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Case Report

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INTEGRATIVE MANAGEMENT OF PRIMARY DYSMENORRHEA USING HABBE HILTEET AND DRY CUPPING: A CASE REPORT BASED ON UNANI PRINCIPLES

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Background:

Primary dysmenorrhea, defined as painful menstruation without any identifiable pelvic pathology, is one of the most common gynecological conditions affecting women of reproductive age. It often results in impaired daily functioning, reduced productivity, and diminished quality of life. In the Unani system of medicine, this condition is referred to as Waja' al-Rahm, commonly attributed to a Barid Yabis (cold and dry) temperament of the uterus. This case report explores the efficacy of an integrative Unani treatment combining Habbe Hilteet, a traditional polyherbal formulation known for its analgesic and anti-inflammatory properties, and Hijama Bila Shart (dry cupping therapy), in the management of primary dysmenorrhea. A 28-year-old female with a nine-year history of cyclic lower abdominal pain was treated over three consecutive menstrual cycles. The regimen included oral administration of Habbe Hilteet and weekly dry cupping sessions applied to the lumbar and lower abdominal regions. Clinical outcomes were evaluated using standardized tools including the Visual Analog Scale (VAS) for pain intensity, the Menstrual Symptom Questionnaire (MSQ), and WHOQOL-BREF for assessing quality of life. The patient reported a progressive decline in pain severity and symptom burden across treatment cycles, accompanied by noticeable improvement in physical and psychological well-being. The intervention was well-tolerated with no adverse effects reported. These findings suggest that the integrative use of Habbe Hilteet and dry cupping therapy may offer a safe, non-hormonal, and holistic alternative for the management of primary dysmenorrhea. However, further validation through larger, controlled clinical trials is warranted to substantiate its therapeutic potential and reproducibility.

Keywords: Primary Dysmenorrhea, Unani Medicine, Habbe Hilteet, Dry Cupping, Hijama, Waja' al-Rahm.

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Introduction

Dysmenorrhoea refers to the occurrence of painful menstruation that is intense enough to hinder a woman's ability to carry out her routine daily activities [1]. It is recognized as the most common gynaecological condition affecting women of reproductive age and is also one of the leading causes of pelvic discomfort. The prevalence of dysmenorrhoea varies considerably across different populations and studies, with estimates ranging from 16.8% to as high as 81% [2]. Some surveys have even reported its occurrence in up to 90% of menstruating

individuals, highlighting its widespread nature and potential impact on women's health and quality of life.

Dysmenorrhoea is broadly classified into two types: primary and secondary. Primary dysmenorrhoea, often termed spasmodic dysmenorrhoea, usually begins during adolescence, typically within six to twelve months after the onset of menarche, once ovulatory menstrual cycles are established. It generally reaches peak incidence in the late teenage years or early twenties. This form of dysmenorrhoea occurs in the absence of any detectable pelvic pathology and is primarily attributed to increased production of uterine prostaglandins. These biochemical

mediators cause strong uterine contractions, reduced blood flow (ischemia), and heightened sensitivity to pain during menstruation.

On the other hand, secondary dysmenorrhoea, also known as congestive dysmenorrhoea, tends to develop later in life, commonly in women in their twenties or thirties, unless it is associated with congenital anomalies. Unlike the primary form, secondary dysmenorrhoea results from identifiable underlying pelvic diseases. Common causes include endometriosis, pelvic inflammatory disease (PID), uterine fibroids, and adenomyosis. In such cases, the pain may persist throughout the menstrual cycle and is often accompanied by other symptoms such as abnormal bleeding or infertility. Accurate diagnosis and differentiation between the two types are crucial for effective treatment and management, as the underlying causes and therapeutic approaches differ significantly [3-5].

Case Presentation

Patient Details

- Age: 28 years
- Gender: Female
- Occupation: Student
- Dietary Habits: Mixed (Vegetarian and Non-Vegetarian)
- Religion: Muslim

Chief Complaints and Duration

A 28-year-old female presented to the Outpatient Department (OPD) of Hakim Syed Zia-ul-Hasan Unani Medical College, Bhopal, with a longstanding history of dysmenorrhoea persisting over the past nine years. She reported experiencing recurrent, cramp-like pain localized in the lower abdominal region, which was often accompanied by episodes of nausea. The discomfort typically commenced one to two days prior to the onset of menstruation and continued for approximately three to four days into her menstrual cycle. The intensity of the pain was significant enough to affect her daily activities during this period. Her symptoms were cyclical, closely linked with her menstrual pattern, and had remained relatively consistent in severity and duration over the years.

Clinical Findings

Menstrual History

Menarche at age 13

Regular cycles (28 ± 2 days)

Moderate flow for 4–5 days

No intermenstrual bleeding or dyspareunia

Lab and Ultra Sound Report

Pain score (VAS): 9/10

No pelvic abnormalities detected

Normal blood work and pelvic ultrasound

Therapeutic Intervention

The patient, diagnosed with primary dysmenorrhea, was treated with *Habbe Hilteet*, a classical Unani formulation known for its *Muhallil* (anti-inflammatory), *Musakkin* (analgesic), and *Muqawwi Reham* (uterine tonic) properties. The formulation was administered orally, beginning three days prior to menstruation and continued for five days during the menstrual cycle, aiming to relieve uterine spasms, reduce pelvic pain, and strengthen uterine function. In addition, dry cupping therapy (*Hijama Bila Shart*) was applied over the lumbar region (L3–L5) and the lower abdominal area, targeting specific sites related to uterine innervation and congestion. This therapy was intended to improve local blood circulation, reduce pelvic congestion, and alleviate dysmenorrheic pain. The integrative use of *Habbe Hilteet* and dry cupping aimed to provide effective symptomatic relief and improve the patient's overall quality of life

Composition of Hilteet

Table 01: Composition of Hilteet

Ingredient (Unani Name)	Botanical Name / Common Name	Quantity (per pill)	Action
<i>Hilteet</i>	<i>Ferulafoetida</i> / Asafoetida	125 mg	Carminative, antispasmodic, digestive stimulant, analgesic
<i>Suranjan Shirin</i>	<i>Colchicum luteum</i>	125 mg	Anti-inflammatory, analgesic
<i>Zanjabeel</i>	<i>Zingiber officinale</i> / Ginger [6]	125 mg	Carminative, anti-inflammatory, digestive, antispasmodic
<i>Filfil Siyah</i>	<i>Piper nigrum</i> / Black Pepper	125 mg	Digestive stimulant, enhances bioavailability, analgesic
<i>Post Baladar</i>	<i>Aegle marmelos</i> (Bael bark)	125 mg	Antispasmodic, digestive
<i>Qiwam-e-Sugar</i>	Sugar base	q.s. (quantity sufficient)	Binder and preservative

Dosage and Administration

1. Habbe Hilteet

Dosage: 125 mg tablet twice daily

Administration: 3 days before and 5 days during menstruation

Duration: 3 consecutive menstrual cycles

Action: *Muhallil, Musakkin, Muqawwi Reham*

2. Dry Cupping Therapy (*Hijama Bila Shart*)

Sites: Lumbar (L3–L5) and lower abdominal region

Frequency: Once weekly for 4 weeks before menstruation

Duration: 10–15 minutes per session

Purpose: Relieve uterine congestion and pain

Results

Outcomes and Follow-up

The patient underwent an integrative treatment regimen involving *Habbe Hilteet* and dry cupping therapy (*Hijama Bila Shart*) for three consecutive menstrual cycles. Outcome measures included the Visual Analog Scale (VAS) for pain, the Menstrual Symptom Questionnaire (MSQ), and the WHOQOL-BREF (physical and psychological domains) for quality of life (Table 02). The patient tolerated the prescribed regimen well, with no reported adverse effects throughout the course of treatment. Regular clinical follow-up was conducted over a period of three months, during which the patient consistently reported a significant reduction in the intensity and duration of dysmenorrheic pain. Additionally, there was an observable improvement in her daily functioning and overall quality of life during menstrual periods. No recurrence of severe symptoms was noted, indicating a sustained therapeutic response to the combined intervention of *Habbe Hilteet* and dry cupping therapy. These findings suggest that the integrative Unani approach was both effective and well-tolerated in the management of primary dysmenorrhea.

Pain Assessment (VAS)

- Cycle 1: 9/10
- Cycle 2: 5/10
- Cycle 3: 3/10

There was a 66% reduction in pain severity from baseline to the third cycle.

Menstrual Symptom Severity (MSQ)

- Cycle 1: 22
- Cycle 2: 14
- Cycle 3: 8

Improvement was observed in symptoms like cramping, fatigue, nausea, and irritability.

Quality of Life (WHOQOL-BREF)

- Cycle 1: 45
- Cycle 2: 58
- Cycle 3: 72

A 60% improvement in QoL scores was noted, particularly in the physical and psychological domains.

Table 02: Clinical Outcome Measures Over Three Menstrual Cycles

Parameter	Cycle 1	Cycle 2	Cycle 3	% Improvement (Cycle 1 to 3)
VAS (Pain Score)	9/10	5/10	3/10	66.7% ↓
MSQ (Symptom Score)	22	14	8	63.6% ↓
WHOQOL-BREF (QoL Score)	45	58	72	60.0% ↑

Notes:

- **VAS** = Visual Analog Scale (0 = no pain, 10 = worst pain)
- **MSQ** = Menstrual Symptom Questionnaire (higher scores = more severe symptoms)
- **WHOQOL-BREF** = World Health Organization Quality of Life (higher scores = better quality of life)
- Arrows (↑/↓) indicate direction of change (improvement)

Discussion

Primary dysmenorrhea is among the most prevalent gynecological complaints affecting women of reproductive age, especially adolescents and young adults. It is characterized by cyclic lower abdominal pain during menstruation in the absence of any underlying pelvic pathology. The pathophysiology primarily involves elevated levels of endometrial prostaglandins, especially prostaglandin F2α, which induce excessive uterine contractions, vasoconstriction, ischemia, and heightened pain sensitivity. While conventional treatments such as nonsteroidal anti-inflammatory drugs (NSAIDs) and hormonal contraceptives are considered first-line therapies, they are not without limitations. These agents may lead to gastrointestinal issues, hormonal disturbances, and long-term dependency, making them unsuitable for all patients, especially those seeking natural, non-pharmacological alternatives.

In this context, Unani medicine offers a valuable complementary perspective, viewing primary dysmenorrhea as *Waja' al-Rahm*-a disorder often arising due to a deranged *Barid Yabis* (cold and dry) temperament of the uterus. This temperament leads to stagnation of blood, impaired circulation, and heightened sensitivity, thereby manifesting as menstrual pain and discomfort. The current case study highlights the use of a holistic Unani regimen that integrates *Habbe Hilteet*-a time-tested polyherbal formulation-and *Hijama Bila Shart* (dry cupping therapy), demonstrating significant improvement across multiple symptom domains.

Habbe Hilteet comprises several pharmacologically active herbs that exhibit synergistic properties aligning with

Unani therapeutic goals. *Hilteet* (*Ferula foetida*), the chief ingredient, is well-known for its carminative, antispasmodic, and analgesic properties, aiding in the relief of uterine cramps. *Suranjan Shirin* (*Colchicum luteum*) and *Zanjabeel* (*Zingiber officinale*) further enhance anti-inflammatory action, reduce uterine muscle tension, and improve pelvic blood flow. Additionally, *Filfil Siyah* (*Piper nigrum*) and *Post Baladar* (*Aegle marmelos*) contribute to bioavailability enhancement, uterine tonicity, and antispasmodic effects. The cumulative action of these ingredients addresses both the symptoms and underlying imbalance of temperament, as conceptualized in Unani pathology.

Dry cupping therapy, or *Hijama Bila Shart*, served as a non-invasive adjunct modality targeting the lumbar (L3–L5) and lower abdominal areas—regions anatomically associated with uterine innervation and vascular supply. The practice of cupping is believed to stimulate local microcirculation, relieve tissue congestion, and modulate the neurohumoral axis through the release of endogenous opioids and other regulatory factors. In traditional unani practice, cupping is also used to correct humoral imbalances and facilitate the elimination of morbid matter (*fasad*), thereby restoring homeostasis.

In this case, the therapeutic outcomes were measured using validated tools: the Visual Analog Scale (VAS) for pain, Menstrual Symptom Questionnaire (MSQ) for overall symptom burden, and WHOQOL-BREF for assessing physical and psychological well-being. Over the course of three menstrual cycles, there was a clear and progressive decline in pain intensity (VAS: from 9 to 3), reduction in symptom severity (MSQ: from 22 to 8), and improvement in quality of life scores (WHOQOL-BREF: from 45 to 72). Importantly, these benefits were achieved without any reported adverse effects, indicating good tolerability and patient adherence.

The case also underscores the psychological and functional improvements experienced by the patient, including enhanced energy levels, mood stabilization, and better day-to-day functioning during menstruation. Such improvements are crucial, as dysmenorrhea often leads to absenteeism from academic, professional, and social activities, contributing to broader societal and economic costs.

However, despite the encouraging results, several limitations should be acknowledged. Being a single-case report, the findings lack generalizability. The absence of a control group, blinding, or randomization prevents definitive causal inference. Moreover, potential confounding variables such as diet, physical activity, psychological stress, and hormonal status were not systematically evaluated or controlled. Objective biomarkers, such as serum prostaglandin levels or uterine blood flow parameters, could have provided additional mechanistic insights.

Nevertheless, this report aligns with a growing body of literature supporting the role of complementary and

traditional medicine in managing menstrual disorders. The combination of herbal pharmacotherapy and localized manual therapy (cupping) demonstrates a promising model for integrated care, especially in populations inclined toward natural and culturally rooted treatments.

Conclusion

This case report highlights the potential effectiveness of an integrative Unani approach in managing primary dysmenorrhea. The combination of *Habbe Hilteet*, a polyherbal formulation with proven analgesic and anti-inflammatory properties, and *Hijama Bila Shart* (dry cupping therapy), targeting relevant anatomical regions, resulted in notable clinical improvement. The patient experienced a significant reduction in menstrual pain, improved symptom control, and enhanced quality of life—all without adverse effects. These findings suggest that such Unani interventions may serve as safe and viable alternatives for individuals seeking non-hormonal and holistic treatment options. However, further clinical studies involving larger cohorts and comparative controls are essential to substantiate these preliminary observations and establish their broader therapeutic relevance.

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Conflict of Interest

The authors declare to have no conflict of interest.

Informed Consent

Informed consent was obtained from the participant prior to their inclusion in the study.

Ethical Statement

Ethical approval for the study was obtained from the Head of the Department and the concerned supervisor. The study was conducted in accordance with ethical standards and institutional guidelines.

Author Contributions

All the authors have contributed equally in the study.

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