



Psoriasis (*Taqashshur al-Jild*): A Review of Unani and Modern Medical Perspectives

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ABSTRACT :

Background: Psoriasis is a chronic, relapsing, immune-mediated inflammatory skin disorder characterized by well-demarcated erythematous plaques with variable scaling. It is associated with significant physical discomfort, psychosocial burden, and impaired quality of life. In Unani medicine, some clinical features of psoriasis have been correlated in Unani literature with concepts such as *Taqashshur al-Jild* and *Da-us-Sadaf*. The Unani understanding of the disease emphasizes disturbances in *Mizaj* and the accumulation of abnormal humoral matter, particularly *Ghair Tabai Saudavi Madda*, along with alterations in the normal condition of the skin.

Objective: The present review aims to provide an overview of psoriasis from both Unani and modern medical perspectives. It further discusses the Unani understanding of psoriasis, including the concepts of *Taqashshur al-Jild* and describes the principles of Unani treatment and its therapeutic approaches for the management of the disease.

Methods: Relevant literature was reviewed from electronic databases, classical Unani literature, standard textbooks, and published scientific articles concerning psoriasis and its management.

Conclusion: Psoriasis represents a complex chronic inflammatory skin disorder that can be understood through complementary conceptual frameworks of modern medicine and Unani medicine. Modern advances have elucidated important immunological mechanisms and provided targeted therapeutic options, while the Unani system offers a holistic approach based on *Mizaj*, *Akhlat*, causative factors, and individualized management. An integrated understanding of both perspectives may provide a broader framework for studying psoriasis and developing evidence-based approaches to its management.

Key Words:- *Taqashshur al-Jild*, *Qoobae Mutaqashshira*, *Saafae- Yabisa*, *Qashaf al jild*, Unani Medicine, Immunopathogenesis

Introduction

Psoriasis is a long-standing, relapsing inflammatory disorder of the skin with an immune-mediated basis. It is clinically characterized by sharply demarcated erythematous plaques with overlying silvery-white scales, commonly involving the scalp, nails, and extensor aspects of the limbs. Patients may experience pruritus, burning, and other symptoms that can adversely affect their daily activities and overall quality of life. (1–4)

The disease has a worldwide distribution, although its prevalence differs considerably across geographical regions and population groups. Approximately 2% prevalence has been reported in Europe and the United States, whereas studies from India have reported prevalence ranging from 0.44% to 2.8%. The development of psoriasis is influenced by a combination of hereditary susceptibility and environmental factors. Infections, psychological stress, trauma to the skin, smoking, obesity, and certain drugs may initiate or aggravate the disease. Its pathogenesis involves complex interactions between genetic factors, epidermal abnormalities, and immune-mediated inflammation, with the IL-23/IL-17 axis playing a central role. Psoriasis may also coexist with systemic conditions such as psoriatic arthritis, obesity, metabolic syndrome, cardiovascular disease, and psychological disturbances. (4–7)

Within the Unani system of medicine, psoriasis is primarily discussed in relation to *Da-us-Sadaf* and *Taqashshur al-Jild*, conditions characterized by dryness and excessive scaling of the skin. Classical Unani physicians associated such disorders with alterations in *Mizaj* and disturbances of the

humoral balance, particularly involving *Sauda* and other *Akhlat-e-Ghair Tabaiyah*. The therapeutic approach includes measures such as *Tasfeeh-e-Dam* (blood purification), *Jali* (cleansing), *Tehleel-e-Auram* (resolution of inflammation), *Tarteel* (moisturization), and *Nuzj wa Tanqiyah* (maturation and elimination of abnormal humors), with the overall aim of restoring physiological balance and normal skin function. (8–11)

Current treatment options for psoriasis include topical corticosteroids, vitamin D analogues, phototherapy, systemic medications, and biologic or targeted therapies. Despite their therapeutic benefits, prolonged treatment may be associated with adverse effects, treatment limitations, contraindications, and considerable economic burden. (1–4,12)

In view of the chronic and multifactorial nature of psoriasis, the present review aims to provide an overview of psoriasis from both Unani and modern medical perspectives, with emphasis on its clinical features, etiopathogenesis, diagnosis, severity assessment, associated comorbidities, and management. It further explores the Unani concepts of *Da-us-Sadaf* and *Taqashshur al-Jild* in relation to the contemporary understanding of psoriasis and highlights its therapeutic approaches.

Materials and Methods

The present review was conducted in two phases. First, selected classical Unani source books were reviewed to identify concepts and descriptions correlating with psoriasis. The major sources included *Al-Qanoon fit-Tibb* (Ibn Sina), *Kamil-us-Sana't* (Ali Ibn Abbas Majoosi), *Tibbe Akbar* (Akbar Arzani), *Sharah al-Asbab wal-Alamat* (Najeebuddin Samarqandi), *Kitab al-Taiseer* (Ibn Zuhri), *Moalijate Buqratiya* (Ahmad Bin Muhammad Tabri), *Mizan al-Tibb*, *Kitab al-Mukhtar fit-Tibb* (Ali Bin Hubal Baghdadi), and *Zakheera Khwarazm Shahi* (Jurjani). Terms related to *Taqashshur al-Jild*, *Da-us-Sadaf*, *Su'-i-Mizaj*, and *Ghair Tabai Saudavi Mada*, along with relevant principles of Unani management, were identified and reviewed.

Second, a structured literature search was conducted using electronic databases, including PubMed/MEDLINE and Google Scholar. Keywords such as “psoriasis,” “psoriasis pathogenesis,” “psoriasis treatment,” “biologic therapy,” “*Taqashshur al-Jild*,” “*Da-us-Sadaf*,” and “Unani medicine” were used individually and in combination. Relevant peer-reviewed articles, reviews, and clinical studies addressing the epidemiology, pathogenesis, clinical features, diagnosis, severity assessment, and management of psoriasis were included. Duplicate and irrelevant publications were excluded. The retrieved literature was critically reviewed and synthesized to provide an integrated overview of psoriasis from both modern and Unani perspectives.

Unani Perspective on the Etiopathogenesis of *Taqashshur al-Jild* (Psoriasis)

Humoral and Temperamental Basis

According to Unani medicine, health depends on the balance of the four humours (*Akhlat*)—*Dam* (blood), *Balgham* (phlegm), *Safra* (yellow bile), and *Sauda* (black bile)—a concept introduced by *Buqrat* (Hippocrates). Any disturbance in their quality or quantity leads to disease, while restoration of this balance promotes health. (13)

Taqashshur al-Jild is primarily attributed to the predominance of abnormal *Sauda* (black bile), along with *Rutoobat-e-Radiyah* (morbid matter) and weakness of the skin. (13) The disease is also associated with *Su-e-Mizaj-e-Jild*, which causes persistent alterations in skin function and contributes to chronic dermatological manifestations. Excessive dryness and scaling indicate the involvement of abnormal *Sauda*, whereas erythema and itching suggest the presence of *Safra Muhtaraq* (oxidized or burnt bile), which may eventually transform into *Sauda-e-Safrawi*. (14)

The chronic and seasonal nature of psoriasis may also be considered in relation to *Mizaj* (temperament). Modern concepts such as genetic susceptibility and HLA variations may be interpreted alongside the Unani concept of temperament, suggesting that multiple humoral and temperamental factors may contribute to the development of psoriasis rather than a single humour alone. (13)

In Unani medicine, *Sauda* may become abnormal either qualitatively (*Kaifiyat*) or quantitatively (*Kammiyat*). Abnormal black bile may develop through the oxidation or transformation of other humours, particularly *Safra* and *Balgham*, resulting in different clinical manifestations. In addition to *Sauda Ghair Tabai*, other abnormal humours and morbid materials implicated in the pathogenesis include *Khilt-e-Hareef wa Laza*, *Khilt-e-Sauda Muhtaraq*, *Balgham-e-Shor*, *Balgham-e-Zujaji*, and *Khushk Boraqi Madda*. (7,10,13,16)

Classical Unani Descriptions and Scholarly Perspectives

Classical Unani scholars have described psoriasis-like disorders using various terms, including *Qooba-e-Mutaqashshirah*, *Taqashshur-e-Jild*, *Qooba-e-Muzmin*, *Qashf-e-Jild*, *Sa'afa-e-Qishri*, *Al-Sadafia*, *Chambal*, *Talaq*, and *Apras*. Among these, *Taqashshur-e-Jild* closely resembles the clinical features of psoriasis, although its pathological basis has not been clearly defined in classical literature. (15)

According to *Ibn-e-Zohr*, excessive morbid *Khilt-e-Sauda* accumulates in the skin, impairing its nutrition and excretion. This results in tissue degeneration and the development of dry, scaly lesions. (17) *Ali Ibn-e-Abbas Al-Majoosi* stated that *Khilt-e-Ghaleez* is expelled towards the skin, producing dryness, itching, and accumulation of *Sauda*. (18)

Ibn-e-Sina described this condition as *Qooba-e-Mutaqashshar* and attributed it to abnormal or burnt black bile. He explained that toxic humours

accumulate beneath the skin, causing malnourishment, scaling, and itching, particularly when associated with heat. (19)

Similarly, **Hakeem Kabeeruddin**, in *Tarjuma-e-Kabir*, explained under *Baheq-e-Aswad (Bars-e-Aswad)* that burnt *Safra* transforms into *Khilt-e-Sauda*, which deposits beneath the skin. Owing to its dry nature, it produces excessive dryness, scaling, itching, burning, fissuring, and may predispose to secondary infection. (20)

Abu Bakr Muhammad bin Zakariya Razi, in *Al-Haavi fit-Tibb*, described *Qooba* as a disorder caused by sour and sticky morbid material. A severe form presents with erythematous patches, itching, and roughness, for which leech therapy was recommended. (21)

Ibn-e-Hubal Baghdadi, in *Al-Mukhtarat fit-Tibb*, explained *Bars-e-Aswad (Qooba-e-Mutaqashshir)* as a condition resulting from thick *Khilt-e-Sauda* deposited in the skin, producing scaling, itching, and burning. He stated that chronic cases are difficult to treat and noted that dry *Qooba* is mainly caused by *Sauda*, whereas redness and moisture indicate the admixture of blood with *Sauda*. He also described *Saafa Yaabisa* as a dry, scaly condition caused by burnt phlegm or abnormal black bile. (22)

In *Al-Qanoon fit-Tibb*, **Ibn-e-Sina** described *Saafa* as beginning with small lesions that gradually become erythematous, scaly plaques. He also noted that *Qooba* is associated with altered black bile mixed with thick morbid material, and that excessive dryness leads to prominent scaling, with exacerbation often occurring during the *Kharif* season. (19)

Ali Ibn-e-Abbas Majoosi, in *Kamil-us-Sana'ah*, described *Taqashshur-e-Jild* as a condition characterized by scaling and persistent itching of the skin. According to him, it develops when *Balgham-e-Mirary* (bilious phlegm) mixes with blood, leading *Tabi'at* (physis) to drive the *Khilth-e-Ghaleez* (viscous humour) towards the skin. Owing to *Zof-e-Jild* (weakness of the skin) and *Zof-e-Dafey'ah* (weakness of the expulsive faculty), these morbid humours fail to be eliminated, accumulate within the skin, and ultimately produce scaling and intense pruritus. (18)

Similarly, *Tibb-e-Akbar* describes *Qooba* as a chronic scaly disease resembling fish scales. (23) *Meezan-ut-Tibb* refers to *Taqashshur-e-Jild* as excessive dryness of the skin leading to scaling. (24) *Firdaus-ul-Hikmat* also attributes the condition to combustion of black bile and skin dryness, resulting in roughness and shedding of scales. (25)

Overall, classical Unani literature consistently associates psoriasis-like scaly dermatoses with derangement of *Sauda*, accumulation of morbid humours in the skin, altered *Mizaj*, and impaired skin function. However, the descriptions vary among classical scholars regarding the specific humour or morbid material involved, indicating that the Unani understanding of *Taqashshur al-Jild* encompasses a multifactorial humoral pathogenesis rather than a single pathological mechanism.

Immunopathogenesis of Psoriasis

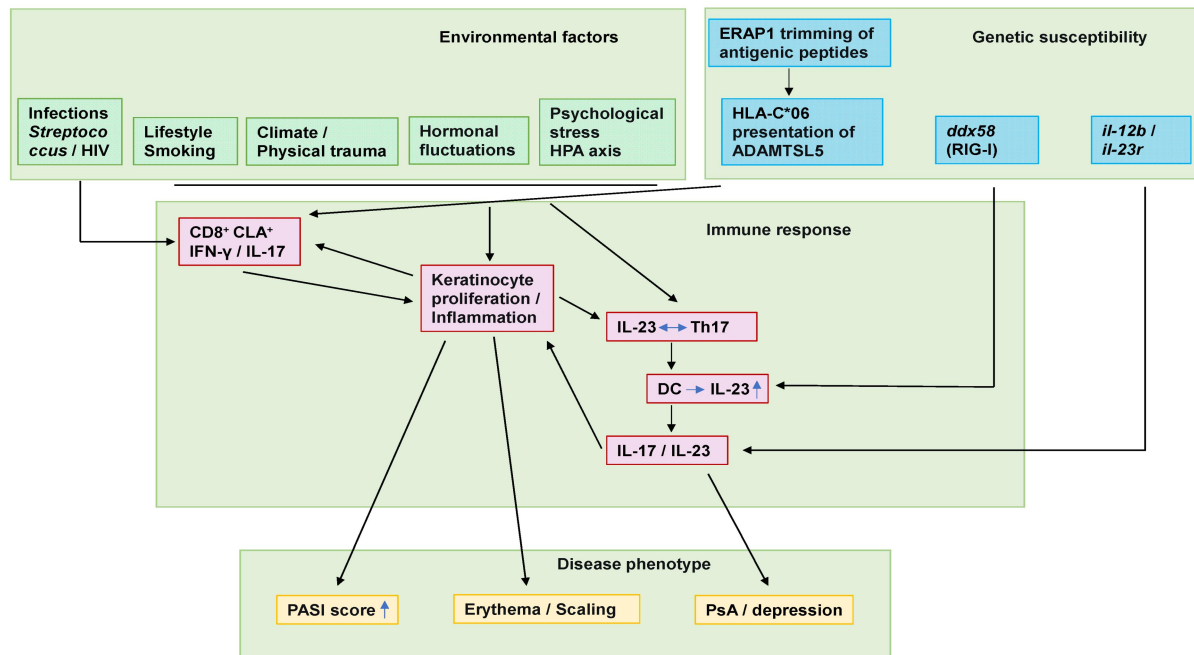
Psoriasis is a chronic immune-mediated inflammatory disorder involving complex interactions between the innate and adaptive immune systems. Activation of plasmacytoid dendritic cells (pDCs) leads to the release of IFN- α and other inflammatory mediators, which activate myeloid dendritic cells (mDCs). Activated mDCs produce **IL-23**, promoting the differentiation and activation of **Th17 cells**. These cells release **IL-17A** and other pro-inflammatory cytokines, which stimulate keratinocyte proliferation and increase the production of antimicrobial peptides, chemokines, and inflammatory mediators. This persistent cytokine-driven interaction between immune cells and keratinocytes sustains chronic inflammation and the characteristic epidermal changes of psoriasis. (26,27)

Role of Genetic Factors

Genetic susceptibility plays an important role in psoriasis, as evidenced by familial aggregation and higher concordance among monozygotic twins. **HLA-Cw6**, located within the **PSORS1 locus on chromosome 6p**, is the major genetic susceptibility factor and contributes substantially to the heritable risk of psoriasis. Other susceptibility loci, including **PSORS1–PSORS10**, have also been identified. Genes such as **CDSN** may influence keratinocyte differentiation and epidermal barrier function, indicating that both immune dysregulation and altered epidermal barrier mechanisms contribute to psoriasis. (28–32)

Environmental Factors

Environmental triggers can initiate or exacerbate psoriasis, particularly in genetically susceptible individuals. Important triggers include **physical trauma, psychological stress, infections, and certain medications**. These factors interact with genetic predisposition and immune dysregulation, contributing to disease onset and progression. (6)



Lifestyle Factors:

Several lifestyle and environmental factors can trigger or exacerbate psoriasis, particularly in genetically susceptible individuals.

- **Drugs:** Beta-blockers, lithium, antimalarials, NSAIDs, and tetracyclines have been associated with induction or aggravation of psoriasis through immune dysregulation, altered keratinocyte proliferation, and inflammatory pathways. (33)
- **Diet, Alcohol, and Smoking:** The role of diet remains uncertain. Excessive alcohol intake may aggravate disease through immune and inflammatory mechanisms, while smoking is associated with palmoplantar pustulosis and poorer treatment outcomes. (33)
- **Trauma:** Physical injury may induce new psoriatic lesions at the site of trauma through the **Koebner phenomenon**. (34,35)
- **Hormonal Changes:** Hormonal fluctuations, particularly during puberty and menopause, may influence disease onset and severity. (33)
- **Stress:** Psychological stress can aggravate psoriasis by activating neuroendocrine and immune pathways, increasing the production of inflammatory cytokines such as IFN- α , TNF- α , and IL-1 β . (33-35)
- **Infections:** Infections, particularly **β -haemolytic streptococcal infections**, may trigger or worsen psoriasis through activation of T lymphocytes. (33-35)
- **Seasonal Variation:** Psoriasis commonly worsens during winter, while increased humidity may improve skin lesions. (36)
- **Sunlight:** Sunlight and ultraviolet exposure may improve psoriasis in many patients; however, excessive exposure or photosensitivity can aggravate lesions in susceptible individuals. (37-39)

Symptoms and Morphology of Psoriatic Lesions

Psoriasis commonly presents as well-demarcated, erythematous papules and plaques covered with dry, silvery-white scales. Lesions may be mildly pruritic and vary in size and distribution. They gradually enlarge by peripheral extension and may merge to form larger plaques. Removal of scales may produce pinpoint bleeding, known as the Auspitz sign. (36,37)

Site of Predilection

Psoriatic lesions predominantly affect extensor and pressure-bearing areas, including the elbows, knees, scalp, lumbosacral region, and back. Lesions may also extend onto the forehead and nape of the neck. (36)

Characteristic Clinical Signs

- **Candle-grease sign:** Scraping produces scales resembling melted candle wax.
- **Grattage test:** Scraping accentuates the characteristic silvery scales.
- **Bulkeley's membrane:** Complete removal of scales reveals a thin, shiny, reddish membrane.
- **Auspitz sign:** Further scraping causes pinpoint bleeding due to dilated dermal capillaries.

- **Woronoff sign:** A hypopigmented halo may appear around resolving lesions, particularly after treatment.
- **Koebner phenomenon:** New lesions may develop at sites of trauma, usually within 7–14 days. (36,38-41)

Therapeutic Approaches to Psoriasis in Unani Medicine

1. Therapeutic Rationale and Fundamental Principles

The Unani approach to the management of psoriasis (*Da'u-us-Sadaf/Taqashshur-e-Jild*) is primarily directed towards correction of the underlying humoral imbalance and elimination of morbid humours. Particular emphasis is placed on the management of abnormal *Sauda* (morbid black bile), which is considered an important pathogenic factor in chronic dry and scaly dermatoses. The principal therapeutic objectives include *Nuzuj* and *Tanqiya-e-Akhlat-e-Saudavia* (concoction and elimination of morbid melancholic humour), *Tasfeeh-e-Dam* (blood purification), *Tadeel-e-Mizaj* (restoration of normal temperament), *Islah-e-Hazm* (correction of digestion), and restoration of systemic and local moisture. Local therapy additionally aims to cleanse, soften, moisturize, and reduce inflammatory changes through drugs possessing *Jali*, *Murakhi*, *Murattib*, and *Muhallil* properties. (42)

Based on these therapeutic objectives, Unani management may broadly be discussed under dietary regulation, pharmacological interventions, and regimenal therapies. These approaches may be used individually or in combination according to the patient's temperament, clinical presentation, severity, and the nature of the morbid material involved. (42,43)

2. Dietary and Lifestyle Modulation

Ilaj Bil Ghiza (dietotherapy) constitutes an important component of Unani management. Dietary regulation is directed towards avoiding foods considered capable of increasing *Ghair Tabai Saudavi Madda* (morbid black-bilious matter) and supporting restoration of an appropriate *Mizaj*. Excessive consumption of meat, sweets, sour and salty foods, and alcohol is traditionally discouraged because such dietary factors are considered to promote the formation or accumulation of abnormal humours, particularly *Sauda* and *Balgham*. (41,43)

A *Barid-Ratab* (cold and moist) dietary pattern is traditionally recommended to counter excessive dryness and support *Tarteel-e-Mizaj*. Easily digestible and nourishing foods such as fresh milk, tender lamb, bottle gourd, pumpkin, spinach, black gram (*Maash*), and *Ma-ul-Jubn* (whey) have been described as suitable dietary choices. Soups prepared from black gram and pumpkin, as well as preparations combining fresh milk with black gram, are also recommended in the traditional dietary regimen. (41,43)

3. Pharmacological Management

Ilaj Bil Dawa (pharmacotherapy) constitutes a major component of Unani management and encompasses both systemic and local interventions. The therapeutic selection is guided by the intended action of the medicine, such as elimination of morbid humour, blood purification, resolution of inflammation, soothing of the skin, promotion of tissue repair, restoration of moisture, and cleansing of the affected surface. (41,43)

3.1 Humoral Evacuation and Corrective Therapy

The traditional pharmacological approach places considerable emphasis on *Nuzuj wa Tanqiya-e-Ghair Tabai Akhlat-e-Saudavia*, whereby abnormal melancholic humour is first rendered suitable for elimination and subsequently evacuated. *Munzijat-e-Sauda* and *Mushilat-e-Sauda* are therefore employed according to the therapeutic requirement. Additional measures include *Tasfeeh-e-Dam*, *Tahleel-e-Auram*, and correction of *Mizaj* and digestion. (42,44)

Among the classical prescriptions, **Nuskha Matbookh**, attributed to Mohammad Tabri, has been recommended for the evacuation of abnormal melancholic humour in *Taqashshur-e-Jild*. It contains several medicinal ingredients, including *Afsanteen*, *Shahatra*, *Pursiya wa Shan*, *Tamar-e-Hindi*, *Haleela Zard*, *Turanjabeen*, *Anjeer*, *Unnab*, *Luk*, *Revand*, *Mavaiz Munaqqa*, and *Baerg-e-Enab-us-Salab*. The ingredients are boiled in water until the volume is reduced to approximately one-third, filtered, and administered orally with sugar and *Roghan Badam Shirin* in divided doses on an empty stomach. The preparation is traditionally described as producing mild purgation and thereby facilitating the elimination of morbid humours. Following evacuation, a nourishing diet comprising goat meat, spinach, and soup prepared from *Maash* and *Kaddu* is recommended for restoration of strength. (31)

Similarly, **Ibn-e-Zohr** emphasized evacuation of melancholic humour in the management of *Taqashshur-e-Jild*. His recommendations included oral administration of *Bisfayij*, *Afteemoon*, *Hajr-e-Lajward*, and *Khareeq-e-Siyah*. *Tiryag Farooq* (2 g) and *Sharbat Ashussoos* (35 mL) were also advised with plain water at specified intervals. For local management, a preparation containing *Maghz Tukhm-e-Kharpozah* with *Roghan Baboona* was recommended for desquamative lesions.

3.2 Single Unani Drugs

A variety of *Advia-e-Mufradah* (single drugs) have traditionally been described for the management of *Da'u-us-Sadaf*. These drugs are selected

according to their humoral and therapeutic actions and may be administered individually or in combination in preparations such as *Joshanda* (decoction), *Khesanda/Zulal* (infusion), and *Safoof* (powder).

Important drugs described in the Unani literature include *Afsanteen* (*Artemisia absinthium*), *Asgand* (*Withania somnifera*), *Tukhm-e-Babchi* (*Psoralea corylifolia*), *Baad Aaward* (*Volutarella divaricata*), *Chiraita* (*Swertia chirayita*), *Post-e-Neem* (*Azadirachta indica*), *Kamela* (*Mallotus philippensis*), *Shahatra* (*Fumaria parviflora*), *Sandal* (*Santalum album*), *Haleela* (*Terminalia chebula*), *Unnab* (*Ziziphus jujuba*), *Qust Shirin* (*Saussurea lappa*), *Berg-e-Inderjau Shirin* (*Wrightia tinctoria*), *Haldi* (*Curcuma longa*), *Mundi* (*Sphaeranthus indicus*), *Bisfaij* (*Polypodium vulgare*), *Chob Chini* (*Smilax china*), *Ghongchi* (*Abrus precatorius*), *Ushba* (*Smilax ornata*), and *Gul-e-Gao Zaban* (*Borago officinalis*).

From a therapeutic perspective, several of these drugs are traditionally categorized as *Musaffi-e-Dam* or blood-purifying agents. These include *Shahatra*, *Haldi*, *Post-e-Neem*, *Babchi*, *Mundi*, *Chiraita*, *Ushba*, *Chobchini*, *Gul-e-Surkh*, and *Sandal Safed*. Drugs employed for *Tanqiya-e-Madda* include preparations containing *Halayla Zard Musaffa*, *Kishmish Munaqqa*, *Maghz-e-Faloos*, *Khayar Shambar*, *Majoon Najah*, *Itrifal Shahtara*, and *Tiryag Farooq*, along with *Sharbat Aslussoos*.

3.3 Compound Unani Formulations

In addition to single drugs, several *Advia-e-Murakkabah* (compound formulations) have been described for the management of psoriasis. These formulations include both systemic and topical preparations and are selected according to their intended therapeutic actions.

Systemic formulations (*Advia-e-Murakkabah Dakhili*):

Various compound formulations administered internally include *Itrifal-e-Shahatrah*, *Majoon-e-Usbah*, *Khameerah-e-Sandal*, *Sharbat-e-Sandal*, *Sharbat-e-Unnab*, *Sharbat-e-Murakkab Musaffi-e-Khoon*, *Arq Murakkab Musaffi-e-Khoon*, *Arq-e-Shahatrah*, *Arq Ushba*, *Sharbat Banafsha*, and *Habbe Musaffi Khoon*. These formulations are traditionally used for their *Musaffi-e-Dam*, *Muhallil*, and other therapeutic properties and are selected according to the patient's clinical condition and *Mizaj*.

Topical formulations (*Advia-e-Murakkabah Maqami*):

Topical compound preparations described for psoriasis include *Marham Hina*, *Marham Gulabi*, *Marham Da'u-us-Sadaf*, *Roghan Babchi*, *Roghan Narjeel*, *Roghan Gandum*, *Roghan Chalmoghra*, and *Roghan Kamelah*. These preparations are primarily used locally to address manifestations such as dryness, scaling, itching, and other cutaneous changes.

The systemic formulations are primarily directed towards humoral correction and purification, whereas topical preparations are intended to act locally on the affected skin by cleansing, softening, moisturizing, reducing inflammation, or supporting restoration of the skin surface. This systemic–local therapeutic framework represents an important characteristic of the Unani approach to chronic dermatological disorders. (44–46)

4. Local Skin-directed Therapy

Local therapy is an important component of Unani management, particularly when dryness, scaling, itching, inflammation, and altered skin texture are prominent. Preparations may be applied in the form of *Tila*, *Zimad*, *Marham*, or *Roghan*. The choice of topical agent is traditionally based on properties such as *Jali* (cleansing), *Murakhi* (softening/emollient), *Murattib* (moisturizing), and *Muhallil* (resolving inflammatory swelling). (41,43)

Topical formulations described in the classical literature include *Marham Hina*, *Marham Gulabi*, *Marham Da'u-us-Sadaf*, *Roghan Babchi*, *Roghan Narjeel*, *Roghan Gandum*, *Roghan Chalmoghra*, and *Roghan Kamelah*. These preparations provide a local therapeutic approach directed towards the prominent cutaneous manifestations of the disease. (44–46)

5. Regimenal Therapy (*Ilaj Bil Tadbeer*)

Ilaj Bil Tadbeer represents the regimenal component of Unani treatment and is intended to facilitate elimination of morbid substances associated with humoral derangement. In the context of chronic skin disorders, classical literature describes procedures including *Fasd* (venesection), *Ta'leeq* (leech therapy), and *Ta'reeq* (sudation). (31,40,44,45)

5.1 Fasd (Venesection)

Mohammad Tabri, in *Moalejat-e-Biqratiyah*, described *Fasd* as an important regimen in the management of *Taqashshur-e-Jild*. He recommended opening the *Rag-e-Ba'saleeqe* (basilic vein) of both upper limbs at an interval of seven days, with continuation of the procedure until adequate evacuation of morbid humours was achieved or signs of reduced patient strength appeared. (11)

5.2 Ta'leeq (Leech Therapy)

Ta'leeq has been described by Ibn Sina and several Indian Unani physicians as a regimen employed in chronic inflammatory skin disorders and non-healing ulcers. Traditionally, its therapeutic rationale involves removal of impure blood, reduction of local inflammatory changes, and support of tissue healing. (19)

5.3 Ta'reeq (Sudation)

Ta'reeq refers to therapeutic induction of perspiration and has been described in classical Unani literature for cutaneous disorders. It is traditionally considered to facilitate elimination of retained or viscous morbid humours. Three principal methods are described: *Hammam* (bathing), *Inkebab* (vapour bath), and *Abzan* (sitz bath). (11,17-25)

Hammam: Therapeutic bathing, performed regularly according to the patient's condition, is traditionally considered useful in chronic skin disorders and may assist in cleansing and softening the skin. (17-25)

Inkebab: This involves exposure to therapeutic vapour generated using drugs possessing *Muhallil-e-Auram* and *Mu'arriq* properties. Herbs such as *Baboona* (*Matricaria chamomilla*), *Akleel-ul-Mulk* (*Astragalus hamosus*), *Qaisoom* (*Artemisia abrotanum*), *Marzanjosh* (*Origanum majorana*), and *Izkhar* (*Andropogon* species) have been described for this purpose. (17,19,22,24)

Abzan: This regimen involves immersion in warm water containing decoctions of selected *Muhallil* and *Mu'arriq* drugs. Classical ingredients include *Tukhm-e-Kataan*, *Tukhm-e-Teerah* *Tezak*, *Tukhm-e-Gazar*, *Tukhm-e-Shaljam*, *Suddab*, *Lablab*, *Badyan*, *Berg-e-Karafs*, *Gandana*, *Karam Kallah*, *Unsul*, and *Roghan-e-Zaitoon*. These ingredients are traditionally boiled in approximately 3 L of water until the volume is reduced to one-third, after which the resulting preparation is used for the bath. (18,19)

6. Overall Therapeutic Framework

Overall, the Unani management of psoriasis encompasses a multidimensional therapeutic strategy rather than reliance on a single intervention. The approach combines dietary modification, correction and evacuation of abnormal humours, blood purification, restoration of *Mizaj*, systemic administration of single or compound medicines, local skin-directed preparations, and selected regimenal procedures. The therapeutic emphasis varies according to the individual's temperament, humoral status, severity and characteristics of the skin lesions.

Discussion

The Unani system of medicine provides a holistic approach to the understanding and management of *Taqashshur al-Jild*, a condition that shares several clinical manifestations with psoriasis. Although psoriasis does not have a direct equivalent description in classical Unani literature, *Taqashshur al-Jild* shares several characteristic manifestations with psoriasis, including dryness, roughening and thickening of the affected skin, excessive scaling, and itching. From the Unani perspective, *Tabi'at* attempts to expel *Khilt-i Ghaliz* towards the skin; when its accumulation exceeds the skin's capacity for elimination, it is considered to contribute to the development of *Taqashshur al-Jild*. This process is associated with the accumulation of *Ghair Tabai Saudavi Maddah* and disturbance of *Mizaj*, resulting in the characteristic cutaneous manifestations.

The management of *Taqashshur al-Jild* is principally based on *Ilāj bi'l-Ghidhā* (dietotherapy), *Ilāj bi'l-Tadbīr* (regimenal therapy), and *Ilāj bi'l-Dawā* (pharmacotherapy). These modalities are selected according to the patient's *Mizaj*, disease condition, and individual requirements. Diet and regimenal measures are directed towards supporting the correction of the underlying derangement, while systemic medicines are employed for *Tanqiya* and *Islah-e-Mizaj*. Topical preparations are used to manage local manifestations such as scaling, dryness, and itching.

Thus, the Unani approach combines correction of the underlying systemic disturbance with management of the local skin manifestations. This individualized and holistic therapeutic framework represents an important aspect of the Unani perspective on psoriasis and *Taqashshur al-Jild*.

Conclusion

This review summarizes the important aspects of psoriasis from both Unani and conventional medical perspectives, including its clinical presentation, etiopathogenesis, and principles of management. The Unani system provides a holistic understanding of psoriasis based on the concepts of *Mizaj*, humoral imbalance, and *Ghair Tabai Saudavi Mada*, with emphasis on correction of the underlying derangement and restoration of normal skin health. The review also highlights the therapeutic approaches described in Unani literature and their relevance to the management of psoriasis. Overall, the available literature indicates that Unani medicine provides a traditional conceptual and therapeutic framework for understanding psoriasis, which may provide valuable perspectives for its management alongside the understanding provided by conventional medicine.

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