retention and Evacuation):

Regular elimination of waste products including urine, stool, and sweat is essential to prevent accumulation of *Fuzlāt* (waste matter) and toxins in the body.

Table 4: Dos & Don'ts ^{13,32,33,31}

Dos	Don'ts
• Stay in a clean, moderate climate • Fresh air exposure in the morning • <i>Mā' al-Jubn</i> (Whey) • <i>Mā' al-Sha'ir</i> (Barley water) with <i>Jullāb</i> (preparation of rose water and sugar)¹⁴ • <i>Aghziya Murattiba</i>- Foods of wet/moist temperament having ability to produce the humours which give rise to wetness in the body e.g. milk, <i>Kadū</i> (<i>Cucurbita maxima</i> Duchesne.) cucumber (<i>Cucumis sativus</i> L.), watermelon (<i>Citrullus lanatus</i> (Thunb.) Mastum. & Nakai), clarified butter, almond oil, • <i>Mazoorah i Māsh</i> (soup of <i>Vigna mungo</i> (L.) Hepper) prepared with <i>Maghz-i Bādām</i> (<i>Prunus amygdalus</i> Bastch) and <i>Nakhūd</i> (<i>Cicer arietinum</i> L.).	• Avoid dusty, polluted, or smoke-filled environments. • Refrain from excessive exposure to direct sunlight or dry winds. • Refrain from alcohol, spicy, salty, and sour foods • <i>Aghziya Ghalīza</i> - Dry and viscous foods such as cheese red meat, dry date, '<i>Adas Musallam</i> (<i>Lens esculenta</i> Moench.) etc. These are of two types i.e. <i>Mahmūda</i> (that produces good humour) and <i>Ghayr Mahmūda</i> (that produces morbid humour). • <i>Aghziya Muwallid-i Sawdā'</i> - The foods which produce an excessive quantity of black bile in the body e.g., cabbage (<i>Brassica oleracea</i> L.). brinjal (<i>Solanum melongena</i> L.)

Dos	Don'ts
• <i>Asfeedbaj prepared with Lahm wa maghz i sar i Buzghāla</i> (meat and brain of goat kids) • Increase water intake, preferably lukewarm. • Adequate rest • Light exercise • Mild massage with <i>Roghan-i Murattiba</i>. • Mild exposure of sunlight.	• <i>Aghziya Hirrifa</i> - Spicy (Pungent) foods that may produce heat in the body e.g. pepper • <i>Aghziya Musakhkhina</i> - Foods producing heat in the body e.g. spices. • <i>Aghziya Mujaffifa</i>-Foods causing desiccation of body fluid e.g. roasted gram, salted fish etc. • Sedentary lifestyle • Scratching lesions • Stress • Smoking and drinking alcohol. • Avoid exposure to excess dryness and heat

(B) Interventions for disease management

At Level 1- Solo Physician Clinic/community wellness centres / PHC (Optimal Standard of treatment in situation where technology and resources are limited)

Clinical Diagnosis: Psoriasis is entirely diagnosed clinically with thorough medical history and physical examination, including BMI. However, some investigations, such as complete hemogram, urine routine/microscopic, C-reactive protein, fasting blood sugar, postprandial blood sugar levels, *KOH to rule out fungal infection (Tinea) and serum uric acid levels can be advised.

Management:

‘Ilāj bi’l Dawā’ (Pharmacotherapy)

OPD level management:

Table 5: Single drugs / Compound Formulations for oral administration

Sr. No.	Drug	Dosage form	Dose (per day)	Time of administration	Duration and Frequency	Badraqa (vehicle)
1.	<i>Chirā'ita</i> ^{34,35} (<i>Swertia chirayita</i> (Roxb.) H. Karst.)	Powder	5-7 g.	As directed by physician	As prescribed by physician	Water
2.	<i>Chob Chīnī</i> ³⁴ (<i>Smilax china</i> L.)	Powder	5-10 g.	As directed by physician	As prescribed by physician	Water
3.	<i>Kamila</i> ¹³ (<i>Mallotus philippensis</i> (Lam.) Muell. Arg.)	Powder	1-3 g	As directed by physician	As prescribed by physician	Water
4.	<i>Shāhtra</i> ^{34,35} (<i>Fumaria parviflora</i> Lam.)	Powder	5-10 g.	As directed by physician	As prescribed by physician	Water
5.	<i>Sandal Safed</i> ³⁴ (<i>Santalum album</i> L.)	Powder	5-10 g.	As directed by physician	As prescribed by physician	Water
6.	<i>Zard Chob</i> ³⁴ (<i>Curcuma longa</i> L.)	Powder	5-10 g.	As directed by physician	As prescribed by physician	Water

Sr. No.	Drug	Dosage form	Dose (per day)	Time of administration	Duration and Frequency	Badraqa (vehicle)
7.	<i>Mundi</i> ³⁴ (<i>Sphaeranthus indicus</i> L.)	Powder	15-20 g.	As directed by physician	As prescribed by physician	Water
8.	<i>Ushba</i> (<i>Smilax aristolochiifolia</i> Mill.) ³⁵	Powder	5-10 g.	As directed by physician	As prescribed by physician	Water

Table 6: Compound drugs for Oral / Local administration

Sl. No.	Drug	Dosage form	Dose	Time	Duration	Adjuvant	Precaution/Contraindication
1	<i>Majūn-i Mundi</i> ³⁶	Semi-Solid	5-10 g.	Twice daily	As prescribed by physician	Water	-
2	<i>Arq-i Shāhtra</i> ^{32,37}	Oral	60-144 ml		OD	Nil	NS
3	<i>Sharbat-i Nīlofar</i> ^{32,37}	Oral	24 ml	Morning	OD	with water	NS
4	<i>Roghan-i-Gul</i> ^{32,33}	Local application	Q.S			After mixing with <i>Murdār Sang</i> (Litharge)	NS
5	<i>Roghan-i-Banafsha</i> ^{32,37}	Local application	Q.S			After mixing with <i>Murdār Sang</i> (Litharge)	NS

Ṭilā' (Liniment)¹²

Murdār Sang (Litharge), *Sirka* (vinegar) and *Roghan-i-Gul* or *Mawīz Munaqqā* (*Vitis vinefera* L.), *Turmus* (*Lupinus albus* L.) and *Sirka –i angoori* (vinegar of grapes).

Ḍimād (poultice)³⁰

1. *Tukhm-i Jirjīr* (Seed of *Eruca sativa* Mill.), *Tukhm-i-Mooli* (Seed of *Raphanus sativus* L.) and *Kundur* (*Boswellia serrata* Roxb. ex Colebr.) with *Sirka* (Vinegar)
2. *Hina* (*Lawsonia inermis* L.), *Balut* (*Quercus incana* W. Bartaram), *Gulnār* (Flower of *Punica granatum* L.), *Post-i Anār* (Peel of *Punica granatum* L.), *Jawz al sarw* (*Cupressus sempervirens* L.) and *Sirka* (Vinegar)

Note: Out of the drugs mentioned above, any one or a combination of two or more may be prescribed by the physician. '*Ilāj bi'l Tadbīr* (Regimenal therapy) described under principles of management may be recommended as per assessment of physician about the condition of the patient and stage of disease. The duration of the treatment may vary from patient to patient. The physician should decide the dosage and duration of the therapy based on the clinical findings and response to the therapy.

Recommended and restricted diet & Lifestyle: Same as described under preventive management

Follow Up (With duration) 1st Follow-up after 15 days followed by 2nd follow-up on the 30th day.

Reviews should include:

- Monitoring the symptoms and the ongoing impact of the condition on everyday activities and quality of life.
- Discussing the person's knowledge of the condition, any concerns they have, their personal preferences, and their ability to access services.
- Reviewing the effectiveness and tolerability of all treatments.
- Self-management support.
- Monitoring the long-term course of the condition with periodic review.
- Reviewing the co-morbidities associated with psoriasis.

Referral Criteria:

1. Complications of *Taqashshur al-Jild* (Psoriasis) such as psoriatic arthritis
2. PASI score of 5 to 10 is considered moderate disease, and a score more than 10 is considered severe with substantial impact of quality of life and daily living.²³
3. Generalized pustular psoriasis or erythrodermic psoriasis patients are referred to a higher centre for specific management.
4. Uncontrolled co-morbidities
5. Evidence of an increase in severity/complications

Diagnostic uncertainty

At Level 2: (CHC / Small hospitals (10-20 bedded hospitals with basic facilities such as routine, investigation, X-ray)

- Management with single or compound drugs for internal and external use.
- Management with '*Ilāj bi'l Tadbīr*' (Regimenal Therapy) as described under the principles of management and as per the assessment of physician about the condition of the patient and stage of disease.
- '*Ilāj bi'l Ghidhā*' (Dieto-therapy) and life-style modifications
- Clinical Follow-up
- Referral criteria

Clinical Diagnosis: Same as Level 1. Any fresh case or referred case from Level 1 shall be evaluated thoroughly for confirmation of diagnosis and complications.

Investigations: The diagnosis would be primarily clinical, along with some investigations which will be necessary to investigate complications or exclude other differential diagnosis as follows:

- Complete blood count/ESR
- Renal function Test, liver function test,
- Fasting lipids, glucose, and thyroid functions
- Complete urine examination
- High sensitivity C-reactive protein.

- Serum electrolytes
- X-ray of affected Joints (Psoriatic arthritis)
- Tests for Biologics are referred to a specialised tertiary level center

Management:

Patients referred from Level- 1, may be continued with the same treatment, if appropriate for the presenting complaints. For new patients at this level, the management described in Level- 1, may also be considered while giving prescriptions. At this level, the patient may be preferably treated in the indoor department

Table 7: Compound Formulations for oral administration/local application

Sr. No.	Drug	Dosage form	Dose per day	Time	Duration & Frequency	Badraqa (vehicle)	Precaution/ Contraindication
1.	<i>Itrīfal Shāhtra</i> ³⁴	Semi-solid	5-10 g	As directed by physician	As prescribed by physician	Water	Nothing specific (NS)
2.	<i>Ma'jūn-i Najāh</i> ³⁴	Semi-solid	5-10 g	As directed by physician	As prescribed by physician	Water	Nothing specific (NS)
3.	<i>Safūf-i Chob Chīnī</i> ³⁴	Powder	5-10 g	As directed by physician	As prescribed by physician	Water	Nothing specific (NS)
4.	<i>Roghan-i Hindī</i> ³⁸	Oil	QS / . / For external use	As directed by physician	As prescribed by physician	-	Nothing specific (NS)
5.	<i>Marham-i Hina</i> ³⁹	Ointment	QS./ For external use	As directed by physician	As prescribed by physician	-	NS
6.	<i>Tila Baras-i-Aswad</i> ⁴⁰	Liniment	QS./ For external use	As directed by physician	As prescribed by physician	-	NS
7.	<i>Habb-i-Musaffi Khoon</i> ³⁴	Pills	250–500 mg	As directed by physician	As prescribed by physician	Water	NS

Local applications^{32, 31}

Ṭilā' (Liniment): Prepared from *Tukhm-i Hulba* (Seed of *Trigonella foenum-graeceum* L.), *Bihīdāna* (Seed of *Cydonia oblonga* Mill.), *Khatmī* (*Althaea officinalis* L.) and *Aspghol* (*Plantago ovata* Forssk.) and mixed with *Roghan-i Gul*.

Ḍimād (Poultice): Prepared with *Gulāb* (*Rosa damascena* Mill.) boiled in vinegar.

Table 8: Munḍij-o-Mushil therapy (Concoctive and Purgative therapy)^{32,33,31}

Sr. No.	Formulation	Dosage form	Dose	Rout & Time	Duration	Badraqa (vehicle)	Precaution/ Contraindication
1.	<i>Sharbat-i Banafsha</i> and <i>Turanjabīn</i> (<i>Alhagi maurorum</i> Medik.),	<i>Sharbat</i> <i>Safoof</i> (<i>Munḍij</i>)	35ml 35gm	Oral/ Morning before the meal	6days	Dissolved with Hot water	Pregnancy & Diabetes Mellitus
Note: After completion of course of above <i>Munḍij</i> (concoctive) and appearance of signs of <i>Nuḍj</i> (concoction) in urine, following <i>Mushil</i> (purgative) will be given							

Sr. No.	Formulation	Dosage form	Dose	Route & Time	Duration	Badraqa (vehicle)	Precaution/ Contraindication
2.	<i>Joshānda-i Aftīmūn</i> (decoction of <i>Cuscuta reflexa</i> Roxb.)	Decoction (Mushil)	100ml	Oral/ Morning before the meal	3-4days	Water	Pregnancy
OR							
3.	<i>Gul-i Banafsha</i> khushk (dried Flower of <i>Viola odorata</i> L.), <i>Halayla Kābulī</i> (<i>Terminalia chebula</i> Retz.), <i>Halayla Zard</i> (<i>Terminalia chebula</i> Retz.), 17.5 gm each, <i>Sanā Makkī</i> (<i>Senna alexandrina</i> Mill.), <i>Bisfā'ij</i> (<i>Polypodium vulgare</i> L.), crushed <i>Turbud</i> (<i>Operculina turpethum</i> (L.) Silva Manso), <i>Gul Surkh</i> (Flower of <i>Rosa damascena</i> Mill.), <i>Nīlofar</i> (<i>Nymphaea lotus</i> L.), <i>Tukhm-i Kāsnī</i> (Seed of <i>Cichorium intybus</i> L.), <i>Asl al-Sūs</i> (<i>Glycyrrhiza glabra</i> L.) 10.5gm each, <i>Ustūkhūdūs</i> (<i>Lavandula stoechas</i> L.) 14gm, <i>Mawīz Munaqqā</i> (<i>Vitis vinefera</i> L.) 35 gm., <i>Ālū Bukhāra</i> (<i>Prunus domestica</i> L.) 20 pieces and <i>'Unnāb</i> (<i>Zizyphus jujuba</i> Mill. & Lamk.) 20 pieces, <i>Sapistān</i> (<i>Cordia dichotoma</i> Forst.f.) 20 pieces, to be boiled in 1260 ml of water After evaporation of 2/3rd of water, the decoction be filtered and preserved, and mixed with <i>Maghz-i Falūs-i Khayār Shambar</i> (Fruit pulp of <i>Cassia fistula</i> L.) 37.5gm and <i>Turanjabīn</i> (<i>Alhagi maurorum</i> Medik.), 37.5gm.	Decoction (Mushil)		Oral / Morning before the meal	4-5days	Water	Pregnancy & Diabetes Mellitus

'Ilāj bi'l Tadbīr (Regimenal Therapy) ^{13,32,31}

- **Faşd (Venesection):** It is indicated on both hands on *Rag-e Ba'saleeqe* (basilic vein) and if patient's condition allows then repeat the process with a gap of 7 days.
- **Hammām (Turkish Bath)** should be taken on every third day.

Recommended and restricted diet & Lifestyle:

Same as described under preventive management

Follow-up (with duration):

The follow-up may be done once a fortnight. The patients who are responding well may be treated as per the assessment of physician.

Referral Criteria

- Same as mentioned earlier at level 1, plus
- Failure of acute exacerbation to respond to initial medical management.
- In erythrodermic patients with generalized pustular psoriasis, patients with febrile and unstable vitals or secondary infections.
- Cases with prominent joint damage and marked functional impairment.
- Uncontrolled complications such as Cardiovascular disease, Cancer, HIV, metabolic syndrome, psychiatric illness or hyperuricaemia.
- Any other complications that threaten the life of the patient.

At Level 3: (Ayush hospitals attached with teaching institutions/ Ayush research institutions having indoor facility/ District level/ state level Ayush hospitals / Tertiary care Allopathic hospitals having Ayush facilities)

- Management with single or compound drugs for internal and external use
- Management with *'Ilāj bi'l Tadbīr* (Regimenal Therapy) described under principles of management as per the assessment of physician about the condition of the patient and stage of disease
- *'Ilāj bi'l Ghidhā'* (Dieto-therapy) and lifestyle modifications
- Clinical Follow-up
- Referral criteria

Clinical Diagnosis: Same as Levels 1 & 2. Confirm diagnosis and severity with the help of investigations such as skin biopsy (only done for cases in which clinical diagnosis is not clear), Further investigations like inflammatory bio markers, ECHO, MRI, CT scan, and chemical analysis of uric acid renal stones etc may be advised as per individual case needs.

Investigations: Same as Levels 1 and 2.

Additional Investigations may be done as follows:

- ✓ Radiographs of involved Joint(s)
- ✓ Dermatology quality of life assessment
- ✓ Fibroscan to detect early liver damage in patients with a history of Methotrexate use for 2-3 years and alcohol consumption.

Management:

Patients referred from Level 1 or 2, may continue the same treatment, if appropriate for the presenting complaints. For new patients at this level, the management described at Level-1 and Level-2, may also be considered while giving prescriptions. At this level, the patient may be preferably treated in the indoor department.

Table 9: Single drugs/Compound Formulations for oral administration/local application

Sr. No.	Drug	Dosage form	Dose per day	Time	Duration & Frequency	Badraqa (vehicle)	Precaution/ Contraindication
1.	<i>Arq-i-Mundi</i> ³⁴	Liquid	60-120 ml	Twice daily	As prescribed by physician	Water	Nothing specific (NS)
2.	<i>Ma'jūn-i Ushba</i> ³⁴	Semi solid	5-10 g.	As directed by physician	As prescribed by physician	Water	NS
3.	<i>Ma'jūn-i Chob Chīnī</i> ³⁴	Semi solid	5-10 g.	As directed by physician	As prescribed by physician	Water	NS
4.	<i>Marham-i Gulabī</i> ³⁴	Ointment	QS./ For external use	As directed by physician	As prescribed by physician	-	NS
5.	<i>Marham-i Quba</i> ³⁴	Ointment	QS./ For external use	As directed by physician	As prescribed by physician	-	NS

Table 10: Research Formulations of CCRUM for oral and local administration in Psoriasis

Sr. No.	Drug	Dosage form	Dose (per day)	Time of administration	Duration / Frequency	Adjuvant	Precautions/ contraindications
1	UNIM-401	Infusion (prepared by soaking in water overnight) for oral use	17gm	Morning on empty stomach	OD	Nil	Nothing specific (NS)
	UNIM-402 ⁴¹	Oil for local application	as required			-	
2	UNIM-401	Infusion (prepared by soaking in water overnight) for oral use	17gm	Morning on empty stomach	OD	Nil	NS
	UNIM-403 ⁴²	Oil for local application	as required			-	

Faşd (Venesection): ^{13,31}

Same as described under level 2

Hammām (Turkish Bath)

Same as described under level 2

Recommended and restricted diet & Lifestyle:

Same as described under preventive management and Level 1

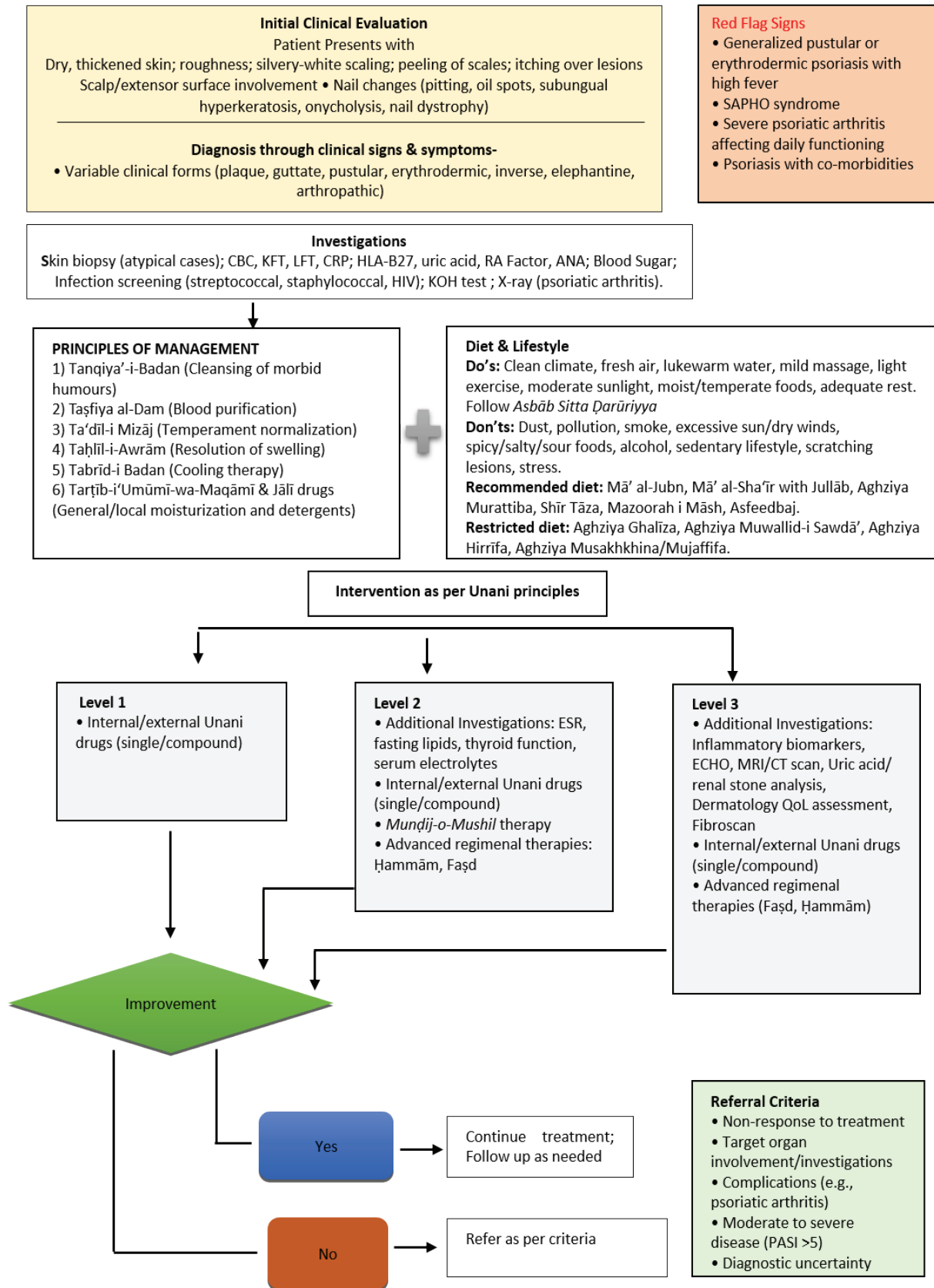
Follow-up (with duration):

The follow-up may be done once a fortnight. The patients who are responding well may be treated as per the assessment of physician.

Referral criteria:

- ✓ Same as Level 2, plus
- ✓ Any condition or serious complication beyond the scope of Unani treatment.

ALGORITHM FOR CLINICAL ASSESSMENT AND MANAGEMENT OF PSORIASIS (TAQASHSHUR AL-JILD)



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URTICARIA

(*Sharā*)

(ICD 10 code: L50.0- 50.9; ICD-11 Code: EB05)

(Urticaria Disorder (TM2): SN4K)

Sharā (NUMC: J-52)

CASE DEFINITION

Urticaria (hives) is characterized by the rapid onset of lesions known as wheals that consist of a central mid dermal swelling with or without surrounding erythema, with associated pruritus, lasting anywhere from 1 to 24 hours. The term urticaria is named after the stinging nettle plant (*Urtica dioica*), which contains histaminic acid. Associated angioedema can sometimes be seen, characterized by swelling of the deeper dermis and subcutaneous tissue lasting up to 72 hours.^{1,2}

INTRODUCTION³⁻⁶ (*Incidence/ Prevalence, Morbidity/ Mortality/ Risk factors*)

- Urticaria is a common skin disease. About 8–20% of individuals in the community experience an attack of urticaria at least once in their lifetime.³
- It can be seen in all ages and sexes but is slightly more common in young adults. In 40–50% of the patients, urticaria and angioedema are seen in combination, only urticaria or angioedema is seen in 40% and 20% of the people, respectively.⁴
- Urticaria is a mast cell–driven disorder characterized by the recurrent development of hives (urticaria) and/or swelling (angioedema).³
- Urticaria affects nearly 1% of the world population, with over 100 million new cases each year. India lacks specific epidemiological studies but contributes heavily to total global burden.
- Chronic cases appear commonly in adults, especially women. India bears a significant burden of urticaria in absolute terms—accruing the highest number of Disability-Adjusted Life Year (DALYs) globally.
- In children (<14 years) at a tertiary hospital in Northern India, 57% had spontaneous urticaria; about 12% had dermatographism, 2% had cold-induced, 1.3% aquagenic, and 1.7% cholinergic urticaria.^{5,6}

ETIOPATHOGENESIS

The underlying event leading to urticaria is mast cell degranulation, with release of histamine and other pro inflammatory molecules. There are numerous stimuli that can lead to mast cell activation through various pathways (Fig.1).

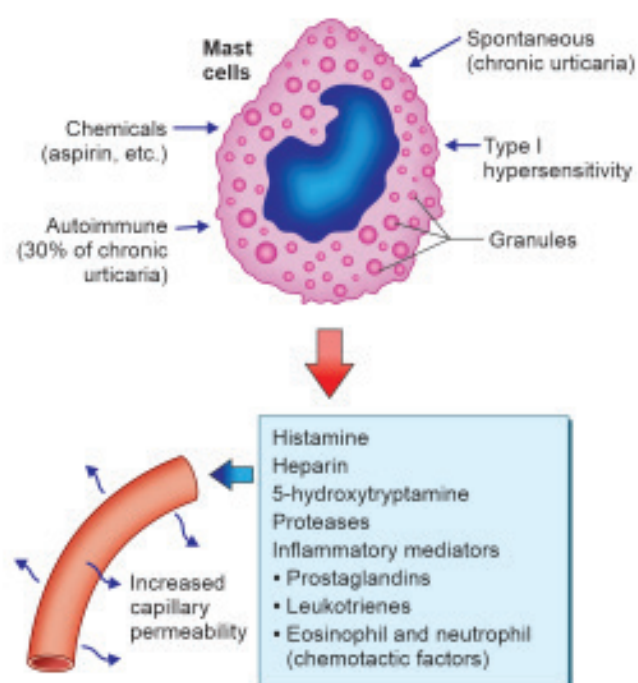


Fig1: Diagrammatic Overview of Urticaria

This release can be triggered by allergic, pseudoallergic, toxic, and physical mechanisms ¹

- Urticaria is allergic when specific antigens crosslink specific IgE antibodies attached to mast cells.
- Pseudoallergic urticaria describes the release of mast cell mediators after exposure to foods or medications but without the presence of specific immunoglobulin (IgE) antibodies.
- Endogenous or exogenous substances such as opiates, codeine, or complement proteins can alter the sensitivity of mast cells to both the stimuli.

1. Acute urticaria

The most common cause of acute urticaria is viral infections, particularly of the upper respiratory tract. Other common causes of acute urticaria are listed in the Box below Food-induced type I hypersensitivity reactions are a rare cause of acute urticaria in adults, but occur more commonly in children.

Table 1- Causes of Acute Urticaria¹

Causes of Acute Urticaria	
Infections (~40%)	Viral respiratory, especially rhinovirus and rotavirus (cause in 80% of children), Helicobacter pylori, Mycoplasma, hepatitis, mononucleosis, and parasitic helminths
Drugs (~10%)	Beta-lactam antibiotics, nonsteroidal anti-inflammatory drugs (NSAIDs), aspirin, ACE inhibitors, diuretics, opiates, contrast media, and blood
Foods (~1%) - Adults	Shellfish, fresh water fish, berries, nuts, peanuts, pork, chocolate, tomatoes, spices, food additives, and alcohol

Causes of Acute Urticaria	
Foods (~1%) - Children	Milk and other dairy products, eggs, wheat, and citrus
Inhalants	Pollens, molds, dust mites, and animal dander
Systemic diseases	Lupus erythematosus, Still's disease, thyroid disease, cryoglobulinemia, mastocytosis, and carcinomas
Emotional stress	
~50% Idiopathic	

2. **Chronic urticaria:** The most common underlying causes of chronic urticaria are:

- Autoreactivity or expression of circulating mast cell secretagogues including autoantibodies (autoimmune urticaria). This is now known as Type IIb CSU.
- Autoallergic Variety also known as Type I CSU.
- Chronic infections.
- Intolerance to food components.

Table 2 : Causes of Chronic Urticaria ¹

Autoreactivity	Autoimmunity (anti-FcεRI-Ab, anti-IgE-Ab) (40–50%)
Chronic infection	Hepatitis B, H. pylori
Intolerance	Foods, drugs, pseudoallergy
Other causes	Type I allergy, internal disease
Idiopathic	~50%

Though not all the factors listed above are seen in all cases, it must be noted that patients of CSU should not be subjected to detailed investigations. In the majority of patients with chronic urticaria, an underlying disease will not be found.

Unani Medicine's Perspective:

According to Unani Medicine, *Sharā* (urticaria / hives) is a condition in which elevated, red , itchy lesions appear abruptly on the skin. ^{7,8}

Etiology

- Accumulation of *Dam* (sanguine) mixed with *Ṣafrā'*(yellow bile), *Balgham Ghayr Ṭabī'* (abnormal phlegm), thick matter salty in nature or *Sawdāwī Khilṭ* (Black bile) beneath the skin. ^{7,8}
- It is caused by production of strong *Bukhārāt* (vapours) of *Damawī* (sanguineous), *Balghamī* (phlegmatic) and *Sawdāwī* (melancholic) nature and their accumulation beneath the skin due to narrowing of skin pores.⁷
- Accumulation of vapours produced by mixing of *Balgham Shor* (salty phlegm) in the blood.^{7,8}
- *Sū' al-Haḍm* (Indigestion)
- *Qabḍ* (Constipation).

- Excessive eating.
- Teething in children
- Excessive alcoholism
- Nervine weakness.
- Irregular menses in women
- Females are more prone than male.
- Youngsters are more affected than old age^{7,8,9}

Pathophysiology

According to Unani medicine, “*Sharā* (urticaria) arises from the predominance of *Dam* (sanguine) mixed with *Ṣafrā’* (yellow bile) resulting in the production of excessive thin morbid matter and heat leading to the production of *Bukhārāt* (vapours) of hot nature. These vapours when accumulated beneath the skin due to weakness and narrowing of the skin pores, give appearance of red coloured small eruptions accompanied with severe restlessness and itching. Sometimes it is caused by predominance of *Dam* (sanguine) mixed with *Balgham Māliḥ* / *Balgham Shor* (saline phlegm) leading to production of large white eruptions with swelling and discharge of fluid. When *Sawda* (black bile) is mixed with *Dam* (sanguine), then eruptions are associated with scaling of the skin and itching. In the light of above, there are three types of *Sharā* (urticaria) in Unani Medicine i.e. *Sharā Damawī* (sanguineous urticaria), *Sharā Balghamī* (phlegmatic urticaria) and *Sharā Sawdāwī* (Melancholic urticaria).^{7,8,9}

CLINICAL PRESENTATION¹⁰⁻¹⁴

- **Lesion morphology:** Wheals are abrupt, well-circumscribed, raised, itchy erythematous to pale lesions varying from millimeters to several centimeters; they appear, migrate, and typically resolve within twenty-four hours without residual marks. They cause intense pruritus and/or burning sensations.
- **Angioedema:** Characterized by sudden swelling of deeper dermis, subcutaneous tissue, or mucosa (e.g., lips, eyes, genitals); often painful (not pruritic), resolving within up to 72 hours
- **Distribution & duration:** Can affect any part of body, including scalp, palms, and soles.
- **Associated symptoms:** May include systemic manifestations like headache, dizziness, throat tightness, wheezing, GI discomfort (nausea, vomiting, diarrhea), arthralgia, fever etc.
- **Dermographism & physical triggers:** Stroking skin may reproduce wheals (“dermatographism”) within minutes; characteristic of physical urticaria-physical factors (pressure, temperature changes, vibration, sunlight) may precipitate symptoms
- **Alarming features indicating vasculitis or anaphylaxis:** Wheals lasting more than 24 hours, painful, non-blanching, or leaving purpura/hyperpigmentation suggest urticarial vasculitis. Associated symptoms such as hypotension, stridor, GI symptoms, or confusion point toward systemic anaphylaxis.



Fig 2: Urticaria: pale pink edematous wheals with a surrounding flare



Fig 3: Urticaria: itchy pink wheals

Courtesy: Illustrated Synopsis of Dermatology and Sexually Transmitted Diseases, Neena Khanna Fourth edition.

Unani Medicine's Perspective: Clinical presentation^{7,8,9}

- Red coloured small eruptions or white coloured large eruptions
- Severe restlessness
- Itching
- Swelling
- Discharge of fluid from red eruptions
- Scaling of the skin

CLINICAL EXAMINATION

Clinical examination of urticaria involves assessing the patient's overall health, including vital signs, identifying potential triggers (as mentioned in tables 1 & 2), and performing a physical examination of the urticarial lesions.

The physical examination of urticaria includes¹⁵

- Type/Appearance of lesion.
- Size
- Shape
- Colour of lesion
- Margin
- Number
- Site of lesion
- Distribution-whether lesions are localized or generalized.

Table 3: Classification of urticaria

Classification of urticaria is based on duration and Cause ¹⁶⁻¹⁸	
Acute spontaneous urticaria	Characterized by the sudden appearance of wheals and/or angioedema lasting less than six weeks.
Chronic spontaneous urticaria (CSU)	Refers to spontaneous wheals and/or angioedema persisting for six weeks or longer. This term is interchangeable with "urticaria" or "chronic idiopathic urticaria." There are two types Type I and Type IIb

Chronic inducible urticaria (CIndU)	Involves wheals triggered by physical stimuli (e.g., pressure, temperature changes) that continue for six weeks or more—also known as “physical urticaria.”
Summary for different types of classifications for urticaria¹⁶⁻¹⁸	
Category	Subtypes / Examples
Acute (<6 weeks)	Spontaneous (infection, allergy, idiopathic).
Chronic (≥6 weeks) aka CSU	CSU (no trigger) and CIndU (physical/special triggers).
Inducible Urticaria	Dermatographic, Cold, Heat, Delayed pressure, Solar, Vibratory, Aquagenic, Cholinergic, Contact, Adrenergic.
Contact Urticaria	Contact with chemicals found in foods, plants, and medicines elicits urticaria.

DIFFERENTIAL DIAGNOSIS ^{19, 20}

Table 4: Differential diagnosis of urticaria

Differential diagnosis	Characteristic and diagnostic features
Urticarial vasculitis	Wheals lasting >24 h, often painful/burning, with residual hyperpigmentation or purpura. May present with systemic symptoms (fever, arthralgia, nephritis); biopsy shows leukocytoclastic vasculitis.
Cutaneous mastocytosis (urticaria pigmentosa)	Brown/orange lesions, positive Darier’s sign (wheal upon stroking), smaller fixed lesions.
Bullous pemphigoid (prodromal)	i. Urticarial plaques evolving into tense bullae; histopathology shows subepidermal blisters with ii. eosinophilic infiltrate.
Urticarial dermatitis	Mix of urticarial wheals and eczematous patches; spongiosis and lymphocytic infiltrate on biopsy.
Cutaneous lupus erythematosus	May mimic urticaria; biopsy reveals interface dermatitis, basal vacuolization, mucin deposition.
Henoch–Schönlein purpura, (IgA vasculitis) cryoglobulinemia	Purpuric vasculitis lesions, systemic signs (renal, joint, abdominal).
Fixed drug eruption	A drug reaction that occurs at the same location on skin with each exposure to a specific drug, potentially mimicking urticaria.
Atopic dermatitis	It can sometimes present with urticarial - appearing lesions.
Insect bites	It can cause localized urticarial lesions.
Pityriasis rosea	It may be mistaken for urticaria due to its appearance, but it has a characteristic herald patch and follows a specific pattern of distribution.
Contact dermatitis	It can sometimes manifest as urticarial lesions, especially in irritant or allergic contact dermatitis.
Sweet syndrome (Acute febrile neutrophilic dermatosis)	The condition may present with urticarial lesions (oedematous, erythematous plaques that can mimic urticaria) along with fever and other systemic symptoms.

Table 5: Unani Medicine’s Perspective: Differential Diagnosis^{7,8,9}

Character	<i>Sharā Damawī</i>	<i>Sharā Balghamī</i>	<i>Sharā Sawdāwī</i>
Dominant humor	<i>Dam</i> (sanguine)	<i>Balgham</i> (phlegm)	<i>Sawdā</i> (black bile)
Etiology	Predominance of <i>Dam</i> (sanguine) mixed with <i>Ṣafrā’</i> (yellow bile)., production of vapours of hot nature	Predominance of <i>Dam</i> (sanguine) mixed with <i>Balgham Māliḥ</i> / <i>Balgham Shor</i> (saline phlegm)	Predominance of <i>Dam</i> (sanguine) mixed with <i>Sawdā</i> (black bile)
Clinical presentation	Small, red eruptions with itching and severe restlessness	Large, soft, oedematous eruptions with less intense itching.	Dark eruptions with itching and scaling
Diurnal variation	Itching usually occurs all day long	Itching is more in the night	No Specific Pattern
Triggering factors	<i>Ghidhā’ Hārr</i> (diet of hot temperament)	<i>Ghidhā’ Bārid wa Ghidhā’ Raṭb</i> (Diet of cold and wet temperament)	<i>Al-Aghdhiya al-Muwallida li’l Sawdā’</i> (black bile producing diet)

SUPPORTIVE INVESTIGATIONS²¹⁻²⁸

Some principles that determine the investigation are:¹

1. Acute urticaria is generally not investigated.
2. Acute recurrent urticaria is frequently clarified with a history, as a possible trigger (food, medication, activity) can be identified. One should not forget to enquire about mucosal contacts, such as toothpaste, latex condoms, or even semen. Everything that comes in contact with the mucosa should be sought for, like drugs (prescription and over-the-counter; asking directly about aspirin and nonsteroidal anti-inflammatory drugs [NSAIDs]), all foodstuffs including spices, drinks and even chewing gum.
3. Chronic urticaria often remains idiopathic. Now there is a concept of endotypes and there are certain investigations that can be employed to differentiate the types of CSU, but they relate to the course and preferred treatment and need expert interpretation by centers that are proficient in these tests. Certain drugs like anti histamines, Omalizumab and BTK inhibitors are prescribed on the basis of these tests and endotype classification.

We will detail the current investigation strategy for Acute and CSU keeping the principles as above in view based on the best current evidence [Table 4 and 5]. Provocation tests for CINDU are given in Table 6

Table 6: Investigations for Acute Urticaria

1. Full blood count with differential white cell count 2. CRP levels and/or ESR 3. Culture of relevant specimens 4. Serum allergen-specific IgE tests* 5. Prick tests* 6. Oral drug challenge tests	Most cases do not need any testing
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*ONLY if IgE mediated Type 1 hypersensitivity is suspected as a cause of urticaria , avoid unnecessary testing. [Sardana K. Urticaria and Angioedema Current Insights. CBS Publishers & Distributors Private Limited; 2022.]

Table 7: Investigations for CSU

Differential blood count. ESR and/or CRP, IgG anti- TPO and total IgE	Routine Tests
i. Infectious diseases ii. Thyroid Gland disorders (thyroid hormones and autoantibodies) iii. Concomitant CIndU (see below) iv. Severe systemic diseases (e.g. tryptase) v. Other (e.g. lesional skin biopsy)	Extended diagnostic Tests For identification of underlying causes or eliciting factors and for ruling out possible differential diagnoses if indicated based on history.

Sardana K. Urticaria and Angioedema Current Insights. CBS Publishers & Distributors Private Limited; 2022.

Table 8:- Investigations for CIndU

Challenge test/ Provocative test: Recommendations for confirming the relevance and threshold of triggers for inducible urticaria.	Type	Challenge test
	Cold Urticaria	Apply cold stimulus (e.g. ice cube on forearm) and observe for wheal-and-flare reaction during skin rewarming.
	Heat urticaria	Heat provocation and threshold test.
	Solar urticaria	Photo Test to various wavelengths of light.
	Symptomatic dermatographism	Stroke skin with firm object (e.g. tongue blade or other instrument with a firm edge.), or a dermographometer.

DIAGNOSTIC CRITERIA

The diagnosis will be done based upon the clinical presentation, clinical examination and investigations as mentioned above.

PRINCIPLES OF MANAGEMENT

Red Flag Signs

These signs should be assessed before initiating treatment to identify cases requiring management/consultation through modern medicine.

1. Angioedema of airway structures & family History.
2. Respiratory distress (stridor, wheezing).
3. Cardiovascular signs (hypotension, tachycardia, syncope).
4. Hives that persist > 24–48 hours or ulcerate.
5. Systemic signs (fever, weight loss, night sweats, arthralgia).
6. Chronic hives (> 6 weeks).
7. Urticaria as a part of severe allergic reaction.
8. Urticaria with symptoms of anaphylaxis (dizziness, breathing troubles and swelling of tongue, lips, mouth or throat).

Unani Medicine's Perspective:^{7,8,9}

The general line of treatment as mentioned in classics:

- *Izāla'-i-Sabab* (Removal of Cause)
- *Tanqiya'-i-Badan* (cleansing of morbid matter/ humour from body)
- *Taftih-i-Masām* (inducing deobstruction of pores)
- *Tahlil-i-Abkhira* (dispersion of vapours)
- *Itfā'-i-Abkhira* (stopping production of vapours)
- *Taṣfiya al-Dam / Tanqiya'-i-Khūn* (blood purification)

A complete plan for managing urticaria in an individual patient may involve educational, behavioural, psychological, and physical therapies, as well as Unani topical and oral drugs (single and compound formulations).

In some people, a single physical, behavioural, or pharmaceutical intervention may be sufficient to alleviate symptoms. In severe and chronic instances, numerous therapies may be utilized sequentially or in combination to treat patients.

'*Ilāj bi'l Dawā*' (pharmacotherapy) [IUMT-7.1.10] and '*Ilāj bi'l Tadbīr*' (regimenal therapy) [IUMT-7.2.0] are considered the mainstay of treatment in case of Urticaria. '*Ilāj bi'l Tadbīr*' (regimenal therapy) includes *Fasd'* (Venesection) [IUMT-7.2.6]^{5,6,8}, *Hijāma* (cupping) [IUMT-7.2.30]^{5,6,8}, *Bakhūr / Dhūnī* (incense) [IUMT-6.2.112]^{5,6}, *Inkibāb* (vapour bath) [IUMT-6.2.115]⁵, *Naṭūl* (douche) [IUMT-6.2.95]⁵, *Dimād* (poultice) [IUMT-6.2.52]^{5,6,8}, *Ṭilā* (liniment) [IUMT-6.2.53]⁵, *Sakūb* (irrigation) [IUMT-6.2.94]⁵ and *Ḥammām* (therapeutic bath) [IUMT-7.2.70], *Mundij wa Mushil* therapy (Concoctive and Purgative therapy) etc.^{7,8,9}

A. Prevention Management²⁹

Preventive strategies of acute and chronic urticaria focus on avoiding triggers, minimizing exposure to known allergens, stress management, avoidance of histamine-rich foods and skin care like regular moisturization, avoidance of scratching and sun protection.

Diet and Lifestyle

- Low-Impact Aerobic exercise such as Walking, Swimming and Cycling is recommended
- Adequate nutrition should be taken. A diet rich in vitamins C & D, minerals like Zinc and Magnesium, and Omega-3 fatty acids help in recovering from urticaria. Probiotics help in reducing the urticaria caused due to autoimmune disorder.
- Avoid strenuous exercise
- Avoid common allergens such as dairy products, gluten rich diet, eggs, soy, nuts, fish and shellfish.
- Avoid potential irritants like artificial additives, processed foods, and high sugar foods.
- Spicy and pungent diets, sweet dishes, Meat should be avoided

Table 9: Unani Medicine's Perspective:^{7,8,9}

Dos	Don'ts (Disease aggravating factors)
• Intake of <i>Tafshīl</i> (dehusked lentil cooked with vinegar) • Intake of <i>Mā' al-Sha'ir</i> (Barley water)	• Allergens • Non-vegetarian food

Dos	Don'ts (Disease aggravating factors)
- Intake of <i>Mā' al-Jubn</i> (Whey), if caused by melancholic vapours. - Intake of <i>Aab-e-Anar</i> Pomegranate Juice - Intake of <i>Khall</i> (Vinegar). - Intake of <i>Aghdhiya Barida</i> (The food of cold temperament having ability to produce the humours which induce coldness in the body) e.g. <i>Khas</i> (<i>Chrysopogon zizanioides</i> (L.) Roberty), <i>Kāsinī</i> (<i>Cichorium intybus</i>, L., etc.) - Intake of <i>Aghdhiya Latifa</i> (Food stuffs which are easy to digest but have little nutritional value, and produce such a sanguine which is normal in viscosity). - Intake of <i>Mā' al-Fawākih</i> (fruit juice)	- Stress and worries - Extreme emotional disturbances - Spicy and pungent diets - Sweet dishes - Meat <i>Ghidhā' Hārr</i> (Foods of hot temperament having ability to produce the humours which induce heat in the body) e.g. onion, garlic, etc. <i>Al-Aghdhiya al- Muwallida li'l Sawdā'</i> (black bile producing diet) like brinjal - Exposure to heat and sunlight⁵

Note: Patient is advised to follow the rules of *Asbāb Sitta Ḍarūriyya* (six essential factors) as advised by physician.

Avoiding the causes that may lead to Urticaria, such as avoidance of spicy and pungent foods and refraining from various allergens and triggers etc.

Correction of humoural and temperamental derangement: *Sharā* is mainly caused due to involvement of abnormal sanguine, abnormal phlegm and abnormal black bile. So, the main focus should be on correction of humoural imbalance, either the quality or quantity.

Yoga³⁰

- ✓ Regular practice of yogic techniques such as Neti (nasal cleansing), selected Asanas—including Tadasana (Palm Tree Pose), Trikonasana (Triangle Pose), Veerabhadrasana I & II (Warrior Poses I & II), Setu Bandhasana (Bridge Pose), and Shavasana (Corpse Pose)—along with breathing practices (Pranayama) such as Nadi Shodhana (alternate nostril breathing), Bhramari (humming bee breathing), and Sheetali (cooling breath), play a significant role in maintaining overall health.
- ✓ These practices collectively help in reducing psychological stress, improving blood circulation, facilitating detoxification, and regulating immune function. Furthermore, the inclusion of Dhyana (meditation) and Yoga Nidra (yogic relaxation) enhances mental stability and promotes psychosomatic balance. Together, these interventions contribute to strengthening the body's natural defense mechanisms and may aid in reducing the risk or progression of disorders such as Urticaria.

A. Interventions

At Level 1- Solo Physician Clinic/Health Clinic/PHC (Optimal standard of treatment where technology and resources are limited)

Clinical Diagnosis: Urticaria is diagnosed after a complete medical history, psychiatric history, triggering factors and physical examination. Confirm whether the lesions are consistent with the presentation of urticaria. Check for the type of lesion, colour of the lesion, margin, shape, number, size, site, blanchability and dermatographism. Some investigations, like CBC

(Complete blood count), ESR (Erythrocyte sedimentation rate), CRP (C-Reactive protein), Stool Examination, total IgE may be done.

OPD level management – If the patient shows mild features of *Sharā* (urticaria), two or more of the following forms of medications may be given along with diet restriction and avoidance of allergens:

Table 10: Single and Compound drugs for internal/external use

Sr. No.	Drug	Dosage form	Dose (per day)	Time of administration	Duration and Frequency	Badraqa (vehicle)
1.	<i>Kamila</i> (<i>Mallotus philippensis</i> (Lam.) Muell. -Arg.) ^{31,32}	Powder	1-3 g. in two divided doses	After meal	15 days to 1 month	Water
2.	<i>Chiraita</i> (<i>Swertia chirayita</i> (Roxb.) H. Karst.) ³¹	Powder	5-7 g. in two divided doses	After meal	15 days to 1 month	Water
3.	<i>Kalonji</i> (<i>Nigella sativa</i> L.) ^{31,32}	Powder	1-2 g. in two divided doses	After meal	15 days to 1 month	Water
4.	<i>Khayar</i> (<i>Cucumis sativus</i> L.) ^{31,33}	Powder of seeds	5-7 gm in two divided doses	After meal	15 days to 1 month	Water
6.	<i>Habb-i- Musaffi-e-Khoon</i> ³⁴	Pills	250-500 mg in two divided doses	After meal	15 days to 1 month	Water
7.	<i>Ma'jūn-i-Chob Chīni</i> ³⁵	Semi-solid preparation	5-10 g. in two divided doses	After meal	15 days to 1 month	Water
8.	<i>Jawārish Tamar-i-Hindi</i> ³⁵	Semi-solid preparation	5-10 g. in two divided doses	After meal	15 days to 1 month	Water
9.	<i>Sharbat-i-Nilofar</i> ³⁵	Syrup	25-50 ml in two divided doses	After meal	15 days to 1 month	Water
10.	<i>Marham Gulabi</i> ³⁵	Ointment for local application	Q.S. for external use	As directed by the physician	15 days to 1 month	-
12.	<i>Dimad Muhallil</i>	Poultice for local application	Q.S. for external use	As directed by the physician	15 days to 1 month	-

‘Ilāj bi’l Tadbīr (Regimenal Therapy).

- **Sakūb (Irrigation)** [IUMT-6.2.94] of lukewarm water on the body.⁷
- **Ṭilā (Liniment)** [IUMT-6.2.53] prepared with vinegar, rose water,, *Āb-i-Karafs* (juice of *Apium graveolens* L.), and *Roghan-i-Gul*.⁷

- **Ṭilā (Liniment) [IUMT-6.2.53]** prepared by mixing *Āb-i-Innabussalab* (juice of *Solanum nigrum* L.), *Āb-i-Kishniz* (juice of *Coriandrum sativum* L.), *Āb-i-Kaknaj* (juice of *Alkekengi officinarum* Moench), *Arad-i-Jao* (flour of *Hordeum vulgare* L.), vinegar.⁷
- **Naṭūl (Douche) [IUMT-6.2.95]** with decoction of leaves of *Zaitoon* (*Olea europaea* L.) after cooling.⁷
- **Bakhūr / Dhūnī (Incense) [IUMT- -6.2.112]** of *Zard Chob* (*Curcuma longa* L.).⁷
- **Inkibāb (Vapour bath) [IUMT-6.2.115]** with *Ajwain* (*Trachyspermum ammi* (L.) Sprague) and sugar.⁷

Recommended and Restricted Diet and Lifestyle: Same as described under preventive management.

Follow-Up (every 15 days or earlier as per the need)

Reviews should include:

- Monitoring the person's symptoms and the ongoing impact of the condition on their everyday activities and quality of life.
- Monitoring the long-term course of the condition.
- Discussing the person's knowledge of the condition, any concerns they have, their personal preferences, and their ability to access services.
- Reviewing the effectiveness and tolerability of all treatments.
- Self-management support.

Referral Criteria

- Non-response to treatment
- Frequent and chronic urticaria episode.
- If itching is more severe.
- Patients suffering from angioedema.
- Substantial impact on their quality of life and activities of daily living.
- Evidence of an increase in severity/complications
- Diagnostic uncertainty.
- Uncontrolled comorbidities such as diabetes mellitus, hypertension etc.
- Urticaria with symptoms of anaphylaxis
- Hereditary angioedema, physical urticaria not responding to treatment.

At Level 2 (CHC/Small hospitals (10-20 bedded hospitals with basic facilities such as routine investigation, X-ray)

Clinical Diagnosis: Same as level 1. The case referred from Level 1, or a fresh case must be evaluated thoroughly for any complications.

Investigations: The diagnosis would be primarily clinical. However, some investigations may be necessary to investigate complications or exclude other differential diagnoses as follows:

1. Infection screens
2. Thyroid panels

3. Provocation for ClndU:

- i. Cold urticaria: ice cube/cold-water test.
- ii. Dermographism: stroking skin test.
- iii. Heat urticaria: warm water provocation.
- iv. Solar urticaria: visible light exposure.
- v. Aquagenic urticaria: warm-water compress test.
- vi. Cholinergic urticaria: exercise/hot-bath test.
- vii. Contact urticaria: prick/patch tests.

Management: Same as level 1 and/or treatments mentioned at this level.

Other procedures:

- Application of cool, damp cloth to affected areas can reduce itching and inflammation.
- Narrowband UVB therapy may be considered beneficial for chronic urticaria.
- Reduce stress through relaxation techniques (Meditation and Yoga).
- Avoidance of tight clothing or excessive skin pressure in pressure induced urticaria.

Management: Same as level 1 and/or the following treatment:

Table 11: Single and compound Unani drugs for internal use

Sr. No.	Single and Compound Unani Formulations	Dosage form	Dose per day	Time	Duration & Frequency	Badraqa (vehicle)	Precaution/ Contraindication
1	<i>Chobchini (Smilax china L.)</i> ³¹	Powder	5-10 g in two divided doses	After meal	15-30 days	Water	N.S (Nothing specific)
2	<i>Khaksi (Sisymbrium irio L.)</i> ³¹	Powder	5-10 g in two divided doses	After meal	15-30 days	Water	N. S
3	<i>Shāhitra (Fumaria parviflora Lam.)</i> ³¹	Powder	5-10 g in two divided doses	After meal	15-30 days	Water	N. S
4	<i>Neem (Azadirachta indica A. Juss.)</i> ³⁶	Powder	6-10 g in two divided doses	After meal	15-30 days	Water	N. S
5	<i>Babchi (Cullen corylifolium (L.) Medik.)</i> ³⁶	Powder	3-5 g in two divided doses	After meal	15-30 days	Water	N. S
6	<i>Karanjwa (Guilandina bonduc L.)</i> ³¹	Powder	3-5 g in two divided doses	After meal	15-30 days	Water	N. S
7	<i>Zard Chob (Curcuma longa L.)</i> ³¹	Powder	5-10 g in two divided doses	After meal	15-30 days	Water	N. S
8	<i>Karanj (Pongamia pinnata (L.) Pierre)</i> ³²	Powder	1-2g in two divided doses	After meal	15-30 days	Water	N. S

Sr. No.	Single and Compound Unani Formulations	Dosage form	Dose per day	Time	Duration & Frequency	Badraqa (vehicle)	Precaution/ Contraindication
9	<i>Khamīra Sandal</i> ³⁴	Semisolid	5-10 g in two divided doses	After meal	15-30 days	Water	Diabetes Mellitus Type I&II
10	<i>Ma'jūn-i-Ushba</i> ³¹	Semisolid	5-10 g in two divided doses	After meal	15-30 days	Water	Diabetes Mellitus Type I&II
11	' <i>Araq-e-Mundi</i> ^{31, 35}	Liquid form	60-120 ml in two divided doses	Before meal	15-30 days	Water	N. S

Ointment for external application

Sr. No.	Formulation	Dosage Form	Dose per day	Time	Duration & Frequency	Precaution/ Contraindication
1.	<i>Marham Kafoor</i> ³⁴	Ointment	Q.S. for external use	As directed by Physician	1-2 months	N. S
2.	<i>Marham Kharish Jadeed</i> ³⁴	Ointment	Q.S. for external use	As directed by Physician	1-2 months	N. S

'Ilaj bi'l Tadbīr (Regimenal therapy):

- **Hijāma bilā Sharṭ (Dry cupping)** [IUMT-7.2.32]^{7,8,9}
- **Bakhūr / Dhūnī (Incense)** [IUMT- -6.2.112] with *Tukhm-i-Neem* (seeds of *Azadirachta indica* A. Juss.) on the affected part.⁸
- **Ḍimād (Poultice)** [IUMT-6.2.52] prepared by mixing powder of *Maghz Badam Talkh* (kernel of *Prunus amygdalus* var. *amara*), *Boora Armani* (Armenian earth), *Tukhm-i-Turb* (seeds of *Raphanus sativus* L.) on the body or affected site. This is to be done after *Kimād* (fomentation) with hot water or after *Ḥammām* (therapeutic bath).⁵
- **Faşd (Venesection)** [IUMT-7.2.6]^{7,8,9}
 - *Faşd-i-Bāsilīq* (bloodletting from basilic vein).^{7,8,9}
 - *Faşd-i- Akḥal* (median cubital vein bloodletting) can be performed.⁷
 - *Faşd-i-Şāfin* (bloodletting from saphenous vein).⁷

Management for Acute Urticaria

In Unani Medicine, acute urticaria is understood as that type of urticaria in which the causative humour is Dam (sanguine) mixed with *Şafrā'* (yellow bile) or Balgham (phlegm) particularly Balgham Shor (salty phlegm). In such cases *Tanqiya* (evacuation) is done by using appropriate formulations based on the underlying humoral imbalance⁷.

For evacuation of morbid yellow bile mixed with Dam (sanguine), the following formulation is used:

Table 12: Formulation for evacuation of morbid yellow bile mixed with Dam (sanguine)

Sr. No.	Formulation	Dosage form	Dose	Time	Duration	Badraqa (vehicle)	Precaution/ Contraindication
1.	• <i>Imlī</i> (<i>Tamarindus indica</i> L.), • <i>Ālū Bukhāra</i> (<i>Prunus domestica</i> L.), • 'Unnāb (<i>Zizyphus jujuba</i> Mill.) 70 gm. each, • <i>Mawīz Munaqqā</i> (<i>Vitis vinefera</i> L.) 35 gm., • <i>Halayla Siyāh</i> (<i>Terminalia chebula</i> Retz.), • <i>Halayla Kābulī</i> (<i>Terminalia chebula</i> Retz.), • <i>Halayla Zard</i> (<i>Terminalia chebula</i> Retz.), • <i>Banafsha</i> (<i>Viola odorata</i> L.), • <i>Sanā Makkī</i> (<i>Senna alexandrina</i> Mill.), • <i>Gulāb</i> (<i>Rosa damascena</i>, Mill.), • <i>Afsantīn</i> (<i>Artemisia absinthium</i> L.), • <i>Asl al-Sūs</i> (<i>Glycyrrhiza glabra</i> L.) 14 gm. each, • <i>Tukhm-i Kāsīnī</i> (<i>Cichorium intybus</i> L.), • <i>Tukhm-i Kasūs</i> (<i>Cuscuta reflexa</i> Roxb.) 10 gm. each are soaked and boiled in 1400 ml. water till the liquid is reduced to 350 ml. • Seventy gm. of <i>Shīr-i Khisht</i> (<i>Fraxinus ornus</i> L.) is added to the filtrate and taken orally.	Decoction	100ml	Morning before meal	7 days	-	Pregnancy

In cases of acute urticaria in which there is predominance of Dam (sanguine) mixed with salty phlegm, management involves *Mundij wa Mushil* therapy (Concoctive and Purgative therapy) for morbid phlegm evacuation which is as follows:⁷

Table 13: *Munḍij wa Mushil* therapy (Concoctive and Purgative therapy) for morbid phlegm evacuation

Sr. No.	Formulation	Dosage form	Dose	Time	Duration	Badraqa (vehicle)	Precaution/Contraindication
1.	- Decoction of Post-i Halayla Kābulī (<i>Terminalia chebula</i> Retz.) 36 gm., - Shāhtra (<i>Fumaria parviflora</i> Lam.) 24 gm., - Tukhm-i Kasūs (<i>Cuscuta reflexa</i> Roxb.) 10 gm., - Tukhm-i Kāsini (<i>Cichorium intybus</i> L.) 10 gm., - Post-i Bekh-i Bādiyān (<i>Foeniculum vulgare</i> Mill.) 7 gm., - Ālū Bukhāra (<i>Prunus domestica</i> L.) 20 Numbers and - Unnāb (<i>Zizyphus jujuba</i> Mill.) 20 Numbers mixed with - Maghz-i Amaltās (Fruit pulp of <i>Cassia fistula</i> L.) 54 gm. and - Ma'jūn-i Dabīd al-Ward 54 gm.	decoction	100ml	Morning before meals	5 days	-	Pregnancy
Note: After completion of course of above <i>Munḍij</i> and appearance of signs of <i>Nuḍj</i> in urine, following purgative drugs has to be added to the above formulation used for <i>Nuḍj</i>							
2.	Ayārij-i- Fayqrā	powder	3-5 gm	Early morning before meal	2-3 days	water	Pregnancy

Chronic Urticaria: In Unani Medicine, chronic urticaria is understood as that type of urticaria which is caused by predominance of Dam (sanguine) mixed with Sawdā (black bile). In such cases, tanqiya of Sawdā (black bile) is done by administration of *Munḍij wa Mushil* therapy (Concoctive and Purgative therapy)⁷ for morbid black bile evacuation

Table 14: *Munḍij wa Mushil* therapy for morbid black bile evacuation

Sr. No.	Formulation	Dosage form	Dose	Time	Duration	Badraqa (vehicle)	Precaution/Contraindication
1.	Halayla Siyāh (<i>Terminalia chebula</i> Retz.),	decoction	100ml	Morning before meals	15-20 days	-	Pregnancy

Sr. No.	Formulation	Dosage form	Dose	Time	Duration	Badraqa (vehicle)	Precaution/ Contraindication
	• <i>Halayla Kābulī</i> (<i>Terminalia chebula</i> Retz.), • <i>Halayla Zard</i> (<i>Terminalia chebula</i> Retz.), • <i>Āmla</i> (<i>Phyllanthus emblica</i> L.) 17 ½ gm. each, • <i>Gāozabān</i> (<i>Borago officinalis</i> L.), • <i>Bisfā'ij</i> (<i>Polypodium vulgare</i> L.), • <i>Bādranjboya</i> (<i>Melissa axillaris</i> (Benth.) Bakh.f.), • <i>Ustukhudūs</i> (<i>Lavandula steochas</i> L.) 14 gm. each, • <i>Turbud</i> (<i>Operculina turpethum</i> (L.) Silva Manso) 7 gm., • <i>Shāhtra</i> (<i>Fumaria parviflora</i> Lam.) 24 ½ gm., • <i>Ālū Bukhāra</i> (<i>Prunus domestica</i> L.) • 20 Numbers, <i>Mawīz Munaqqā</i> (<i>Vitis vinefera</i> L.) are soaked and boiled in 1600 ml of water till 600 ml. of liquid is left. • Thirty five grams of <i>Aftīmūn</i> (<i>Cuscuta reflexa</i> Roxb.) is added to it and boiled again till it is reduced to 400 ml. The boiled material is filtered and 52 ½ gm of • <i>Maghz-i Falūs-i Khiyār Shambar</i> (Fruit pulp of <i>Cassia fistula</i> L.), 3 gm. of • <i>Ghārīqūn</i> (<i>Laricifomes officinalis</i> (Vill.) Kotl. & Pouzar.) and honey are added to the filtrate.						
Note: After completion of course of above <i>Mundij</i> and appearance of signs of <i>Nudj</i> in urine, following purgative drugs has to be added to the above formulation used for <i>Nudj</i>							
2.	<i>Ḥabb-i-Aftimun</i>	pills	5-10gm	Early morning before meal	2-3 days (after <i>Nudj</i>)	water	Pregnancy

Recommended and Restricted Diet and Lifestyle: Same as described under preventive management.

Follow Up (every 15 days or earlier as per the need)

Referral Criteria

- Same as mentioned earlier at level 1, plus
- Failure of acute exacerbation to respond to initial medical management
- If swelling of the eyes, mouth, hands, feet, or genitals occur with hives that is called as angioedema.
- Any other complications that threaten the life of the patient.

At Level 3 (Ayush hospitals attached with teaching institution, District Level/Integrated/ State Ayush Hospitals, Tertiary care allopathic hospitals having Ayush facilities), multiple departments/facilities for diagnosis and interventions. Must provide additional facilities like dieticians, counselling, and physiotherapy unit.

Clinical Diagnosis: Same as levels 1& 2.

Investigations:

- Screening for neutrophil rich infiltrates in skin biopsy, performing gene mutation analysis for hereditary periodic fever syndromes.
- Autologous Serum Skin Test (ASST)
- In cases of suspected hereditary angioedema (HAE), test for complement C4 levels: If mean wheal duration >24 hours, perform biopsy of skin lesion to assess for signs of urticarial vasculitis.
- Complement activity tests.
- Anti-nuclear antibody, rheumatoid factor, and/or anti-citrullinated protein.
- Thyroid autoantibodies to TSH receptor, thyroglobulin, thyroid peroxidase and sodium/iodine symporter
- Biopsy to be done when there is doubt regarding the diagnosis (lesions persisting beyond 24 hrs, non-blanchable, fever, joint pains etc.)

Management: Same as levels 1&2 and/or treatment mentioned at this level.

In addition to the level 1 and level 2 management strategies, Unani medicine has a number of specific remedies that can ease the symptoms in patients presenting urticaria with angioedema or in those who have not responded to treatment due to a lack of symptoms, co-morbid conditions, or the use of other immune-suppressive, oral hypoglycemic agents, or antihypertensives. Palliative care medications can therefore be provided based on the sphere of action or keynote prescription in these disorders as well as other advanced pathological states.

Table 15: Single and compound Unani drugs for internal use

Sr. No.	Single and Compound Unani drugs	Dosage form	Dose per day	Time	Duration & Frequency	Badraqa (vehicle)	Precaution/ Contraindication
1.	<i>Aftimoon</i> (<i>Cuscuta reflexa</i> Roxb.) ³⁷	Powder	3-5 g in two divided doses	After meal	15-30 days	Water	Pregnancy
2.	<i>Şibr</i> (<i>Aloe Vera</i> (L.) Burm. f.) ³²	Powder/Decoction	1-4 g in two divided doses	After meal	15-30 days	Water	Pregnancy
3.	<i>Sana</i> (<i>Senna alexandrina</i> Mill.) ^{31,32}	Powder	5-10 g. in two divided doses	After meal	15-30 days	Water	Pregnancy
4.	<i>Ḥabb-ul-Neel</i> (<i>Indigofera tinctoria</i> L.) ³⁶	Powder	1-1.5 g in two divided doses	After meal	15-30 days	Water	Pregnancy
5.	<i>Qurş-i-Asfar</i> ³⁴	Tablet	775 mg in Morning and 775 mg in evening	After meal	1-2 months	Water	N. S
6.	<i>Ma'jūn-i-Chob Chīnī Ba Nuskha Kalan</i> ³⁴	Semisolid	5 gm twice a day	After meal	1-2 months	Water	Diabetes Mellitus
7.	<i>İṭrīfal-i-Shāhītra Shahatra</i> ^{31,35}	Semisolid	5-10 gm in two divided doses	After meal	1-2 months	Water	Diabetes Mellitus
8.	<i>'Araq-e-Chiraita</i> ³⁴	Liquid	125 ml twice a day	Before meal	1-2 months	Water	N. S
9.	<i>Ma'jūn Musaffi-e-Azam</i> ³⁸	Semisolid	5 gm twice a day	After meal	1-2 months	Water	Diabetes Mellitus
10.	<i>Ushban</i> ³⁸	Semisolid	6 gm twice a day	After meal	1-2 months	Water	Diabetes Mellitus

Ointment for external application

Sr. No.	Formulation	Dosage form	Dose per day	Time	Duration & Frequency	Precaution/ Contraindication
1.	<i>Marham Hina</i> ³⁸	Ointment	Q.S. for external use	As directed by Physician	1-2 months	NS
2.	<i>Marham Siyah</i> ³⁸	Ointment	Q.S. for external use	As directed by Physician	1-2 months	NS
3.	<i>Marham Raskapoor</i> ³⁵	Ointment	Q.S. for external use	As directed by Physician	1-2 months	NS

'Ilāj bi'l Tadbīr (Regimenal therapy):

- *Faşd* (Venesection) [IUMT-7.2.6]^{7,8}
- *Ḥammām* (Therapeutic bath) [IUMT-7.2.70]^{7,8,9}
- *Ḥijāma bi'l Sharṭ* (Wet cupping) [IUMT-7.2.31]^{7,39}

Note: For the management of acute and chronic urticaria, *Tanqiya-i-Şafrā'* (evacuation of morbid yellow bile) and *Munḍij wa Mushil* therapy (concoctive and purgative therapy) are recommended for the evacuation of morbid *Balgham* (phlegm) and morbid *Sawda* (black bile), similar to Level-2 above, according to the cause of the disease.

Recommended Diet and Lifestyle: Same as levels 1&2

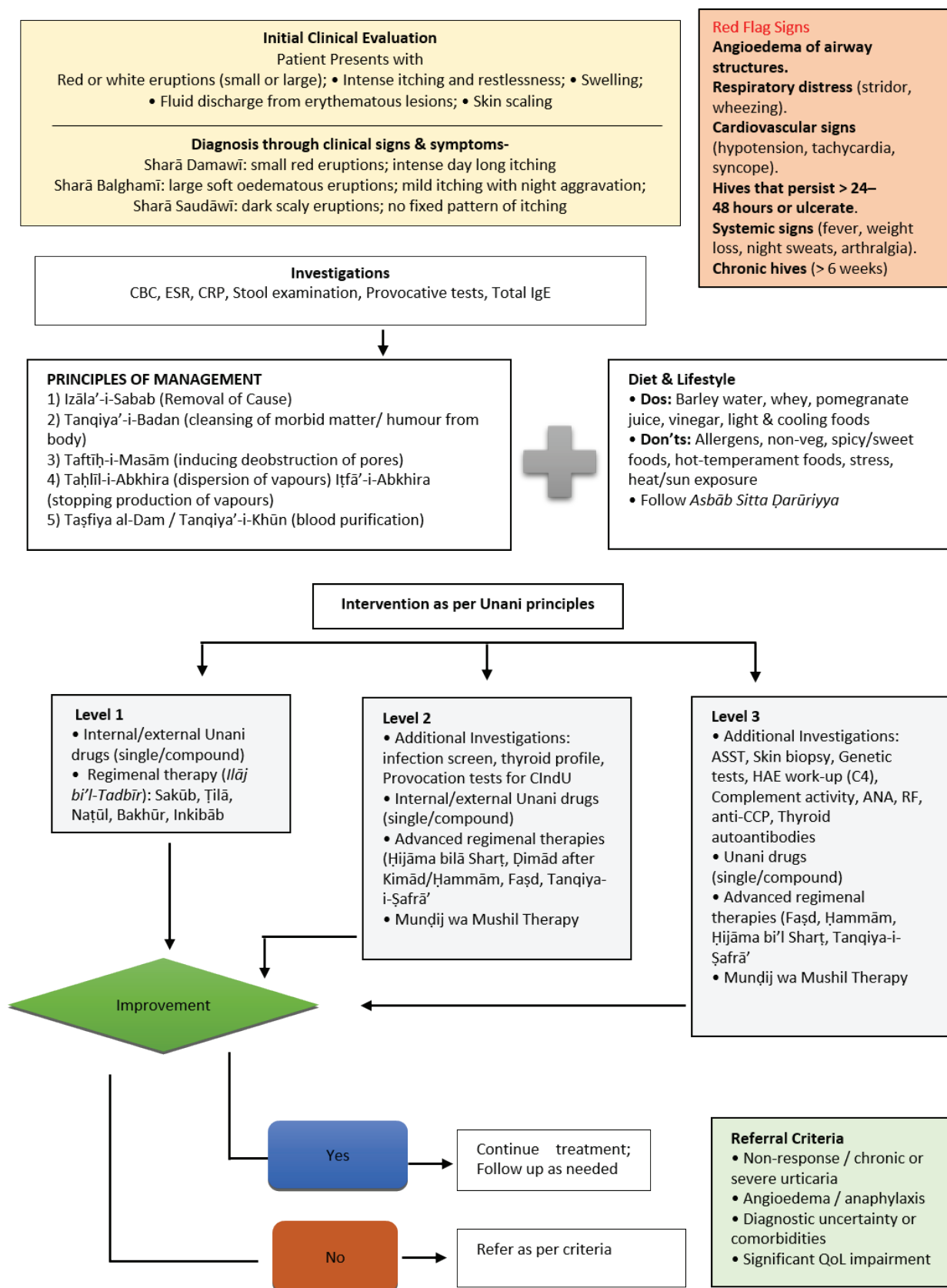
Restricted Diet and Lifestyle: Same as levels 1&2

Follow Up: (every 15 days or earlier as per the need)

Referral Criteria

- Same as mentioned earlier at level 2.
- Other modalities can be considered depending on the case and to rehabilitate properly.

ALGORITHM FOR CLINICAL ASSESSMENT AND MANAGEMENT OF URTICARIA (SHARĀ)



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VITILIGO

(Baraş)

VITILIGO

(Baraş)

Vitiligo (ICD-11 for mortality and morbidity statistics: ED63.0)

Vitiligo disorder (TM2) SN4D

Vitiligo: Baraş (NUMC: J-1)

CASE DEFINITION^{1, 2, 3, 4}

Vitiligo is a chronic, acquired autoimmune skin disorder characterized by well-demarcated hypopigmented or depigmented macules and patches resulting from the selective destruction of melanocytes in the epidermis. It may affect the skin, mucous membranes, and hair follicles, and can be associated with systemic autoimmune conditions such as thyroiditis, uveitis, and sensorineural hearing loss.

Before addressing vitiligo, it is important to understand the basic target cell that is affected by the disease and for that a basic overview of the melanin pathway is essential. Melanin is formed from the essential amino acids tyrosine and phenylalanine through a series of enzymatic steps in the liver and skin. Tyrosine is formed in the liver by the hydroxylation of the essential amino acid phenylalanine under the influence of phenylalanine hydroxylase which is in turn converted to DOPA and further into the pigment under the influence of tyrosinase enzyme (Fig. 1). The melanin is made within the melanosomes which are of two types —eumelanosomes (containing eumelanin), or pheomelanosomes (containing pheomelanin). These melanosomes pass into the dendritic processes of the melanocyte to be further transferred into neighboring keratinocytes

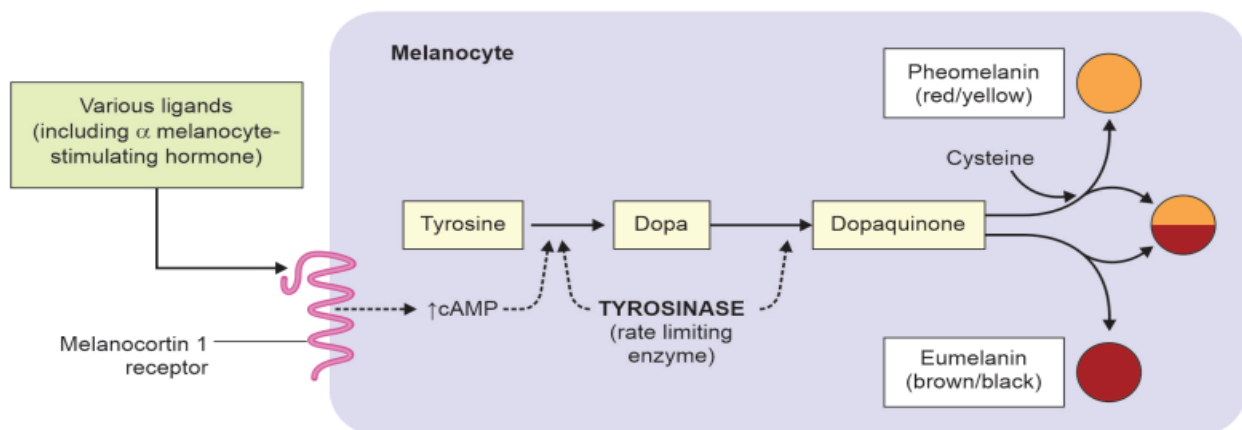


Fig 1 Pathway of Melanogenesis

An overview of the disorders is given in the figure below and it must be noted and explicitly emphasized that it's only the disorders that have a loss of melanocytes can cause vitiligo and this contrast from disorders that cause decrease in melanin. (Fig 2)

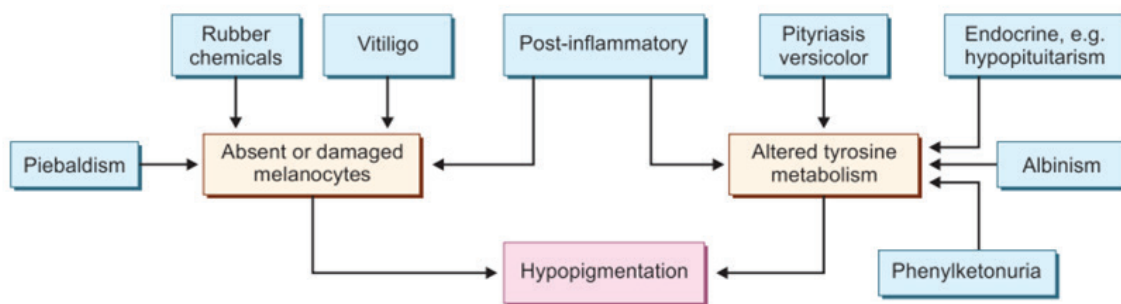


Fig 2: Overview of hypopigmentation disorders based on the main pathogenetic steps

Unani perspective:

In Unani medicine, *Baraṣ* is the term used for vitiligo, a type of chronic skin condition, characterized by white patches on the skin which gradually increase in size over time. While these lesions are often localized but, in some cases, they may gradually expand and involve larger areas of the body. When the depigmentation becomes widespread, the condition is termed as *Baraṣ Muntashir*, indicating a diffuse or generalized form of vitiligo.^{5,6,7}

INTRODUCTION (Incidence/Prevalence, Morbidity/Mortality/Risk Factors)^{8,9,10,11}

- Vitiligo, a common depigmenting skin disorder, has an estimated prevalence of 0.5–2% of the population worldwide. The prevalence of vitiligo is quite variable around the world, being more frequent in Africa (0.4%), Europe (0.4%), and Oceania (1.2%), than in North America (0.2%) and Asia (0.1%).
- In India, the reported prevalence of vitiligo ranges from approximately 0.5% to 2.5%, with some regional studies indicating even higher figures in specific populations.
- There is no difference in prevalence between races or genders. Females typically acquire the disease earlier than males. Onset may occur at any age, although about half of patients will have vitiligo by 20 years of age.
- It is broadly classified into non-segmental vitiligo (NSV) and segmental (SV), with NSV being the most common form.
- Vitiligo significantly impacts patients' psychological and social well-being

In Unani medicine, *Baraṣ* is a condition characterized by whiteness appearing on the outer surface of the body. In some cases, it affects only a few organs, while in others, it may spread to the entire body, resulting in complete depigmentation. This condition arises due to the predominance of *Ghalaba'-i-Balgham* (predominance of phlegmatic humour) in the blood and weakness in the *Quwwat Mughayyira* (transformative faculty) of the affected organs. *Baraṣ* has been categorized into different types—primarily *Baraṣ Abyaḍ* (the white form of vitiligo) and *Baraṣ Aswad* (a type of ichthyosis). The etiology of *Baraṣ Abyaḍ* is dominance of *Balgham* (phlegm) and the cause of *Baraṣ Aswad* is *Sawdā* (black bile) which plays a central role in its pathogenesis. These humoral disturbances alter the *mizāj* (temperament) of the affected organ, impairing its normal metabolic and transformative faculties such as *Quwwat Mughayyira wa Mushabbiha* (transformative and assimilative faculties), responsible for converting nutrients into tissue, leading to defective tissue formation and depigmentation of skin.^{6,7,12} The discoloration may penetrate deeply, potentially involving tissues all the way down to the bone.⁵

Updates in pathogenesis and its relevance^{13,14,15}

Various theories have been propounded for the causation of vitiligo which are listed in the box below

1. Genetic predisposition
2. Autoimmune destruction of melanocytes.
3. Neural pathways (explains the stress and segmental type)
4. Metabolic abnormalities & oxidative stress - Accumulation of toxic metabolites and oxidants that damage melanocytes.
5. Self destruction of melanocytes (autocytodestructive)

The effect of these factors is largely confined to autoimmune damage which has a close relationship of specific immune cells and cytokines which are important as many new drugs have been approved to target the specific cytokines which helps to prevent “by-stander cells” and also helps to ensure targeted therapy

The autoimmune theory revolves around the role of CD8+ T-cells and T_{RM} cells. The former is a cell that causes cell damage and the latter is a memory cell that leads to relapses. In fact formal studies have shown that biopsies of vitiligo shows melanocyte destruction with presence of melanocyte specific CD8+T-cells as compared to controls. These T-cells result in cell damage apoptosis via the release of IFN-γ which mediates its action via JAK/STAT pathway.

Etiology:¹²

- *Ḍuʿf Quwwat Mughayyira* (debility of transformative faculty)
- *Ḍuʿf Quwwat Mushabbiha* (debility of assimilative faculty)
- *Ghalabaʿ-i-Balgham* (predominance of phlegmatic humour)
- *Fasād-i-Dam* (abnormality of sanguine)
- *Sūʿ-i-Mizāj Bārid Uḍwi* (morbid cold temperament of an organ)
- *Sūʿ-i-Mizāj Bārid Raṭb Uḍwi* (morbid cold and moist temperament of an organ)

Pathophysiology:

According to Unani medicine, one of the major cause of *Baraṣ* (vitiligo) is *Fasād-al-Dam* (abnormality of sanguine) and *Burūdat-al-Dam* (coldness of sanguine). When the digestive faculty fails to adequately process food, it leads to the production of impure sanguine, and when this impurity is associated with an excess production of *Balgham* (phlegm) or an overall cold temperament within the body, it contributes to the development of *Baraṣ* (vitiligo).^{7,12, 16}

According to Unani medicine, the physiology of tissue metabolism is governed by four essential faculties:

1. *Quwwat Jādhiba* (absorptive power) – the ability of tissues to absorb nutrients effectively from the surrounding environment.
2. *Quwwat Māsika* (retentive power) – the capacity of tissues to retain absorbed nutrients long enough to enable proper assimilation.
3. *Quwwat Mughayyira wa Mushabbiha* (transformative and assimilative power) – the faculty responsible for transforming and structurally adapting nutrients to form tissue components.
4. *Quwwat Dāfiʿa* (expulsive power) – the mechanism by which tissues eliminate metabolic waste, directing it into the bloodstream for systemic removal.

A dysfunction particularly in *Quwwat Mughayyira wa Mushabbiha* (the transformative and assimilative faculties), is believed to impair the conversion of nutrients into appropriate tissue structure. This impairment may contribute to tissue anomalies such as depigmentation, as observed in disorders like vitiligo.¹⁷

The temperament of organ shifts towards *Sū'-i-Mizāj Bārid* (morbid cold temperament) or *Sū'-i-Mizāj Bārid Raṭb* (morbid cold and moist temperament), there is an associated increase in the presence of *Balgham* (phlegm) in its blood supply, which serves as the organ's source of nutrition. This pathological state adversely affects the *Quwwat-i Mughayyira* (transformative faculty), resulting in an impaired conversion of nutrients into the specific structural form required by the tissue. Consequently, the nourishment fails to integrate properly, leading to functional disruption and structural abnormalities within the organ as in *Baraṣ* (vitiligo).

The underlying cause of *Baraṣ Abyaḍ* (the white form of vitiligo) is *Balgham* (phlegm), whereas *Baraṣ Aswad* (a type of ichthyosis) is attributed to an excess of *Sawdā'* (black bile).^{7,18}

Other contributing factors may include genetic or hereditary predisposition, as well as trauma or ulcers, which can trigger the onset of the condition.⁵

CLINICAL PRESENTATION 11, 19,20

Vitiligo is clinically defined by the appearance of well-demarcated hypopigmented or depigmented macules and patches, resulting from the selective loss of functional melanocytes. These lesions are typically asymptomatic, though mild pruritus may occasionally be reported. In individuals with darker skin tones, the contrast between affected and unaffected areas is more pronounced. Lesion margins may exhibit intermediate hypopigmented zones, forming characteristic patterns such as trichrome or hypochromic vitiligo. Poliosis—depigmentation of hair within affected areas, often presenting as white locks on the scalp—is considered an indicator of deeper melanocyte involvement. Due to the absence of melanin, depigmented regions are more vulnerable to solar erythema. In cases of universal vitiligo, widespread depigmentation is observed. Additionally, lesions may develop at sites of skin trauma, a phenomenon known as koebnerization.

An international consensus in 2011 standardized the classification of vitiligo, distinguishing segmental vitiligo (SV) from all other forms, which were grouped under non-segmental vitiligo (NSV). The consensus also introduced mixed vitiligo—coexistence of SV and NSV in a single patient—as a clinically distinct subgroup, categorized under NSV due to similar pathophysiological behaviour.

Clinical Subtypes of Vitiligo

Table 1: Expanded Classification¹⁹ (Adapted from Ezzedine et al.)

Type of Vitiligo	Subtypes
1. Non-Segmental Vitiligo (NSV): Non-Segmental Vitiligo (NSV): The most prevalent form, presenting as bilaterally symmetrical depigmented patches. Commonly affected sites include periorificial regions (around the mouth, eyes), dorsal fingers, and intertriginous zones. The distribution often corresponds to areas of repetitive mechanical trauma, reflecting the Koebner phenomenon.	- Focal¹ - Mucosal - Acrofacial - Generalized - Universal - Rare variants (e.g., leukoderma punctata, hypochromic vitiligo, follicular vitiligo)

Type of Vitiligo	Subtypes
2. Segmental Vitiligo (SV): Segmental Vitiligo (SV): Characterized by unilateral, localized depigmentation following a dermatomal pattern. It typically has an early onset, rapid stabilization, and limited progression, and is often resistant to conventional therapies.	- Focal ¹ - Unisegmental - Bi- or multisegmental
3. Mixed Vitiligo: Mixed Vitiligo involves the simultaneous presence of segmental and non-segmental lesions in the same individual. It may show asymmetric distribution and is important to recognize for therapeutic and prognostic considerations.	- Coexisting SV and NSV - Further classified by SV severity
4. Unclassified Vitiligo: Unclassified Vitiligo includes atypical or early-stage cases that do not fit clearly into the above categories. Examples include focal lesions at onset, asymmetrical multifocal patches, or isolated mucosal involvement.	- Focal onset - Multifocal asymmetrical NSV - Isolated mucosal involvement

¹Focal vitiligo may appear in both NSV and SV and is classified based on disease progression.



Figure 3- Segmental vitiligo, unilateral depigmented patches over the chest and arm, characteristic of segmental vitiligo with dermatomal distribution



Figure 4- Acrofacial Vitiligo(non-segmental type, depigmented macules limited periorificial areas, distal extremities and /or face

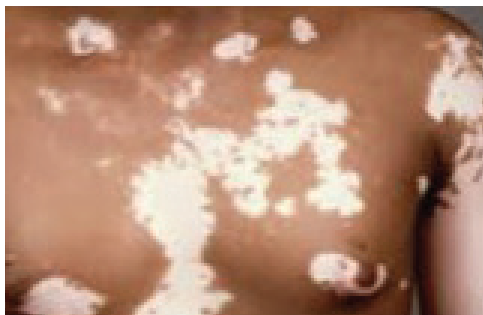


Figure 5- Generalized vitiligo, bilateral, often symmetrical, depigmented macules or patches



Figure 6- Trichrome Vitiligo, multiple depigmented macules on the chest and shoulders, showing a trichrome pattern.

Clinical presentation:

Unani Perspective: 5,21,22,23,24

1. **Appearance of white patches:** The hallmark manifestation is the development of well-defined, hypopigmented to depigmented macules on the skin
2. **Texture:** The affected area often exhibits a smooth or slippery surface.
3. **Gradual spread:** Initially, these spots are small and localized. However, the lesions gradually increase in size.
4. **Common sites of involvement:** Though vitiligo can affect any part of the body, it is most frequently observed on the face and hands.
5. **Hair whitening in advanced stages:** In chronic and severe cases of vitiligo, depigmentation may extend to the hair follicles, resulting in whitening of the hair which occurs due to an excess of cold and moist temperament associated with dominant phlegmatic humor (*Balgham*).
6. In certain cases of vitiligo, the affected skin may appear slightly depressed in comparison to the surrounding normal skin. When digital pressure is applied, the depression persists longer than normal, indicating underlying tissue atrophy or altered dermal integrity. Moreover, on pricking the lesion with a fine needle, instead of blood, a milky white fluid may exude.

Prognostic Indicators: 21, 25,26

Lesions that are not associated with hair depigmentation have a better prognosis. If the lesion reddens upon rubbing, it indicates a potentially curable condition. However, if the lesion contains depigmented hair and, upon pricking, exudes a milky-white fluid, it reflects deep-seated temperamental derangement and is traditionally considered non-curable due to the extensive loss of pigment-producing capability. If blood or a reddish fluid ooze out, it suggests that treatment may still be effective, and recovery is possible.

CLINICAL EXAMINATION 11,27,28

Important points of history that are helpful in the diagnosis of vitiligo include:

- Age at onset of lesions
- Factors or events that may cause the onset of vitiligo
- Symptoms associated with the lesions
- Progression or spread of lesions
- Changes observed in lesions over time
- Presence of concomitant diseases
- Current medications
- Occupational history/exposure to chemicals or radiation
- Family history of vitiligo and autoimmune diseases

Physical Examination of vitiligo will include these features:

- The most affected areas include the face, neck, forearms, dorsal hands, fingers, feet, and scalp. On the face, lesions typically show a periocular or perioral distribution.

- In cases of generalized involvement, lesions may also be seen on the areolae, nipples, and genital region. Sites frequently exposed to friction or trauma—such as bony prominences (elbows, knees)—are often involved, which may reflect the Koebner phenomenon, observed in 20–60% of vitiligo cases.
- Vitiligo manifests as depigmented macules or patches with a convex border without signs of inflammation with normal skin around.
- Macules are milky-white in color, well-demarcated with any shape
- Ranges in size from a few millimeters to a few centimeters.
- Signs of other associated diseases may also be present like goiter, anemia, generalized wasting, premature grey hairs, alopecia areata and weakness, etc
- Leukotrichia, or depigmentation of body hair within vitiliginous macules, may be noted during examination and is considered a marker of poor response to repigmentation therapies, as spontaneous recovery of pigment in affected hair is uncommon.

DIFFERENTIAL DIAGNOSIS 8,29,30,31,32

As has been depicted in the figures above the loss of melanocytes is not seen in many disorders and chemical leukoderma and piebaldism are the only TWO disorder that can be mistaken for vitiligo. Rest of the disorder are hypopigmented and not depigmented. Thus the clinician should distinguish between these two entities.

Table 2: The following diseases must be considered in differential diagnosis of Vitiligo:

Category	Condition	Differential Features
Chemically Induced Leukoderma	Occupational leukoderma	• Local loss of skin pigmentation resulting in white patches. • Depigmentation due to repeated exposure to phenols, catechols, PPD, hand rubs & rubber chemicals. • Affects contact areas.
	Drug-induced depigmentation	• Topical (e.g., corticosteroids, imiquimod) or systemic drugs (e.g., chloroquine); typically, localized and reversible. • Are Never depigmented hence are not a close differential of vitiligo
Genetic Syndromes	Hypomelanosis of Ito	• Whorled, streaked hypopigmentation along Blaschko’s lines; associated with neurologic or skeletal abnormalities. • Congenital and hence easily differentiated as vitiligo is rarely congenital
	Piebaldism	• Stable congenital leukoderma with white forelock and depigmented patches. • Melanocyte absence. • Arranged symmetrically on limbs, trunk and central part of the face, especially the chin • Typically, patients have pigmented islands within white patches.

Category	Condition	Differential Features
		• Waardenburg Syndrome • Depigmentation + sensorineural deafness, often a white forelock.
	Tuberous sclerosis	• Hypopigmented ash-leaf macules; may have seizures and other systemic signs. • Congenital and genetic disorder
	Griscelli Syndrome	• Silvery-grey hair, partial albinism, immune defects. • Congenital and genetic disorder
	Hermansky–Pudlak Syndrome	• Oculocutaneous albinism, bleeding tendency, pulmonary fibrosis.
	Menkes Syndrome	• X-linked disorder of copper metabolism; • Hypopigmentation, kinky hair, • Neurological symptoms.
	Ziprkowski-Margolis Syndrome	• Rare; features include pigmentary anomalies and developmental delays.
Post-inflammatory Hypopigmentation	Pityriasis alba	• Mild, scaly, ill-defined hypopigmented patches, • Mostly in children; often on the face.
	Atopic dermatitis / contact dermatitis	• Hypopigmented areas after eczema resolves; • Irregular margins.
	Lichen planus	• White patches with violaceous border
	Psoriasis	• Hypopigmented post-inflammatory areas after lesion resolution.
	Toxic drug reactions	• Hypopigmentation post-drug rash
	Post-traumatic scars	• Depigmented areas over healed wounds or burns.
	Radiotherapy induced	• Focal hypopigmentation in irradiated/treated sites.
Neoplasm-Associated	Melanoma-associated leukoderma	• Paraneoplastic; associated with melanoma and immune reaction.
	Mycosis fungoides	• Hypopigmented patches, (especially in children); • Requires biopsy.
Infectious Hypomelanoses	Leprosy	• Anaesthetic, hypopigmented patches; • Thickened nerves; • Endemic regions.
	Pityriasis versicolor	• Fine scaling, upper trunk, • Wood's lamp shows Yellow-green fluorescence.
	Leishmaniasis	• Hypopigmentation after healing of cutaneous lesions.

Category	Condition	Differential Features
	Onchocerciasis	“Leopard skin” depigmentation in endemic African areas.
	Treponematoses (pinta, syphilis)	Rare; hypopigmentation in later stages of infection.
Idiopathic Hypomelanoses	Idiopathic guttate hypomelanosis	Multiple, small, round white macules on shins/forearms in elderly; melanocytes preserved.
	Progressive macular hypomelanosis	- Hypopigmented patches on trunk; - Wood’s lamp shows orange-red follicular fluorescence.
Congenital Hypomelanoses	Nevus depigmentosus	Stable, congenital, well-demarcated patch with serrated borders; does not enlarge.
	Nevus anemicus	Vascular anomaly: pale area that does not fill with blood when stroked or exposed to heat.
Other Conditions	Lichen sclerosus et atrophicus	White, atrophic plaques, often in genital area; scarring possible.
	Tinea versicolor	Develops when too much yeast grows on your skin. The excessive yeast leads to a rash that looks like round flat patches which can be lighter or darker than the surrounding skin.

Differential diagnosis (Unani)

Condition	English Equivalent	Differential Features
<i>Bahaq Abyaḍ</i>	<i>Pityriasis alba</i>	Characterized by hypopigmentation, lighter in color than <i>Baraş</i> , yellowish in colour, scales occur, mostly on neck, chest and arms and trunk, does not penetrate deep into the skin. After pricking with needle at the site of <i>Bahaq</i> , blood always comes out and the hairs at the site of lesion never turn white even in chronic disease. ^{33,34}
<i>Bahaq Aswad</i>	<i>Pityriasis nigra</i>	Characterised by hyperpigmentation, scales occur, rough on touch and on rubbing, the affected area becomes reddish. ^{5, 22}
<i>Kalaf</i>	Melasma	Dark hyperpigmented patches (reddish to black) appear on skin without roughness or itching, occurs on face, mostly females are affected commonly pregnant females. ^{5,22, 35}
<i>Judhām</i>	Leprosy	Characterised by whitish yellow patches on skin with loss of sensation, oval in shape and with irregular margins ⁵

SUPPORTIVE INVESTIGATION ^{36, 37,38,39,40,41}

While vitiligo is primarily diagnosed clinically, a skin biopsy may occasionally be performed to distinguish it from other hypopigmentary disorders. Further testing is indicated when signs or symptoms suggest other clinical conditions as associated autoimmune or endocrine

conditions, such as thyroid disease, diabetes mellitus, pernicious anemia, Addison’s disease, or alopecia areata.

Table 3: Investigations may include:^{42, 43,44,45,46,47,48}

Test	Comment
Detailed history and Physical examination	
Complete Haemogram	A Complete haemogram can help detect abnormalities in blood cell counts that may indicate the associated conditions such as anaemia, or polycythemia, chronic infection or inflammations, etc.
LFT & KFT	Vitiligo is often associated with other autoimmune diseases, including thyroid disease, pernicious anemia, diabetes, and Addison’s disease. Vitiligo is primarily diagnosed clinically, but Kidney Function Tests (KFT) and Liver Function Tests (LFT) are frequently included in the investigations to check for systemic autoimmune involvement, associated comorbidities, or to ensure safety before starting systemic treatments.
Advanced investigations	
Wood’s Lamp Examination	Especially helpful in fair-skinned individuals, this handheld UV light highlights vitiligo patches with a bright blue-white fluorescence, making early or subtle lesions easier to detect.
Thyroid panel: TSH, free T3, free T4, Anti-thyroid peroxidase antibody	Thyroid functional problems and autoimmune thyroid diseases have been linked to vitiligo. The two most significant and prevalent autoimmune thyroid conditions connected to vitiligo are Hashimoto thyroiditis and Graves’ disease.
Antinuclear antibody (ANA)	ANAs are crucial for the identification of systemic autoimmune rheumatic disorders (SARDs) or any organ-specific autoimmune diseases.

DIAGNOSTIC CRITERIA⁴⁹

Vitiligo is typically diagnosed clinically, based on the presence of acquired, amelanotic, non-scaly, chalky-white macules with well-defined margins. These lesions often follow characteristic distribution patterns, including periorificial areas, lips, distal extremities, genitalia, segmental zones, and sites of friction.

Confirmatory laboratory investigations are generally unnecessary, except when required to rule out other differential diagnoses.

Histopathological examination of the central portion of a vitiligo lesion reveals complete loss of melanin pigment in the epidermis and an absence of melanocytes. Occasionally, lymphocytic infiltration may be observed at the advancing margins of the lesions, suggesting active disease progression.

Table 4: Assessment Tools for Extent and Severity:

Tool	Comments
VASI (Vitiligo Area Scoring Index)	Widely used in clinical trials; validated for assessing extent and depigmentation.
VES (Vitiligo Extent Score)	Validated for clinical use and has high intra- and inter-rater reliability. Self-administered version (SA-VES) also validated.
VIDA (Vitiligo Disease Activity Score)	- Simple clinical scale validated for assessing disease activity; - Based on patient history.
VETF Score (Vitiligo European Task Force)	Comprehensive, validated scale used in research; include extent, stage, and spread.
DLQI (Dermatology Life Quality Index)	Broadly validated across dermatological conditions, including vitiligo.
Skindex-29 / Skindex-16	Skin-specific QoL instruments; validated in vitiligo and other conditions.
VIS (Vitiligo Impact Scale)	Specifically developed and validated for assessing the psychosocial impact of vitiligo.

Table 5: The clinical criteria for the diagnosis of segmental vitiligo: ⁵⁰

Essential criteria (major)
Acquired depigmented macules occurring unilaterally not crossing the midline or with minimal spill onto the opposite side
Localized to a particular body area/site
Patterned distribution including recognizable patterns, viz., blaschkoid, dermatomal, phylloid, checkerboard, linear/oblong or any other specific type
Additional criteria (minor)
Age at onset <15 years
Leucotrichia >50% over the affected lesion
Leucotrichia extending beyond the margin
Presence of islands of normal or hyperpigmentation within the lesion or segment without treatment
Margins >50% irregular/straight line
Stability achieved in disease progression by 1 year
<i>Patients fulfilling all essential and one or more of the additional criteria are classified as segmental vitiligo and remaining patients as nonsegmental vitiligo.</i>

PRINCIPLES OF MANAGEMENT: ^{5, 7,12,21,22, 51}

The Unani medicine advocates a comprehensive and stepwise approach for managing vitiligo, including correction of underlying humoral imbalances and restoration of normal temperament. Key principles include:

1. *Tanqiya'-i-Badan* (cleansing of morbid matter/humour from body): Treatment begins with the removal of harmful substances from the body using appropriate '*Ilāj bi'l Tadbīr* (Regimenal Therapy). This includes the administration of *Mundij* (concoctive) followed by *Mushil* (purgative) therapy. *Nudj-o-Tanqiya-i Balgham* (concoction and cleansing of phlegm) is carried out through *Ishāl* (inducing purgation) and *Qay'* (inducing emesis). Other therapies can be used for evacuation of morbid material like *Idrār-i Bawl* (inducing diuresis) and *Hijāma* (cupping).⁹

Tabrīd (cooling of body or part of body): After completion of the evacuative procedures, *Mubarridāt* (cooling agents) are prescribed to restore the balance of heat and temperament disturbed during the elimination phase. For individuals with *Mizāj Ḥārr* (hot temperament), *Luab-e-Isphaghol* (Mucilage of *Plantago ovata* Forssk.) is prescribed; for those with *Mizāj Mu'tadil* (equable temperament), *Tukhm-i-Rayḥān* (*Ocimum tenuiflorum* L.) is recommended; and for individuals with cold temperament, *Tukhm-i Jirjīr* (*Eruca sativa* Mill.) is advised.

2. *Iṣlāḥ-i-Sū'-i-Mizāj* (Correction of morbid temperament): Restoration of the patient's natural temperament is achieved through the regulated use of *Ghidhā'* (diet) and *Dawa* (medicine) tailored to the individual's humoral constitution.
3. *Ta'dīl-i-Dam* (moderation/tempering of blood) and *Taṣfiya al-Dam* (blood purification): For this purpose, *Muaddilat wa Musaffiyat-i-Dam* (blood moderators and purifiers) are administered.
4. *Taqwiyat-i-Mi'da* (toning up of stomach): Tonics for the stomach are advised post-evacuative therapy to strengthen digestion and ensure better assimilation of food and medicine, thereby aiding the healing process.
5. Combined Use of Internal and External Medication: Management also includes the simultaneous use of oral formulations and topical applications.

- External Medication

Jazibat-i Dam (drugs that increase local blood circulation) drugs are used. For this purpose, *Adwiya-i-Musakhkhina* (calorific drugs), *Muḥammirat* (rubefacients), *Munaffiṭat* (vesicants) and *Muhalllat-i Balaghim* (phlegm resolvents) etc. are used.

6. *Tazahha bil Shams* (Sun Exposure Therapy): This therapy involves applying medication over depigmented areas followed by controlled exposure to sunlight.
7. '*Ilāj bi'l Dawā*' (Pharmacotherapy) [IUMT-7.1.10] and '*Ilāj bi'l Tadbīr* (regimenal therapy) [IUMT-7.2.0] are considered the mainstay of treatment in case of *Baraṣ* (vitiligo).

'*Ilāj bi'l Tadbīr* (Regimenal Therapy) includes;

Mundij-wa Mushil Therapy [MM Therapy] (concoctive and purgative therapy) [IUMT-6.1.134] & [IUMT-6.1.146], *Qay'* (emesis) [IUMT-7.2.3], *Idrār-i-Bawl* (diuresis) [IUMT-7.1.169], *Riyāḍat* (Exercise) [IUMT-7.2.80], *Hijāma* (cupping) [IUMT-7.2.30], *Taḥlīl-i-Mādda* (dissolving morbid matter) [IUMT-7.1.114] and *Jadhb-i-Mawād* (absorbing morbid matter) [IUMT-7.1.110] through *Tanfīṭ* (blistering/vesication) [IUMT-7.1.158], *Takhshin* (roughening of skin surface), *Dalk* (massage) [IUMT-7.2.92], *Tadhīn* (oiling/application of oil on affected body part) [IUMT-6.2.116], *Tamrīkh* (embrocation/anointing) [IUMT-6.2.106],

application of *Ḍimād* (poultice) [IUMT-6.2.52], application of *Ṭilā* (liniment) [IUMT-6.2.53] as well as *Ta'rīq* (diaphoresis) [IUMT-7.2.69] through *Tazahha bil Shams* (Sun Exposure) etc.^{12,23}

Red Flag Signs

These signs should be assessed before initiating treatment for need for management/consultation through modern medicine.

- Rapidly spreading or widespread depigmentation – suggests active disease needing early intervention.
- Poliosis (white hair in lesions) – Indicates deep melanocyte loss; often resistant to treatment.
- Mucosal or genital involvement – Associated with higher psychosocial impact and poor response.
- Onset after age 60 or in infants – Atypical; consider alternative diagnoses (e.g., lymphoma, post-inflammatory changes).
- Associated autoimmune diseases – Screen for thyroid, diabetes, etc.

A) Prevention, Management and Dos & Don'ts: ^{5, 12, 21, 22}

Lifestyle:

Asbāb Sitta Ḍarūriyya (six essential factors)

According to Unani medicine, health is preserved, and disease is prevented by maintaining balance in the *Asbāb Sitta Ḍarūriyya* (the six essential factors). These foundational factors guide holistic lifestyle interventions and are especially important in managing chronic disorders such as *Baraṣ* (Vitiligo). The focus is on preventing humoral imbalance, correcting temperament (*Mizāj*), and supporting the body's natural healing mechanisms.

1. **Hawā (Air)**:^{21,22, 52}

- Refrain from exposure to excessive cold or moisture, as these can worsen the phlegmatic temperament associated with vitiligo. Pigmentary conditions like vitiligo exhibit seasonal variation, with a noticeable increase in cases or symptom severity during the winter season.
- Moderate sunlight exposure is recommended.

2. **Ma'kūlāt wa Mashrūbāt** (Foods and Drinks):

Diet: Diet plays a crucial role in the management of vitiligo, as food influences the quality of blood and the overall *Mizāj* (temperament) of the body. The following dietary recommendations are advised.

- Easily digestible foods that support the production of pure and healthy blood are recommended, as optimal blood quality is considered essential in restoring normal skin pigmentation.
- Diet should be taken in moderate quantity.
- Consumption of goat meat and bird meat (e.g., chicken) is advised.
- Foods like fish, dates and citrus fruits to be avoided.

- *Aghdhiya Hārra* (diets having hot temperament) are preferred to correct the underlying *Sū'-i-Mizāj* (morbid temperament).
- *Aghdhiya Muwallidat-i-Dam* (haematopoietic/ blood producing diets) are preferred.
- Food with *Bārid Raṭb Mizāj* (cold and moist temperament) to be avoided.
- *Aghdhiya-i Muwallida-i Balgham* (phlegm-producing diets) to be avoided.
- Spices and condiments like cinnamon, black cardamom, cloves, black peppercorns, cumin and bay leaves are advised.
- Warm drinking water is advised.

3. *Al-Ḥaraka wa'l Sukūn al-Badanī* (Bodily movement and repose)^{22, 52}

- Engage in moderate physical activity regularly to enhance blood circulation, support digestion, and maintain internal warmth.
- Avoid a completely sedentary lifestyle, as it may contribute to humour accumulation particularly *Balgham* (Phlegm).
- Ensure adequate rest and relaxation to avoid overexertion, which may weaken natural faculties (*Quwwat Tabī'iyya*).
- Sexual activity should be minimized or avoided.

4. *Al-Ḥaraka wa'l Sukūn al-Nafsānī* (Psychic movement and repose)^{51,53}

- Maintain psychological calmness, as individuals affected by vitiligo exhibit a markedly increased risk of developing clinical depression or experience depressive symptoms.

5. *Al-Nawm wa'l Yaqza* (Sleep and wakefulness)^{54, 55}

- Establish a consistent sleep-wake cycle sleep problems may play a role in the development or worsening of vitiligo due to their effects on the immune system as sleep supports immune regulation and skin regeneration

6. *Al-Iḥtibās wa'l Istifrāgh* (Retention and evacuation)⁵¹

- Regular elimination of waste products—including urine, stool and sweat is essential to prevent accumulation of *Fuzlāt* (waste matter) and *Ghayr Ṭabī' Akhlāṭ* (abnormal humours).

Table 6: Dos & Don'ts

Do's	Don't
Easily digestible foods in moderate quantity	Heavy diets
<i>Aghdhiya Muwallidat-i-Dam</i> (haematopoietic/ blood producing diets)	Milk and dairy products
<i>Aghdhiya Hārra</i> (diets having hot temperament)	<i>Aghdhiya-i Muwallida-i Balgham</i> (phlegm-producing diets)
<i>Tawabil-i- Harra</i> (spices and condiments having hot temperament) like cinnamon, black cardamom, cloves, black peppercorns, cumin, and bay leaves	Food having <i>Bārid Raṭb Mizāj</i> (cold and moist temperament)

Do's	Don't
Moderate physical activity	Sedentary lifestyle
Psychological calmness	Mental stress
Regular bowel and bladder habits	Constipation

Yoga ⁵⁶

Yoga and related practices have shown beneficial effects in vitiligo, primarily through modulation of the immune system, stress reduction, and enhancement of systemic antioxidant status. Some of the practices found helpful are as follows:

- Pranayama (breathing exercises)
 - Surya Namaskar (sun salutation)
 - Shavasana, Yoga Nidra for relaxation
 - Meditation to reduce anxiety and autoimmune activation
- (Proper guidance from a yoga expert is essential before practicing yoga for skin disorders)

(B) Interventions

At Level 1- Solo Physician Clinic/Health Clinic/PHC (Optimal Standard of treatment where technology and resources are limited)

- OPD level management
- Advice Dos & Don'ts
- Referral criteria

Clinical Diagnosis: The diagnosis of vitiligo relies primarily on clinical evaluation following a thorough medical history and physical examination. In most cases, no laboratory investigations are required unless there are clinical signs suggestive of associated autoimmune or endocrine disorders. Patient counselling, reassurance, and early initiation of treatment can be effectively initiated.

Management:

OPD level management:

Table 7: Single drugs/Compound Formulations for oral/local administration

Sr. No.	Drugs	Dosage form	Dose	Time	Duration	Badraqa (vehicle)
1.	<i>Babchi</i> (<i>Cullen corylifolium</i> (L.) Medik.) ⁵⁷	Powder	1-3 g	As directed by physician	21 days	
2.	<i>Ajmur</i> (<i>Apium graveolens</i> L.)	Powder	4-8 g	As directed by physician	As directed by physician	
3.	<i>Atrilal</i> (<i>Ammi majus</i> L.) ^{57,58}	Powder	3-10.5 g	As directed by physician	15days	
4.	<i>Bhangra</i> (<i>Eclipta alba</i> (L.) Hassak.) ²¹	Powder	5-7 g	As directed by physician	As directed by physician	

Sr. No.	Drugs	Dosage form	Dose	Time	Duration	Badraqa (vehicle)
5.	<i>Behman Surkh</i> (<i>Salvia sclarea</i> L. Syn. <i>S. haematodes</i> Scop.) ¹²	Powder	7 g	As directed by physician	As directed by physician	
6.	<i>Tukhm-e Shaqā'iq-al-Nomān</i> (seed of <i>Anemone coronaria</i> L.) ¹²	Powder	3-7 g	As directed by physician	As directed by physician	
7.	<i>Shukai</i> (<i>Echinops echinatus</i> Roxb.) ¹²	Powder	4.5 g	As directed by physician	As directed by physician	
8.	<i>Afsanteen</i> (<i>Artemisia absinthium</i> L.) ¹²	Powder	4.5 g	As directed by physician	As directed by physician	
9.	<i>Inab al-Salab</i> (<i>Solanum nigrum</i> L.) ¹²	(Expressed juice)	140 ml	As directed by physician	As directed by physician	
10.	<i>Safūf Baraṣ</i> ^{5,59}	Powder	3-5 g	Twice a day	As directed by physician	
11.	<i>Arq-e-Mundi</i> ⁵⁹	Distillate	60-120 ml	As directed by physician	As directed by physician	

For local application:

Drug	Quantity
• <i>Khardal Surkh</i> (<i>Brassica juncea</i> (L.) Czern. ⁶⁰)	Quantity Sufficient
• <i>Zimād</i> (poultice) of budding leaves of mango tree ¹²	Quantity Sufficient
• <i>Zimād-i Baraṣ</i> ⁶⁰	Quantity Sufficient
• <i>Ḥabb Baraṣ</i> ⁶¹	Quantity Sufficient
• <i>Roghan-e- Baraṣ</i>	Quantity Sufficient

Ḍimād (Poultice):

Sheetaraj (*Plumbago zeylanica* L.), *Karafs Barri* (*Apium graveolens* L.), *Maweez* (*Vitis vinifera* L.), *Telni makkhi* (*Cantharidin*), *Majith* (*Rubia cordifolia* L.).²⁴

Note: Out of the drugs mentioned above, any one or a combination of two or more may be prescribed by the physician. The physician may decide the dosage (per dose) and duration of the therapy based on the clinical findings and response to the therapy.

Recommended and restricted diet & lifestyle—Same as described under preventive management

Follow up (With duration) – Follow-up after every 15 days for 3 months

Reviews should include:

- Monitoring the individual's symptoms and assessing the ongoing impact of vitiligo on daily functioning and quality of life.
- Evaluating lifestyle factors such as diet, stress levels, sun exposure, and skin care practices relevant to vitiligo management.
- Discussing the individual's understanding of the condition, addressing any concerns, and considering their preferences and access to healthcare services.
- Reviewing the effectiveness, tolerability, and side effects of all current treatments, including topical therapies, phototherapy, or systemic interventions.
- Providing guidance and support for self-care practices and psychosocial well-being.
- Conducting periodic reviews to monitor the long-term course of the condition and make necessary adjustments in management.

Referral criteria:

Patients with vitiligo should be referred to a higher-level facility (Level 2 or 3) under the following circumstances:

- Uncertain Diagnosis – Atypical presentation or diagnostic confusion with other hypopigmented disorders (e.g., leprosy, pityriasis alba, tinea versicolor).
- Rapid Progression – Sudden and extensive spread of depigmented lesions.
- Mucosal or Extensive Involvement – Vitiligo affecting genital mucosa, lips, eyelids, or involving >10% of body surface area.
- Severe Psychological Distress – Evidence of anxiety, depression, or social withdrawal due to cosmetic impact.
- Unresponsive to Initial Management – No improvement after a reasonable period of individualized care.
- Suspected Associated Autoimmune Disorders – Presence of signs suggestive of thyroid disease, diabetes, or adrenal insufficiency requires investigation and specialist input.
- Uncontrolled comorbidities.
- Evidence of an increase in severity/complications.
- Non-response to treatment.
- Substantial impact on their quality of life and activities of daily living.

At Level 2: [CHC/SHCO (10-20 bedded hospital) with basic facilities and routine investigation]

- Management with single or compound drugs for internal and external use.
- Management with '*Ilāj bi'l Tadbīr*' (Regimenal Therapy) like *Mundij Mushil* therapy, *Hijāma*, as per the assessment of physician about the condition of the patient and stage of disease.
- *Ilāj bi'l Ghidhā'* (Dieto-therapy) and life-style modifications
- Clinical Follow-up
- Referral criteria

Clinical Diagnosis: Same as Level 1. Any fresh case or referred case from Level 1 shall be evaluated thoroughly for confirmation of diagnosis and complications.

Investigations: The diagnosis would be primarily clinical along with some investigations which will be necessary to investigate complications or exclude other differential diagnoses as follows:

- Complete Haemogram

Management:

Patients referred from Level- 1, may be continued the same treatment, if appropriate for the presenting complaints. For new patients at this level, the management described in Level- 1, may also be considered while giving prescriptions. At this level, the patient may be preferably treated in the indoor department.

Table 8: Single drugs/Compound Formulations for oral administration

Sr. No.	Drug	Dosage form	Dose per day	Time	Duration	Badraqa (vehicle)
1.	<i>Panwad (Senna tora (L.) Roxb.)</i> ²¹	Powder	1-3 g.	As directed by physician	As prescribed by physician	
2.	<i>Chiraita Talkh (Swertia chirayita (Roxb.) H. Karst.)</i> ^{21,59}	Powder	5-7 g	As directed by physician	As prescribed by physician	
3.	<i>Gandhak Amlasar (yellow sulphur) musaffa (washed)</i> ²¹	Powder	500 mg-1 g	As directed by physician	As prescribed by physician	
4.	<i>Tukhm- Khatmi (Althaea officinalis L.)</i> ⁵⁹	Powder	5-10 g	As directed by physician	As directed by physician	
5.	<i>Chaksu (Chamaecrista absus (L.) H.S. Irwin & Barneby)</i> ²¹	Powder	2-3 g	As directed by physician	As directed by physician	
6.	<i>Mawizaj (Staphisagria macrosperma Spach)</i> ¹²	Poultice	Local application	As directed by physician	As directed by physician	
7.	<i>Kundush (Centipeda minima (L.) Braun & Asch.)</i> ¹²	Poultice	Local application	As directed by physician	As directed by physician	After applying expose the skin to sunlight
8.	<i>Shoniz (Nigella sativa L.) with Vinegar</i> ¹²	Poultice	Local application	As directed by physician	As directed by physician	After applying expose the skin to sunlight
9.	<i>Zarnikh Surkh (Arsenic disulfide)</i> ¹²	Poultice	Local application	As directed by physician	As directed by physician	

Sr. No.	Drug	Dosage form	Dose per day	Time	Duration	Badraqa (vehicle)
10.	<i>Habb Mushil</i> ⁶¹	Pills	3-5 g	As directed by physician	As directed by physician	
11.	<i>Safuf barae Baraṣ</i> ⁶¹	Powder	3.5 g	As directed by physician	As directed by physician	
12.	<i>Ma'jūn-i-Kalkalanj</i> ³⁵	Semisolid preparation	As directed by physician	As directed by physician	As directed by physician	water
13.	<i>Tiryāq Kabir</i> ³⁵	Semisolid preparation	As directed by physician	As directed by physician	As directed by physician	water
14.	<i>Iṭrīfal Shahtra</i> ⁵⁹	Semisolid preparation	5–10 g	As directed by physician	As directed by physician	Water

'Ilāj bi'l Tadbīr (Regimenal therapy):

- **Mundij Mushil Therapy**

The duration of the *Mundij* may range from 5 to 12 days or until appearance of *Nudj* (concoction) based on the nature of the disease and the physician's evaluation. Following this, *Mushil* therapy is given on alternate days for three sessions, depending on the disease condition and the physician's clinical judgment.^{21, 51}

- **Mundij-i-Balgham:**

Bekh-i-Badiyan (Root of *Foeniculum vulgare* Mill.) 7 gm., *Badiyan* (*Foeniculum vulgare* Mill.) 7 gm, *Bekh-i-Karafs* (Root of *Apium graveolens* L.) 5gm., *Aslussoos* (*Glycyrrhiza glabra* L.) 5gm., *Parsiaoshan* (*Adiantum cappillus-veneris* L.) 5gm., *Ustukhuddus* (*Lavandula stoechas* L.) 5 gm., *Anjeer* (*Ficus carica* L.) 3 no., *Tukhm-i-Khatmi* (Seeds of *Althaea officinalis* L.) 5gm., *Khubbazi* (*Malva sylvestris* L.) 5gm., *Gaozaban* (*Borago officinalis* L.) 5gm. These drugs are soaked in hot water overnight and strained, cleaned, and taken in the morning with *Khamira Banafsha* 40 gm until appearance of *Nudj* (concoction) followed by *Mushil* therapy.⁵¹

- **Mushil-i-Balgham :**

Ayārij-i-Fayqrā (compound formulation) 51gm, *Ghariqoon* (*Laricifomes officinalis* (Vill.) Kotl. Pouzar) 4gm, *Shahm Hanzal* (*Citrullus colocynthis* (L.) Schrad) 2 gm, *Cheetah lakdi* (*Plumbago zeylanica* L.) 2gm, *Sonth* (*Zingiber officinale* Rosc.) 2 gm, *Saqmoon* (*Convolvulus scammonia* L.) 500 mg, *Sakbeenaj* (*Ferula persica* Willd) 1gm. All drugs to be powdered and prepared in the form of pills with *Aab-i-Karafs*, juice of (*Apium graveolens* L.)³⁵

For local application:

- *Dimād* (Poultice):

Application of *Dimād* containing following ingredients on affected area/patches:

Shahm Hanzal (*Citrullus colocynthis* (L.) Schrad), *Artnitha* (*Haloxylon multiflorum* (Moq.) Bunge ex Boiss.), *Ushnan* (*Salicornia fruticosa* (L.) L.), *Barg-i- Kaner*, leave of (*Nerium oleander* L.) and *Rawghan Gul*.²²

- **Ḍimād** (Poultice):

Application of *Ḍimād* containing following ingredients on affected area/patches and then expose the skin to sunlight for some time:

Tukhm Turb (Seeds of *Raphanus sativus* L.), *Cheetah Lakdi* (*Plumbago zeylanica* L.), *Haldi* (*Curcuma longa* L.), *Katth* (*Senegalia catechu* (L.f.) P.J.H.Hurter & Mabb.), *Nakchikni* (*Centipeda minima* (L.) A. Braun & Asch), *Zangar* (*Verdigris*)²²

Recommended and restricted diet & Lifestyle: Same as described under preventive management

Follow-up (with duration):

Same as Level 1. The patients who are responding well may be treated as per the assessment of physician

Referral criteria:

Patients at Level 2 should be referred to higher centers under the following conditions:

- Same as mentioned earlier at level 1, plus
- No clinical improvement or worsening despite appropriate Unani management.
- Complications requiring advanced diagnostic tools or specialty care.
- Need for multidisciplinary evaluation or emergency care.
- Non-responsiveness in suspected autoimmune, systemic, or rapidly progressing pathology.
- Diagnostic uncertainty requires investigation beyond the available infrastructure.
- Referral should be made to Ayush Level 3 or appropriate higher-level healthcare facilities with specialist services and comprehensive diagnostic setups.
- Any other complications that threaten the life of the patient.

At Level 3: (Ayush hospitals attached with teaching institutions/ Ayush research institutions having indoor facility/ District level/ state level Ayush hospitals/ Tertiary care Allopathic hospitals having Ayush facilities) and multiple departments/facilities for diagnosis and interventions. Additional facilities like dieticians, counselling, and physiotherapy must be provided.

Management with single or compound drugs for internal and external use

Management with '*Ilāj bi'l Tadbīr* (Regimenal Therapy) as per the assessment of physician about the condition of the patient and stage of disease

'Ilāj bi'l Ghidhā' (Dieto-therapy) and lifestyle modifications

Clinical Follow-up

Referral criteria

Clinical Diagnosis: Same as Level 1 and 2. Confirm diagnosis and severity with the help of investigations such as:

- Thyroid function tests (TSH, fT3, fT4), anti-thyroid antibodies, ANA, fasting glucose levels, HbA1c.
- Wood's lamp examination* can be used to enhance the visibility of depigmented lesions, particularly in fair-skinned individuals or early-stage disease. If needed, differential diagnosis from other hypopigmented conditions (e.g., pityriasis versicolor, post-inflammatory hypopigmentation) can be aided by routine investigations and clinical pattern recognition.

* in case of clinical suspicion or doubt

Management:

Patients referred from Level 1 or 2, may continue the same treatment, if appropriate for the presenting complaints. For new patients at this level, the management described at Level-1 and Level-2, may also be considered while giving prescriptions. At this level, the patient may be preferably treated in the indoor department.

Table 9: Single drugs/Compound Formulations for oral administration

Sr. No.	Drug	Dosage form	Dose	Time	Duration	Badraqa (vehicle)
1.	Anjeer (<i>Ficus carica</i> L.) ²¹	Dried fruit	32 g	As directed by physician	As directed by physician	
2.	Halela siyah (<i>Terminalia chebula</i> Retz.) ^{21,57}	Powder	5-7 g	As directed by physician	As directed by physician	
3.	Kalonji (<i>Nigella sativa</i> L.) ^{21,57}	Powder	3-7	As directed by physician	As directed by physician	
4.	Branches (new/soft) of Angur (<i>Vitis vinifera</i> L.) ¹²	Expressed juice	420 g	As directed by physician	As directed by physician	
5.	Waras (<i>Flemingia grahamiana</i> . Wight & Arn.) ¹²	Powder	4 g	As directed by physician	As directed by physician	
6.	Barg Suddab (Leaf of <i>Ruta graveolens</i> L.) ¹²	Powder	3 g	As directed by physician	As directed by physician	
7.	Kundur (<i>Boswellia serrata</i> Roxb. ex Colebr.) ^{21, 57}	Powder	1-3 g	As directed by physician	As directed by physician	
8.	Parsiaoshan (<i>Adiantum cappillus-veneris</i> L.) ²¹	Powder	5-7 g	As directed by physician	As directed by physician	
9.	Sibr (<i>Aloe vera</i> (L.) Burm. f.) ²¹	Powder	5-10 g	As directed by physician	As directed by physician	

Sr. No.	Drug	Dosage form	Dose	Time	Duration	Badraqa (vehicle)
10.	<i>Turbud (Operculina turpethum (L.) Silva Manso)</i> ²¹	Powder	3-5 g	As directed by physician	As directed by physician	
11.	<i>Aqarqrha (Anacyclus pyrethrum (L.) Lag.)</i> ¹²	Powder	Local application	As directed by physician	As directed by physician	After applying expose the skin to sunlight
12.	<i>Booraq</i> ¹²	Powder	Local application	As directed by physician	As directed by physician	After applying expose the skin to sunlight
13.	<i>Habb Hindi</i> ⁶²	Tablet	As directed by physician	As directed by physician	As directed by physician	
14.	<i>Habb-e-Sakbeenaj</i> ⁶²	Tablet	4 g / As directed by physician	As directed by physician	As directed by physician	
15.	<i>Habb-e- Mussafi-e- Khoon</i> ⁵⁹	Tablet	250-500 mg	As directed by physician	As directed by physician	
16.	<i>Ma'jūn-i- Aatrilal</i> ²³	Semisolid preparation	7-12 g	As directed by physician	As directed by physician	
17.	<i>Ma'jūn Baare Baraṣ</i> ⁶¹	Semisolid preparation	18 g	As directed by physician	As directed by physician	
18.	<i>Ma'jūn Mushil</i> ⁶¹	Semisolid preparation	12-24 g	As directed by physician	As directed by physician	
19.	<i>Safuf Kaimri</i> ⁶¹	Powder	3-5 g	As directed by physician	As directed by physician	<i>Arq Jhao</i> 120 ml
20.	<i>Ṭilā'-i-Baraṣ</i> ⁶¹	Liniment	Local application	As directed by physician	As directed by physician	After applying expose the skin to sunlight
21.	<i>Ṭilā' Hindi</i> ⁶¹	Liniment	Local application	As directed by physician	As directed by physician	After applying expose the skin to sunlight
22.	<i>Marham-i- Baraṣ</i> ⁶¹	Ointment	Local application	As directed by physician	As directed by physician	After applying expose the skin to sunlight

Table 10: Research Formulations of CCRUM for oral and local administration in vitiligo

Sr. No.	Drug	Dosage form	Dose (per day)	Time of administration	Duration / Frequency	Adjuvant	Precautions/ contraindications
1	UNIM-001	Capsule for oral use	2 capsules of 500 mg	Morning and evening	BD	Water	Nothing specific (NS)
	UNIM-003	Powder to be mixed with 5 times of water and applied on affected area	As required	Morning. After application the affected area to be exposed to sun for 5-10 minutes	OD	-	

‘Ilāj bi’l Tadbīr (Regimenal therapy):

Mundij Mushil Therapy same as in Level 2

1. *Tanqiya’-i-Badan* (cleansing of morbid matter/humour from body) from the body using appropriate ‘*Ilāj bi’l Tadbīr* (Regimenal Therapy). For the *Tanqiya’-i-Mida Qay’* (emesis) may be inducing by using *Tukhm-i Shibit* (*Anethum graveolens* L.) boiled in *Aab-i Turb*, Juice of (*Raphanus sativus* L.) along with in *Sikanjabīn* may be used.

Tanqiya’-i-Badan (cleansing of morbid matter/humour from body) to be performed through *Mundij Mushil* Therapy mentioned at the Level 2 or another suitable prescription of *Mundij o Mushil-i- Balgham* may be carried out for *Nudj-o-Tanqiya-i Balgham* (concoction and cleansing of phlegm) through *Ishāl* (inducing purgation):

- **Mundij-i-Balgham:**

Tukhm-i-Khatmi, Seeds of (*Althaea officinalis* L.), *Gaozaban* (*Borago officinalis* L.)

Parsiaoshan (*Adiantum cappillus-veneris* L.), *Mawizaj* (*Staphisagria macrosperma* Spach), *Ood* (*Aquilaria malaccensis* Lam.), *Waj* (*Acorus calamus* L.), *Shitraj* (*Plumbago zeylanica* L.), *Fuwwh* (*Rubia cordifolia* L.). Decoction of these drugs used with *Sikanjabin Unsuli* and *Gulqand Asli* for 7 days or till the appearance of *Nudj* followed by *Ayāraj Loghāziya*¹ or *Ayāraj Jalinus* etc. ¹²

- **Mushil-i-Balgham :**

Darchini (*Cinnamomum verum* J. Presl), *Sumbul al-Ṭib* (*Nardostachys jatamansi* (D. Don) DC.), *Mastagī* (*Pistacia lentiscus* L.), *Ood Balsan* (*Commiphora gileadensis* (L.) C.Chr.), *Asarun* (*Asarum europaeum* L.), *Zafran* (*Crocus sativus* L.), *Sazij Hindi* (*Cinnamomum tamala* (Buch.-Ham.) T.Nees & C.H.Eberm.), *Pudina Nahri* (*Mentha aquatica* L.) each 3.5g., *Shahm Hanzal* (*Citrullus colocynthis* (L.) Schrad) 14 gm, *Sibr* (*Aloe Vera* (L.) Burm. f.) 21gm. Dose: 3.5 gm to be given with *Ma al-Asl*. ¹²

For local application:

Ṭilā’ (Liniment):

Application of *Ṭilā’* containing following ingredients on affected area/patches:

Cheetah Lakdi (*Plumbago zeylanica* L.), *Kundush* (*Centipeda minima* (L.) A.Braun & Asch.), *Post Beekh Kabar* (Root bark of *Capparis spinosa* L.), *Farfiyun* (*Euphorbia resinifera* O. Berg), *Sirka* (Vinegar), *Shahad* (Honey). ³⁵

Ḍimād (Poultice):

Application of Ḍimād containing following ingredients on affected area/patches.²³

Gandhak Amla Sar (yellow sulphur), *Burada-i-Jast* (Zinc), *Tukhm-i-Hulba* (*Trigonella foenum-graecum*), *Kali Zeeri* (*Baccharoides anthelmintica* (L.)), *Barg Anjeer Khusk*, (Leaves of *Ficus carica* L.), *Tukhm-i-Sosan*, (Seed of *Iris ensata* Thunb.).

Recommended and restricted diet & Lifestyle: Same as described under preventive management

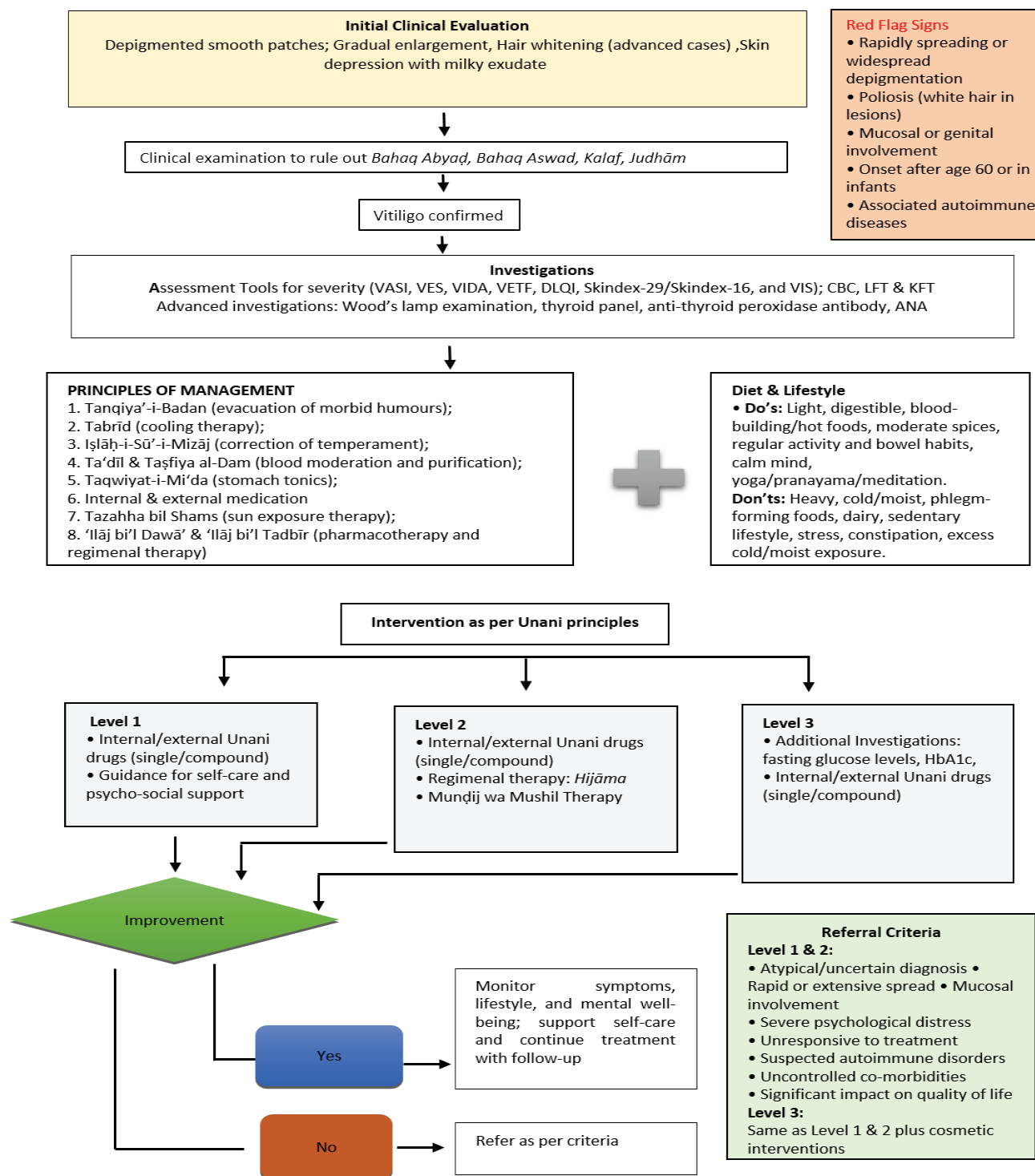
Follow-up (with duration):

The follow-up may be done once a fortnight. The patients who are responding well may be treated as per the assessment of physician.

Referral Criteria: Same as mentioned earlier at level 2 plus,

- Other therapeutic modalities—such as counseling, yoga, dietary modifications, or integrative Ayush approaches etc—may be considered based on the complexity and individualized needs of the patient.
- In select cases, referral to higher centers may also be appropriate for psychological reassurance or cosmetic interventions.

ALGORITHM FOR CLINICAL ASSESSMENT AND MANAGEMENT OF VITILIGO (BARAŞ)



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