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A UNANI PERSPECTIVE ON QUBA (DERMATOPHYTOSIS): CLASSICAL INSIGHTS AND CONVENTIONAL RELEVANCE

Yusra Rehman*[1], Mohammad Anzar Husain[2], S. M. Abbas Zaidi[3], Faiza Hussain[1], Meraj Meraj[4], Munawwar Saeed[1]

[1]PGscholar, Department of Amraze Jildwa Tazeeniyat, Hakim Syed Ziaul Hasan Government Unani Medical College & Hospital Bhopal, India.

[2]Professor & Head, Department of Amraze Jildwa Tazeeniyat, Hakim Syed Ziaul Hasan Government Unani Medical College & Hospital Bhopal, India.

[3]Assistant Professor, Department of Moalajat, Hakim Syed Ziaul Hasan Government Unani Medical College & Hospital Bhopal, India.

[4] PG scholar, Department of Ilājbi'l Tadbīr (Regimenal Therapy), Hakim Syed Ziaul Hasan Government Unani Medical College & Hospital Bhopal, India.

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***Corresponding author**
Yusra Rehman

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Background:
Dermatophytosis, also known as ringworm or tinea, is a common fungal infection that affects the skin, causing rough, scaly lesions. These lesions typically appear on the trunk and may occur either singly or in clusters. It is estimated that approximately 25% of the world's population is affected by this condition. In the Unani system of medicine, *Quba* appears to be analogous to dermatophytosis. Despite minor differences in the etiology and pathophysiology of the disease, the overall clinical presentation and symptoms are quite similar. The primary symptom of dermatophytosis is intense itching, which significantly disrupts the quality of life, causes sleeplessness, induces anxiety, and hampers daily routine activities. In Unani classical literature, the treatment of *Quba* has been well-documented based on practical experiences and traditional knowledge. This review article has been compiled after an extensive literature search using various search engines such as PubMed, Google Scholar, and Science Direct with keywords like Dermatophytosis, Tinea, Fungal Infection, *Quba*, and Unani System of Medicine. Additionally, classical Unani literature was also thoroughly reviewed to explore the concept and treatment of Quba in traditional Unani medicine. Through this review paper, an effort has been made to describe the etiopathogenesis, classification, clinical features, diagnosis, and management of *Quba* (Dermatophytosis) as mentioned in Unani classical texts. The information derived from the literature may provide a better understanding of this persistent skin condition and offer a potential alternative to conventional treatments. Furthermore, this paper attempts to elaborate on various aspects of *Quba*, highlighting the effectiveness of Unani treatment, which may contribute to improving the therapeutic approach for managing dermatophytosis.

***Keywords*:** Alternative Medicine, Dermatophytosis, Quba, Tinea, Unani System of Medicine.

Introduction

During the Middle Ages, scholars from Arab and Persia, such as *Razi*, *Ibn Sina*, *Zahrawi*, and others, developed this ancient system of medicine into a highly advanced and well-established medical system, now known as the Unani system of medicine [1]. The skin is the largest organ of the body, covering its entire external surface. It consists of a complex structure that acts as the body's primary barrier against pathogens, ultraviolet (UV) light, chemicals, and mechanical injuries [2]. *Quba* is a skin condition characterized by rough, dry, and scaly skin, accompanied by other symptoms such as itching, irritation, exfoliation with fish-like scales, and the formation of circular patches on the skin. These patches often appear with a black or reddish hue and are surrounded by a red inflammatory

border. In some cases, a yellow fluid may ooze from the affected area. The progression of this condition is generally associated with the accumulation of pathogenic substances in the body [3,4,5,6]. Dermatophytosis, commonly known as ringworm, is a fungal infection of the skin caused by dermatophytes. It typically appears as round, scaly lesions that develop on the trunk, either singly or in clusters. Each lesion generally has a more inflamed and prominent border than its center. One of the most common forms of this infection is tinea corporis, which specifically affects the body. In medical terminology, all dermatophyte infections are classified using the Latin prefix "Tinea," followed by the anatomical site of the infection [7]. In the Unani system of medicine, *Quba* is considered analogous to dermatophytosis due to its similar clinical presentation. Various classical Unani texts describe this condition under different traditional names, such as *Paryun*, *Daryoon*, and *Daad* [8].

Prevalence

An estimated 10 to 15 percent of people will at some point in their lives become infected with dermatophytes. The World Health Organization (WHO) reports that between 30 and 70 percent of adults are carriers of dermatophytoses, which impact approximately 25 percent of the world's population [9].

Methodology

This review article was compiled after conducting an extensive literature search using various electronic databases such as PubMed, Google Scholar, and Science Direct. The search was performed using specific keywords including Dermatophytosis, Tinea, Fungal Infection, *Quba*, and Unani System of Medicine to gather relevant scientific data and research articles. Additionally, classical Unani literature such as *Al-Hawi* (*Razi*), *Al-Qanun fit-Tibb* (*Ibn Sina*), *Kitab al-Tasrif* (*Zahrawi*), and other traditional Unani texts were thoroughly reviewed to explore the concept, clinical presentation, and treatment of *Quba* (Dermatophytosis) in traditional Unani medicine. The information obtained from both modern scientific literature and classical Unani texts was critically analyzed to correlate the Unani perspective with contemporary dermatological understanding. This method ensured a comprehensive understanding of the disease and its management from both conventional and Unani medicine perspectives.

Etiopathogenesis

In Unani literature

In *Moalejat-e-Buqratiya*, *Ahmad Tabri* stated that *"Quba* affects the external surface of the skin and is typically circular in shape, affecting a wide surface area of the body, and is quite similar to urticaria". Regarding etiopathogenesis, he explained that pathogenic, irritating substances emerge from minuscule capillaries, causing hyperpigmented papules to develop. These papules eventually spread and assume a large circular shape, resembling the clinical features of Quba (dermatophytosis) [10].

In *ZakheeraKhwarzam Shahi*, *Ismail Jurjani* mentioned that *Paryun* is the Persian name for *Quba*, whereas *Daad* is its Hindi name. He elaborated on the two primary causes of Quba, namely corrective faculty and noxious humor. According to him, an imbalance in these two factors contributes to the development of Quba [8].

In *Firdaus-ul Hikmat*, Rabban Tabri stated that when *Quwat-e-Hazma (digestive power)* becomes impaired, it results in the production of deranged blood, which subsequently circulates throughout the body, causing itching and ultimately leading to the development of Quba [11].

According to some other Unani physicians:

Quba occurs due to the mixing of *ghaleezsauda (thick melancholic humor)* with *tez (sharp) blood*. The condition arises when burnt *ghaleezratubat (thick moist humor)* or *Brigham-e-shor (sour phlegm)* combines with sharp blood, resulting in the chronic state of *Quba* [12].

Another explanation provided by Unani scholars is that *Quba* shares similarities with *safa'a (purulent or corrosive substances)*. It is believed that a fluid that is *haad (sharp)*, *harif (irritant)*, and *astringent/pungent*, when combined with *ghaleezsaudavimadda (thick melancholic matter)*, leads to the development of *Quba*. Some scholars also suggested that *balghammaleh (saline phlegm)*, when burned and transformed into *sauda (melancholic humor)*, could also be a potential cause of *Quba* [13].

In conventional literature

According to conventional medicine, dermatophytosis is caused by pathogenic fungi that typically induce superficial infections in both humans and animals [14]. There are around 52 keratin-degrading fungal species classified under nine genera, namely *Trichophyton, Microsporum, Epidermophyton, Arthroderma, Lopophyton, Nannizia, Ctenomyces, Guarromyces,* and *Paraphyton*, that are responsible for dermatophytosis [15,16]. Among them, the filamentous fungus *Trichophyton rubrum* is the most common cause of cutaneous infections in humans, as it infiltrates and feeds on *keratinized tissues* such as skin, hair, nails, and feet. Warm, moist, and occlusive environments favor the growth of this fungus, contributing to the spread and persistence of infection [17].

Classification with Clinical Presentations

The classification of *Quba* according to various Unani scholars is mentioned in Table 1, while the classification of *Tinea (dermatophytosis)* according to conventional medicine is mentioned in Table 2.

Table 1 Classification of *Quba*

S. NO.	Classification in unani literature	References
1)	According to ***Zakariyya Razi***, based on causative humour : 1.*Quba Raṭab (Damwi):* It is associated with blood converted into black bile. 2. *Quba Yabis (Sawdawi)* type is associated with *Balgham Māliḥ* (saline phlegm) which is burnt to be converted into *Sawda*.	[18]
2)	According *to* ***Ibn Sina*:** 1. *Quba-i-Damwi (Raṭab)* *2. Quba-i-Sawdawi (Yabis)* 3. *Quba-i-Mutaqashshir*: This type has extreme dryness leading to scaling. 4. *Quba-i-Ghayr Mutaqashshir:* It does not scale. 5. *Quba-i-Sa'iKhabath*: Spreading in nature. 6. *Quba-i-Waqif*: Always localized. 7. *Quba-i-Ḥad*: Acute in condition with short duration 8. *Quba-i-Raddi*: It has a poor prognosis.	[19]
3)	According to ***Ahmad Tabari*** in his famous book ***Al-Mualajat al-Buqratiya***: 1. *Jins-i-Damwi*: due to abnormality in blood and morbid fluid. 2. *Jins-i-Rutubi*: due to infection, heat and morbid fluid. 3. *Jins-i-Sawdawi*: due to burnt fluid.	[10]
4)	According to the Unani classical book ***Ḡhina Muna***: 1. *KaghaziDaad*: Lesions are superficial. 2. *BhainsaDaad*: Infection is invaded up to the deepest layer of the skin (up to muscle).	[20]
5)	According to the classical text book *"**Kitab al-Mukhtaratfi'l-tibb**"*: 1. *Khushk Daad* (dry) 2. *Tar Daad* (wet).	[21]

Table 2 Classification of Tinea

S. NO.	Classification of Tinea in conventional literature	References
1)	**Tinea corporis** (Ringworm of the glabrous skin): a superficial dermatophytic infection that affects the glabrous skin of the trunk (chest, back & abdomen) and limbs, leaving the other parts of the body like the scalp, beard, hands, feet, and groin.	[22]
2)	**Tinea cruris** or Jock Itch affects the groin, genitalia, pubic area, perineal and perianal areas.	[22]
3)	**Tinea capitis** a patch of alopecia with broken hair and ring formation at the periphery.	[23]
4)	**Tinea pedis** is the dermatophytosis of the planter surface of the feet and toe webs. Also known as Athlete's Foot.	[24]
5)	**Tinea mannum** is a superficial skin infection that involves the palmer surface of the hands and interdigital parts unilaterally and bilaterally.	[25]
6)	**Tinea unguium** (onychomycosis) is an infection of fingernails and toenails.	[25]
7)	**Tinea barbae** is the dermatophytosis of the facial beard area of men.	[26]
8)	Other clinical varientsare: **Tinea imbricates,** **Tinea psuedoimbricate,** **Tinea incognito,** **Majocchigranulom**.	[22]

Clinical Features

Quba (dermatophytosis) is a superficial fungal infection of the skin. The number of lesions may vary from a single lesion to multiple lesions. The shape of the lesion may be oval, circular, annular, or irregular. The borders of the lesions are erythematous and raised. The lesions may contain papules, vesicles, or scales. In most cases, the central part of the lesion

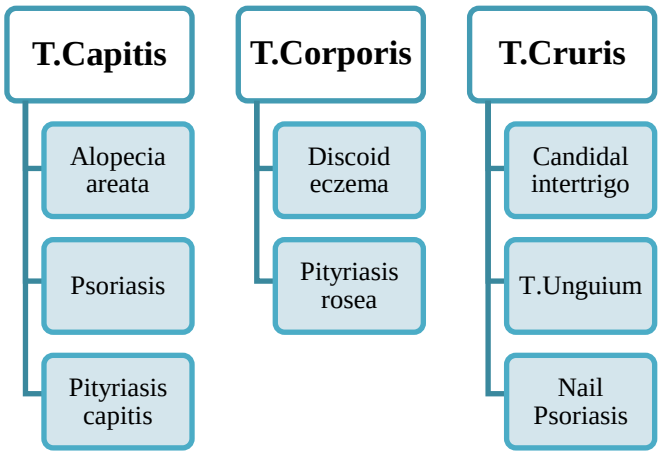
remains clear. Initially, the lesion appears hypopigmented, but over time, it may turn hyperpigmented. The primary symptoms of *Quba* include itching, burning sensation, pricking sensation, and oozing from the affected area, causing discomfort to the patient [14,15,16,17,22,27,28].

Diagnosis

Quba (dermatophytosis) can be easily diagnosed based on its clinical presentation. The typical appearance and symptoms of *Quba*, such as circular or annular lesions with erythematous borders, make it easily recognizable. However, for confirmation, certain diagnostic tools and investigations can be used. Dermoscopy and Wood's lamp examination can aid in identifying the characteristic features of the lesion. Additionally, laboratory investigations such as potassium hydroxide (KOH) mount preparation, fungal cultures, and skin biopsies can be performed to identify the specific fungal species responsible for the infection [14,15,16,17,22,27,28].

Differential Diagnosis [14,15,16,17,22,27,28]

Differential diagnosis of tinea is mentioned in flow diagram 1.



Flow diagram 1 Differential diagnosis of Tinea

Management In conventional medicine

Treatment of dermatophytosis is often dependent on the clinical setting. For instance, uncomplicated single cutaneous lesions can be adequately treated with a topical antifungal agent, but, a second wave due to reinfection with multiple lesions is treated with a topical antifungal along with therapy is usually needed to cure these conditions. Oral treatment options for dermatophytosis are Griseofulvin 500mg/day until cure (4-6 weeks). Terbinafine 250 mg/day for 4-6 weeks etc [15,16,28].

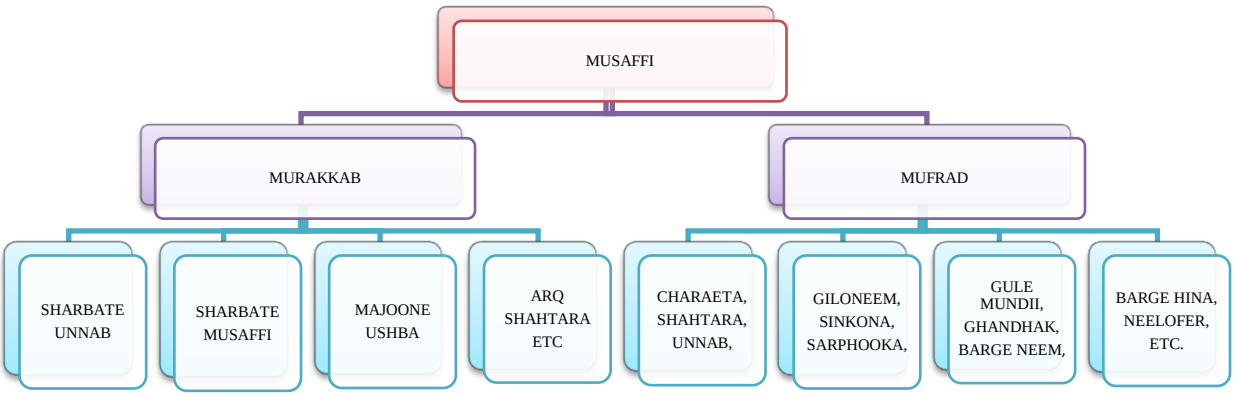
In Unani medicine

In the Unani system of medicine, the first line of treatment described for *quba* is *tanqiya e badan(*removal of harmful material from the body) through *munzij* and *mushil* therapy along with local applications [10,13,29,30].

After clinical examination of *Quba* according to the involved*khilt*, Different types of *munzij and mushil*are chosen for management. Inthe majority of cases *khiltesauda*, dearranged*sauda* is the major humour responsible for *Quba* as mentioned in classical Unani literature and possibly need to get rid of this dearrangedhumour from the body [18,20,31,32].

Blood-purifying drugs are used as a general principle in the treatment of skin diseases. Different
purifying drugs are used which causes excretion of undesirable and waste products from the blood, so in *Quba* different blood purifying drugs are used in its treatment. They are reported to be effective without any adverse effects reaction [33]. Drugs with blood-purifying actions are mentioned in flow diagram 2.

The drugs given below are considered to have blood-purifying actions:



Flow diagram 2 Drugs with blood purification action (musaffiat)

Murakkab drugs (formulation): *SharbteUnnab, Sharbate Musaffi, MajooneUshba, Arqe Shahtara,*etc[34]. Mufrad drugs:*Charaeta, shahtara, unnab, giloneem, sinkona, sarphooka, gulemundii, gandhak, barge neem, barge hina, neelofer*etc[34].

Management through local application: In addition to oral drug use, Unani physicians have placed great emphasis on local treatment in the form of *Zimaad*, *Tila*, and *Tadhīn*.Applying oil over the part of the body is termed *Tadhīn* [35,36,37]. If the disease is acute, superficial and localized, for this local application is usually enough, e.g., *Rogan-e-gandum, roghan-e-alsi, roghan-e-badamtalkh, roghan-e-narjil, butter* and *ghee*[18,38].On the other hand, if the disease is chronic and is situated in deeper tissues, then the management is started with the removal of morbid *saudavi* matters from the body by *Fasd* (venesection) and *Ishal* (purgation) using of decoction of *Aftemoon*and *Maul Jubn*. For local application very potent drugs which are *Haad* and *Muhammir* such as *Hartal* and *Khardal*, are used until fresh bleeding occurs. After this, healing is facilitated by the use of appropriate drugs [34]. *Hijamat Bil Shurt* (Wet Cupping) over the lesion and *Hammam* are also indicated at this stage [39].In the casewhere Quba has penetrated beyond the skin into the muscles, then relatively more potent drugs like *ushq*mixed with vinegar should be applied after leeching [18,40].

Therapeutic approach

Ibn Sina recommended *Ta'léq al-'Alaq* (leeching) - A method of evacuation of bad humours from the body with the help of leeches – is the first step for the treatment of *Qübä* before application of any topical medicine. *Razi* recommended *Hammam* (bathing), *Fasd*(venesection) and *Hijamahbi'l-Shart* (wet cupping) as per the type of *Quba* [24]. *Fasd*(Venesection/phlebotomy): *Fasd* is one of the classical methods of treatment in Unani system of medicine for cleansing, evacuation and diversion of surplus &morbid humours from the body, which helps in relieving inflammatory congestion. The *fasd* would be done through specified veins of the body part and at a specific time [40].

Discussion

This review paper provides a comprehensive analysis of the etiopathogenesis, clinical manifestations, classification, diagnosis, and management of *Quba* (Dermatophytosis) in the context of Unani medicine. The concept of *Quba* has been well-documented in classical Unani literature and is considered to be caused by viscid humours (*GhaleezRatubaat*) and morbid matter (*FasidMawaad*). In Unani medicine, the approach to treating *Quba* is fundamentally different from conventional therapies, emphasizing the concept of Tanqiya-e-Badan (detoxification of the body) using *Munzij-Mushil* (concoctive and purgative drugs), alongside local applications and various regimental therapies such as Venesection (*Fasd*), Leech Therapy (*IrsaleAlaq*), Wet Cupping (*Hijamat Bil Shurt*), and *Hammam* (Bathing Therapy). These therapeutic modalities aim to eliminate the root cause of the disease by removing the morbid matter, thereby promoting long-term healing and minimizing recurrence.

On the contrary, conventional medicine mainly relies on antifungal agents, which, although effective, often result in relapses, treatment failures, and adverse drug reactions. Despite significant advancements in the field of modern medicine, the prevalence of dermatophytosis remains high, contributing to considerable morbidity and psychosocial distress among affected individuals. Moreover, chronic and recurrent dermatophytosis remains a major public health concern, emphasizing the need for alternative treatment approaches that offer better therapeutic outcomes with minimal side effects.

The increasing global interest in Complementary and Alternative Medicine (CAM), especially Unani medicine,

has opened new avenues for exploring natural remedies for various skin conditions, including Quba. Unani medicine provides a diverse range of herbal, mineral, and animal-origin drugs that possess significant antifungal, anti-inflammatory, and immune-modulatory properties, making them highly effective in managing Quba without causing adverse effects or relapses. Furthermore, integrating regimental therapies like Hijamat Bil Shurt, Fasd, and IrsaleAlaq has shown promising outcomes in the effective management of Quba, which may provide long-lasting remission and minimal chances of recurrence.

Conclusion

Given the rising burden of dermatophytosis and the limitations of conventional treatments, Unani medicine offers a potential treatment modality that can help achieve a complete and sustained cure for Quba. However, further clinical trials, scientific validation, and evidence-based studies are highly recommended to establish the efficacy, safety, and standardization of Unani medicines and regimental therapies. Additionally, future studies should focus on comparing Unani treatments with conventional antifungal therapies to assess their long-term outcomes, recurrence rates, and patient satisfaction. Emphasizing the integration of Unani medicine with modern healthcare systems could potentially lead to more effective, safe, and sustainable management of Quba (Dermatophytosis), thereby reducing the disease burden and improving the quality of life of affected individuals.

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Conflict of Interest

The authors declare to have no conflict of interest.

Informed Consent and Ethical Statement

Not Applicable.

References

1. Shabnam A, Qamar AK, Anjum R, Siddiqui A, Qamar S. Fundamentals of Unani system of medicine - a review. European Journal of Biomedical AND Pharmaceutical Sciences, 2017; 4(9): 219-23
2. Yousef H, Alhajj M, Sharma S. Anatomy, Skin (Integument), Epidermis. [Updated 2022 Nov 14]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan.
3. Khan MA. Akseer Azam. Vol. 4. Matba Nizami, Kanpur. 1289 (AH),p 436-439
4. Khan MA. Ramooze Azam. Vol. 2. Delhi Printing Press, Delhi. 1335 AH, p374-376.
5. Jamaluddin. Aqsaraee. Vol. 1. Munshi Nawal Kishore, YNM.p 478-479.
6. Hijazi MR. Kanz-ul-IIaj. S. K. Basheer & Sons Pub., Lahore. YNM,p 479-480.
7. Noble WC. The Skin Microflora and Microbial skin Diseases. Cambridge University Press. 1993,p 232-234, 239, 244-45.
8. Jurjani I., ZakheeraKhawazam Shahi (Urdu translation by Khan HH), Vol-7, Idara Kitabush Shifa, New Delhi, 2010,p.p.24-26.
9. Petrucelli, M. F., Abreu, M. H., Cantelli, B. A. M., Segura, G. G., Nishimura, F. G., Bitencourt, T. A., Marins, M., &Fachin, A. L. (2020). Epidemiology and Diagnostic Perspectives of Dermatophytoses. *Journal of fungi (Basel, Switzerland)*, *6*(4), 310.
10. Tabari, A.M. (1997) Moalajat-e-Buqrätiya, Translation by CCRUM Vol 2. CCRUM, deptt of AYUSH, Ministry of health and family welfare, Government of India, NEW DELHI.
11. Tabri AR. Firdausul Hikmat (Urdu translation by Avval shah Sambhali). Faisal Publications, Deoband. 2002.p 294-295.
12. Qurshi MH. Jame-ul-Hikmat. Idara Kitabus Hifa, 2011.p 997-998.
13. Ibn Sīna.Al-Qānūnfi'lṬibb, Volume 4, 1st ed., Beirut, Dār-al Kutub al-Miyah, 1999, pp. 415-417.
14. Fitzpatrick, T.B., Richard A.J., Klaus, W. and Dick, S. (2001) Color Atlas and Synopsis of Clinical Dermatology. 4th ed. McGraw-Hill Medical Publishing Division.
15. Goldsmith, Lowell A., Stephen, I., Katz, Barbara, A., Gilchrest, Amy, S.P., David, J.L. and Klaus, W. (2012) Fitzpatrick's Dermatology in General Medicine. 8th ed. McGraw-Hill Medical Publishing Division.
16. Griffiths, C., Jonathan, B., Tanya, B., Robert, C., and Daniel, C. (2016) Rooks Textbook of Dermatology Vol - 1. 9th ed. Wiley Blackwell.
17. Munjal, Y.P., Agarwal, A.K., Gupta, P., Kamath, S.A., Nadkar, M.Y., Singal, R.K. and Sundar, S. (2015) API Textbook of Medicine Vol - 1. 10th ed. Jaypee Brothers Medical Publishers (P) Ltd.
18. Razi, A. (1991) Kitab Ul Mansoori (Urdu Translation by CCRUM). CCRUM, deptt of AYUSH, Ministry of health and family welfare, Government of India, New Delhi.
19. Ibn Sina (1998) Al Qanoon Vol -2. Idara Matbuaat Sulaimani, Urdu Bazaar, Lahore.
20. Qumri, H. (2008) Ghina Muna. CCRUM, Institutional Area, opp Block-D, Janakpuri, New Delhi.
21. Hubal, I. (2007): KitabulMukhtarat Fit Tib (Urdu Translation by CCRUM) Vol-4. CCRUM, Deptt of AYUSH, Ministry of health and family welfare, Government of India, New Delhi.
22. Sehgal, V.N. (2011) Textook of Clinical Dermatology. 5th ed. Jaypee Brothers Medical Publishers (P) Ltd
23. Moriarty, B, Roderick H, Morris J. The diagnosis and management of Tinea, BMJ 2012; 345: e4386

24. Finlay AY, Khan GK. Dermatology Life Quality Index (DLQI)-a simple practical measure for routine clinical use. Clin Exp Dermatol. 1994; 19 (3): 210-216.
25. Chander J. Dermatophytosis: Chander J, editor. Textbook of Medical Mycology. 4thed. New Delhi, Jaypee Brothers Medical Publishers, 2018: 167-168.
26. Bhadauria S and Kumar S. Clinical Manifestations of Dermatophytosis: A Review, International Journal of Scientific Research (IJSR), 2015; 4(1): 428-431.
27. Papadakis, Maxine, A., Stephen, J.M. and Micheal, W.R. (2019) Current Medical Diagnosis and Treatment. McGraw Hill Education. 58th ed.
28. Siddappa, K., Sacchidanand, S., Chetan, O. and Arun, C.I. (2016) IADVL Textbook of Dermatology Vol - 1. 4th ed. Bhalani publishing house.
29. Ayyub MM, Tarjuma-e-Aqsarai. (Sharah-e-Maujiz). Lucknow: Matba'a Munshi Nawal Kishore; YNM, 563.
30. Chughtai GM, Misbah-ul-Hikmat. Mochi Darwaza Pub. Lahore, 1939, 1161.
31. Khan Ajmal Hazique. New Delhi: Between Sadi Boiok Depot, N.S. Marg; YNM, 546-47.
32. Chanpuri Kausar, Mijiz-ul-Qanoon. 1sted. New Delhi: Taraqqi-e-Urdu Bureau, 1984, 457
33. Aleem S, Amraz-e-Jild, Aligarh. Saba Pussblishers, 2002, 117-119.
34. Bari A, Jame-ul-Advia. New Delhi: Faisal brothers publication; YNM, 42.
35. Meraj, M. et al. 2024. A Comprehensive Review of Insomnia and Its Regimenal Management in The Unani System of Medicine. *Journal of Drug Delivery and Therapeutics*. 14, 5 (May 2024), 158–162.DOI:https://doi.org/10.22270/jddt.v14i5.6562.
36. Meraj, M., M.I, A.R., Khan, N.A., Husain, S. and Khan, N. 2024. Utilization of unaniregimenal therapy for the management of insomnia: a rapid scoping review. *World Journal of Current Medical and Pharmaceutical Research*. 6, 2 (Jun. 2024), 18-23. DOI:https://doi.org/10.37022/wjcmpr.v6i2.325.
37. Furquan, A. et al. 2024. Unani Regimenal Therapy for Knee Osteoarthritis (Waja 'al Rukba): A Comprehensive Scientific Assessment. *Journal of Drug Delivery and Therapeutics*. 14, 10 (Oct. 2024), 175–181.DOI:https://doi.org/10.22270/jddt.v14i10.6855.
38. Jeelani Makhzan-e-Hikmat G. New Delhi: Aijaz Publishing House. 1996; 2:722-728.
39. Razi AMBZ, Kitabul Fakhir Fit Tib. (Arabic Translation by CCRUM), New Delhi: Ministery of health and Family welfare Govt. of India. 2005; 1:40-42.
40. Kirmani Sharah Asbab N. (Urdu translation by Kabiruddin M). 1st ed. New Delhi: Idara Kitabus Shifa. 2009; 3:240-42.