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PREVENTION AND MANAGEMENT OF UNANI FORMULATION IN1ST & 2ND DEGREE UTERINE PROLAPSE (INZELAQ-E-REHM / NUTUE-REHM)-A RESEARCH ARTICLE

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ABSTRACT

Uterine prolapse is a global health crisis in the aging female and is one of the commonest reproductive morbidities in developing countries with high prevalence among them. Even if mortality resulting from it is trivial, still it has a massive impact on day-to-day activities of a woman afflicted by this condition; hence declining their quality of life (including sexual, urinary and social functions). It is the third most common indication for hysterectomy. In classical Unani text, it was mentioned that, Uterine prolapse is mainly caused by weakness of ribatate rehm due to accumulation of balghame lazij. Moreover, it usually occurs in old age women having excessive rutubat in their body. It is symptomatic in 10% of women which usually require surgery; however mild stages of prolapse which are commonly asymptomatic and surgical intervention is not indicated can be managed conservatively with Unani medicine. The complications associated with Uterine prolapse are decubitus ulcer, carcinoma of cervix, urinary tract infection, renal failure, etc. This article gives a detailed description of uterine prolapse including its causes, pathogenesis, diagnosis, principle of treatment in Unani system of medicine with some Unani formulation contains Herbal drugs.

KEYWORDS: Uterine Prolapse (Nutue-Rehm), Unani formulation.

INTRODUCTION OF UTERINE PROLAPSE (NUTUE-REHM)

Genital prolapse in women is not a condition to modern times, modern diet, or modern living It is a distressing weakness that has probably being with us since very early times when human being first adopted the upright posture. The pelvic organ prolapse is the worldwide problem that affects the quality of life of Millions of women. It is the common condition affecting up to 50% of women over 50 years of age. The Incidence of urogenital prolapse increases with advancing age, menopause and Parity. Furthermore, it is expected that 11% of women over the age of 80 will undergo surgery for such conditions, with an additional 30 % who will require a repeat surgery. Uterine descent is often associated with coexistence anterior, posterior vaginal wall Prolapse and / or an enterocele. The commonly associated symptoms of anterior vaginal wall prolapse are urinary frequency, incontinence, intermittent flow and poor stream. Symptoms associated with posterior vaginal wall prolapse mainly include difficulty in defecation. The sensation of mass per vaginum, urinary, bowel, sexual sy

mptoms is universally described as prolapse symptoms. A detailed description of nut-e-rahem has been mentioned in most of the Unani ancient enclyopedias written by eminent physicians regarding its causes, sign and symptoms, diagnosis, prognosis and management.

In Unani system of medicine, the concept of humoral theory was first proposed by Buqrat. He states that if akhlaat arba (dam, balgham, safra and sauda) are in a state of equilibrium, both quantitatively and qualitatively health is restored. Any derangement in these akhlaat either quantitatively or qualitatively leads to disease. According to humoral concept it is balgham-e-galeez or balgham-e-lazij which are involved and dominated in nut-e-rahem. Hence the abnormal accumulation of this balgham in reham causes weakness of ribatat-e-reham leading to nut-e-rahem. Even in conventional medicine, the cause of uterine prolapse is weakness of supports of uterus due to pregnancy, repeated child birth, menopause, advancing age of women increased intra-abdominal pressure hence it correlates with concept of nut-e-rehem as proposed by unani physicians.

Unani concept of nutu-e-reham (uterine prolapse)

Buqraat (Hippocrates) 400 BC suggested infertility, wet feet, excessive exertion; excessive coitus could be the causative factors in uterine prolapse. As he was well aware of genital prolapse, the first method his treatment was to tie the women to a ladder which was then turned upside- down and shaken violently in the hope of reducing the prolapse. The second method of treatment was to apply cupping to both the buttocks and to the lower abdomen in the hope of sucking the prolapse back into the place. Third method of treatment was to raise the foot end of the bed and sponge the prolapse with cold wine until it was reduced, it was then supported in place by vaginal pessary impregnated with half pomegranate soaked in wine. Fourth method of treatment was mechanical blocking of vagina by vaginal pessary which was the most widely accepted treatment of genital prolapsed till 1800. Jalinoos (Galen) AD 130 believed that a genital prolapse was capable of reducing itself and he used fumigation to the vulval area to encourage this. Jalinoos (Galen) AD 130-200 also mentioned about the displacement of womb. Md Akbar Arzani AD 721 gave a detailed account of nutu-e-reham and advocated treatment for it. Razi AD 860-925 attributed the account of nutu-e-reham and described in brief about the disease. Al Majoosi AD 930-994 mentioned in his book kamil-us-sana about uterine diseases with special reference to nutu-e-reham.

MATERIAL AND METHODS

The study is carried out to assess the efficacy and therapeutic response of unani drugs in the management of 1st & 2nd degree uterine prolapse in the PG Dept of Qabalath-o-Amraz-e-Niswan, at Government Nizamia Tibbi College and Government Nizamia General Hospital, Charminar, Hyderabad. 60 patients are registered and 40 patients are selected for the trial. These 40 patients are divided into two groups with 20 patients in each group. Consent is taken after counseling and explanation.

Case Evaluation

Clinical history of each patient was carefully recorded in detail. This includes: age, socio economic status and parity. Pt with history of Mass per vagina, lower abdominal pain, backache, frequency of micturition, stress incontinence of urine, bowel irregularity, white discharge, vaginal laxity, hyper mobility of the uterus. Any symptoms related with endocrinological disorders were also noted.

Counseling done for significant past and family history

A detailed general and systemic examination was done. Temperature pulse, blood pressure was noted, the CVS and RS were examined.

Per abdomen examination was done to rule out any organomegaly

Per speculum examination was done to visualize the vagina, cervix and to know the degree of cervical descent.

Bi manual examination was done to note the position, size, consistency and mobility of the uterus and to rule out any adnexal mass. Per rectal examination was done wherever necessary.

Temperamental evaluation was done.

Investigations done: There is no specific lab investigation to confirm the Diagnosis of the Uterine Prolapse. However, the clinical examination and other routine test include

Routine Examinations: CBP (complete blood picture), ESR (Erythrocyte sedimentation rate), RBS (Random blood sugar), CUE (Complete urine examination)

Special Investigations: Ultra sonography (USG)

Study design

Standard control randomized single blind study. Randomization was done by number method using probability sampling method. Evaluation of result was done by,

By relief of symptoms.

By student's paired t' test.

By chi-square test.

Sample size – 40 patients of clinically diagnosed as Uterine prolapsed

20 patients in Group-A 20 patients in Group-B

Duration of therapy - 3 cycles (3 months) – for 10 days in each cycle/as per the assessment of the patient in 3 consecutive cycles.

Pharmacognosy of drugs

Drugs which are selected for the trial were finalized on the basis of their efficacy in the management of uterine prolapse, and their pharmacological effects, easy availability with least side effects in both groups. Group-A and Group-B

Group A medicine and Group B medicine has been categorized as habit, qabiz musakin-e-dard(analgesic), muqawwi-e-reham, muhalil. Antioxidant. Along with this medicine a common Joshanda (classical munjiz-e-balgam) an oral medicine is also prepared.

Test group

Group-A Medicines: It consists of sufoof, joshanda, humool.

1) NUSQ-E-SAFOOF(ORAL)

S. No.	Name of the drug	Dosage in grams
1.	MAJU SABJ (Quercus infectoria oliv)	2 grams
2.	MAYEEN KHURD (Tamarix gallica linn)	2 grams
3.	AQAQIYA (Acacia arabica willd)	1 gram
4.	GUL-E-DHAVA (Anogeissus latifolia wall)	3 grams

5.	MOCHARAS (Malabaricum bombex willd)	2 grams

Total10 grams in two divided doses.

2) NUSQ-E-JOSHANDA: (munjiz)

S. No	Name of the drug	Dosage in grams
1.	Beeq-e-karafs (Ranunculus scelaratus linn	4 grams
2.	Beeq-e-azkhar (Andropogon laniger roxb)-	4 grams
3.	Beeq-e-kasini (Cicorium intybus linn)-4 gr	4 grams
4.	Post-e-anaar (Punica granatum linn)	3 grams
5.	Katha sufaid (Acacia catechu willd)	2 grams
6.	Gul-e-surkh (Rosa damascena mill	3 grams

Total 20 grams in two divided doses

MUSHIL: MUNZIJ+TURBUD SUFAID (Operculina turpethum linn)-5 grams.
TABREED: LUAAB-E-ISAPGOL (Plantago ovata forsk), 10 grams in a glass of water.

3) NUSQ-E-HUMOOL: (Local application)

S. No.	Name of the drug	Dosage in grams
1.	SAMG-E-ARABI (Acacia arabica willd)	3 grams
2.	LUAAB-E-GHEEGAWAR (Aloe barbendesis offinalis)	2 tola
3.	ROGAN-E-GUL (Rosa damascena mill)	2 tola
4.	MAJU SABJ (Quercus infectoria oliv)	2 grams

GROUP-B MEDICINES: It consists of sufoof and douch.

1) NUSQ-E-SUFOOF(Oral)

S.NO.	Name of the drug	Dosage in grams
1.	ASHOK CHAAL (Saraca indica linn)	3 grams
2.	BARG-E-HEENA (Acacia Arabica willd)	2 grams
3.	SUFOOF-E-SUPARI (Areca catechu linn) 5 grams	5 grams

Total 10 grams in two divided doses

2) NUSQ-E-DOUCH: (External use)

S.NO.	Name of the drug	Dosage in grams
1.	BARG-E-HINA (Lawsomia alba lam)	5 grams
2.	BARG-E-BAKAIN (Melia azadirachta linn)	5 grams
3.	POST-E-ANAAR (Punica granatum linn).	5 grams

Methods of preparation of trial medicines

Preparation and administration of decocotion (joshanda) munjiz

The Joshanda is common for both group A and group B and its method of preparation follows. All the drugs have been soaked in overnight in 400 ml of water and boil in morning after preparation of decoction of 200 ml and it should be divided into two doses one dose given in the morning and second dose given in the evening before meals, for 10 days followed by 3 alternative purgatives with 3 alternative tabreed.

Mushil: Munzij+Turbud Sufaid (Operculina turpethum linn)-5 grams.

All the drugs have been soaked in overnight in 200 ml of water and boil in morning after preparation of decoction of 100 ml. this 100 ml is given in early morning and nothing should be taken by mouth until 3-4 motions has to pass. After that soft and easily digestible food should be taken like moong ki daal ki khichidi etc.

Tabreed: Luaab-E-Isapgol (Plantago ovata forsk), 10 grams in a glass of water. Seeds are soaked in 300 ml of water overnight, stirred in morning with spoon and sieved and given 100 ml morning and 100 evening on the next day of mushil.

Preparation and Administration of powder(sufoof) of group-A medicine

All drugs are taking in dry form and grinded up to fine powder and divided into two doses each dose given 5 grams BD after meals for 10 days course for 3 cycles.

Preparation of humool

All the drugs are mixed thoroughly and soaked in cotton ball. This cotton ball tagged with a thread and thread are kept in posterior fornix for 6-8 hours daily for 10 days course and the same procedure repeated in 3 cycles.

Preparation and Administration of powder (sufoof) of group-B medicine

All the drugs took in dry form and grinded up to fine

powder and divided into two doses each dose given 5 grams powder twice daily after meals for 10 days course for 3 cycles.

Preparation of Douche

All the drugs are soaked in 200 ml of water during night boiled in the morning to make a decoction of 100 ml. with the help of glycerin syringe of 100 ml, this medicine is inserted into posterior fornix of vagina.

OBSERVATIONS AND RESULTS

The present study was carried out in department of ilmul Qabalath-o-Amraze Niswan Government Nizamia Tibbi College & General Hospital charminar, Hydrabad. during the year 2015-2017. This is a Randomized single blind trial with two groups. Patients were divided into two groups of 20 each and the results were obtained. Results were derived on the basis of changes in Clinical features, pelvic examination findings & objective parameters. Objective parameter like HB% and USG findings were done to all patients before and after treatment. After treatment the most of the clinical features are subsided. The clinical profile and response with Group A and Group B medicine has been discussed as follows with statistical tables.

According to pelvic examination of findings

According to HB%

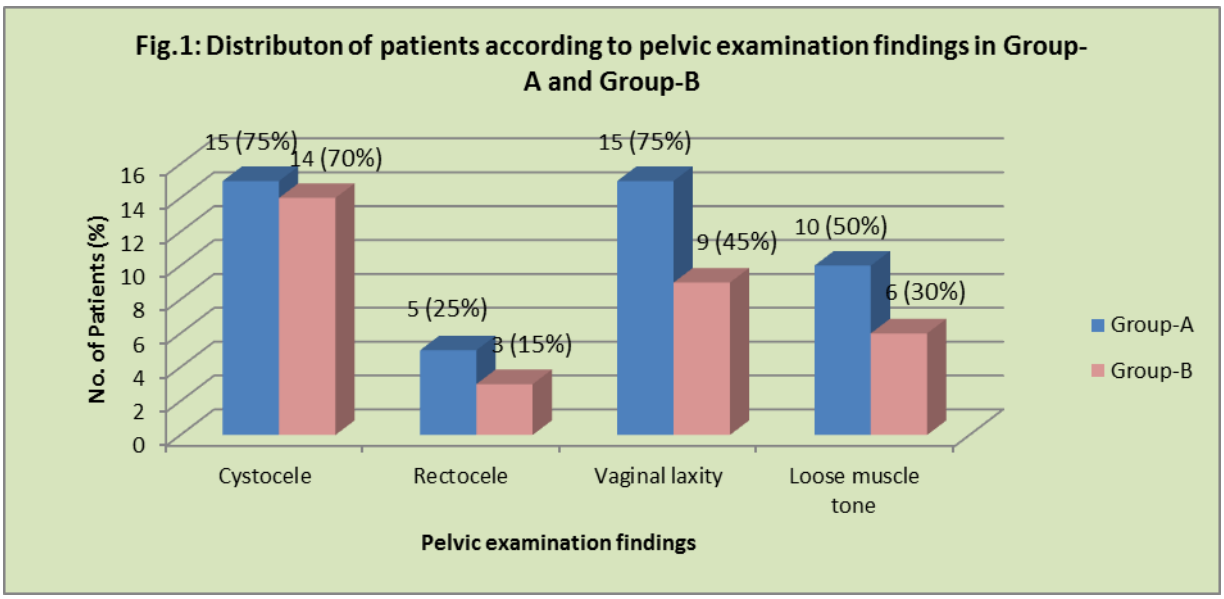
Remission of symptoms before and after treatment.

Remission of pelvic examination findings before and after treatment

Mean therapeutic response in Group A and Group B

Table 1: Showing distribution of patients according to pelvic examination findings in Group A and Group B.

No.	Pelvic examination findings	Group-A		Group-B	
		No of Patients	Percentage	No of Patients	%
1	Cystocele	15	75.0	14	70.0
2	Rectocele	5	25.0	3	15.0
3	Vaginal laxity	15	75.0	9	45.0
4	Loose muscle tone	10	50.0	6	30.0

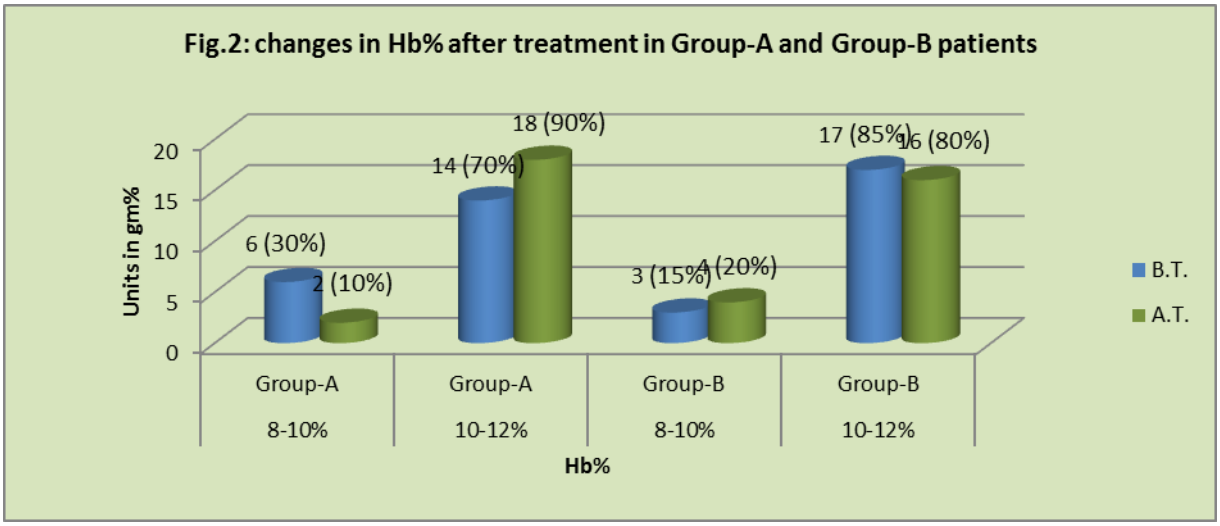


In the above observation the given data shows, the distribution of patients in group A and group B according to pelvic examination findings.

Result: It has been observed that highest number 15(75%) patients out of 20 registered has cystocele, and lowest number that is 3(15%) patients out of 20 has rectocele.

Table 2: Showing changes in Hb% in Group A and Group B patients after treatment.

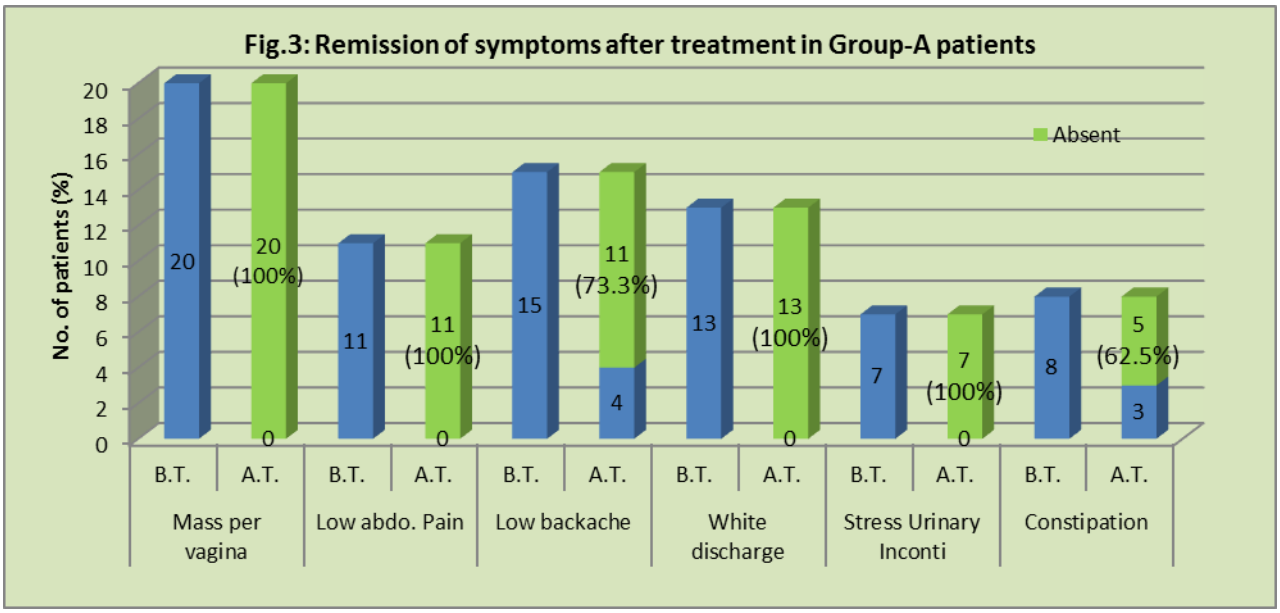
No.	HB %	Group A (No. of patients)		Group B (No. of patients)	
		Before treatment	After treatment	Before treatment	After treatment
1	8-10%	6 (30.0)	2(10.0)	3(15.0)	4(20.0)
2	10-12%	14 (70.0)	18(90.0)	17(85.0)	16(80.0)
	Total	20	100.0	20	100.0



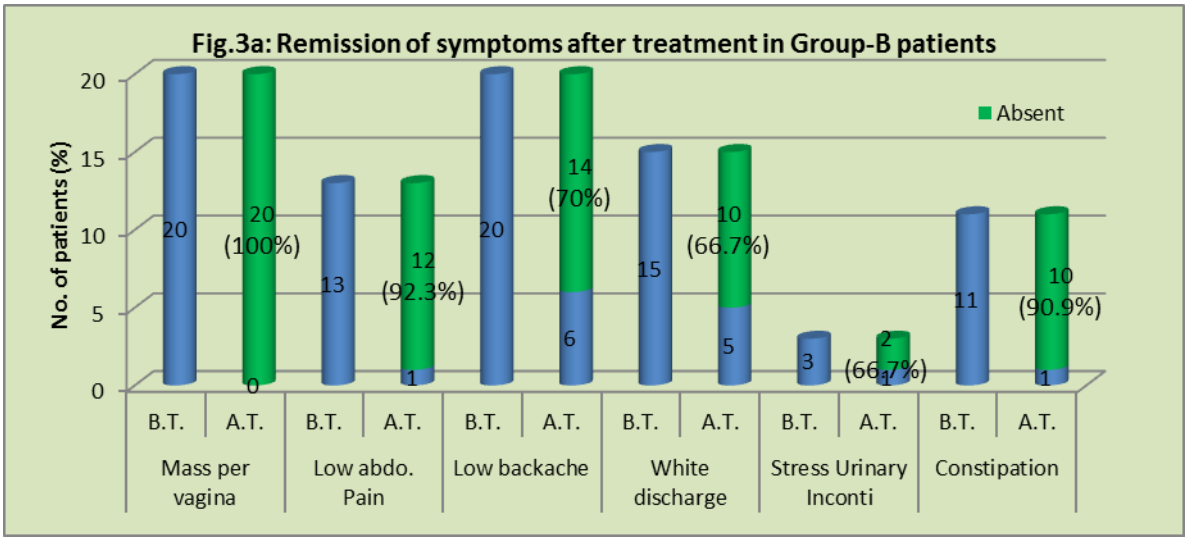
Distribution of patients according to HB% was done to assess the general health condition. High percentages of patients are seen with HB % in between 10-12% that is 14 (70%) in group A and 17 (85%) in group B. After treatment there was slight increase in group A that is from 14 patients to 18 patients are seen with HB% in between 10-12%. In group B there was slight decrease in that is from 17 patients to 16 patients are seen with HB% in between 10-12%.

Table 3: Showing distribution of patients according to remission of symptoms before and after treatment in group A and Group B.

S. No.	Symptoms	Group-A (No. of patients)			Group-B (No. of patients)		
		B.T.	A.T.	Remission (%)	B.T.	A.T.	Remission (%)
1	Mass per vagina	20	0	20 (100.0)	20	0	20 (100.0)
2	Low abdominal pain	11	0	11 (100.0)	13	1	12 (92.3)
3	Low back ache	15	4	11 (73.3)	20	6	14 (70.0)
4	White discharge	13	0	13 (100.0)	15	5	10 (66.7)
5	Stress urinary incontinence	7	0	7 (100.0)	3	1	2 (66.7)
6	Constipation	8	3	5 (62.5)	11	1	10 (90.9)



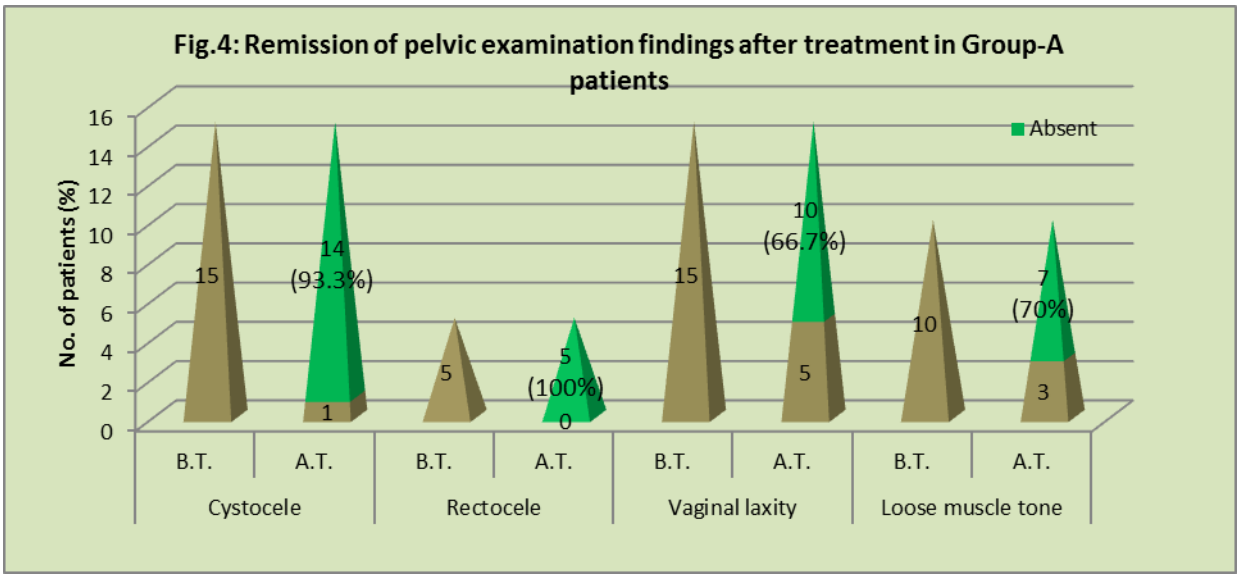
The observations show the remission of symptoms in Group A patients: the percentage of remission of mass per vagina is 100%, lower abdominal pain is 100%, low back ache is 73.3%, white discharge is 100%, stress urinary incontinence is 100 %, constipation is 62.5%. In the above observation, the highest response were observed in mass per vagina, lower abdominal pain, white discharge and SUI i.e.100.



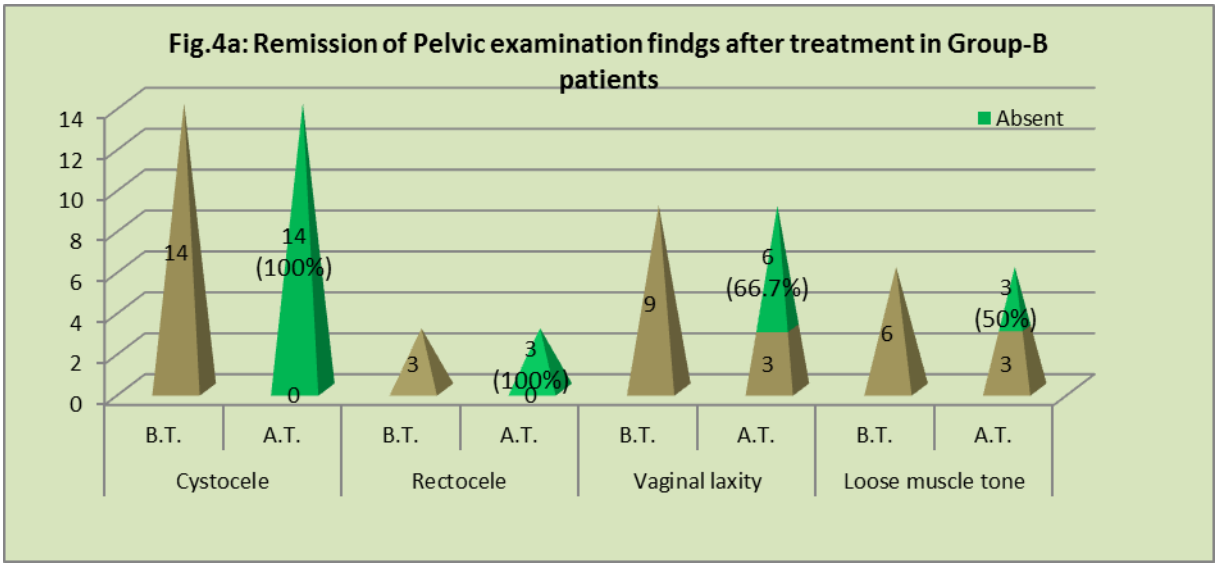
The observation shows the remission of symptoms in Group B patients: the percentage of remission of mass per vagina is 100%, lower abdominal pain is 92.3, low back ache is 70%, white discharge is 66.7%, stress urinary incontinence is 66.7 %, and constipation is 90.0%. In the above observation, the highest responses were observed in mass per vagina i.e.100%.

Table 4: Showing distribution of patients according to remission of Pelvic examination finding before and after treatment in group A and Group B.

S. No.	Pelvic examination findings	Group-A (No. of patients)			Group-B (No. of patients)		
		B.T.	A.T.	Remission %	B.T.	A.T.	Remission %
1	Cystocele	15	1	14 (93.3)	14	0	14 (100.0)
2	Rectocele	5	0	5 (100.0)	3	0	3 (100.0)
3	Vaginal laxity	15	5	10 (66.7)	9	3	6 (66.7)
4	Loose muscle tone	10	3	7 (70.0)	6	3	3 (50.0)



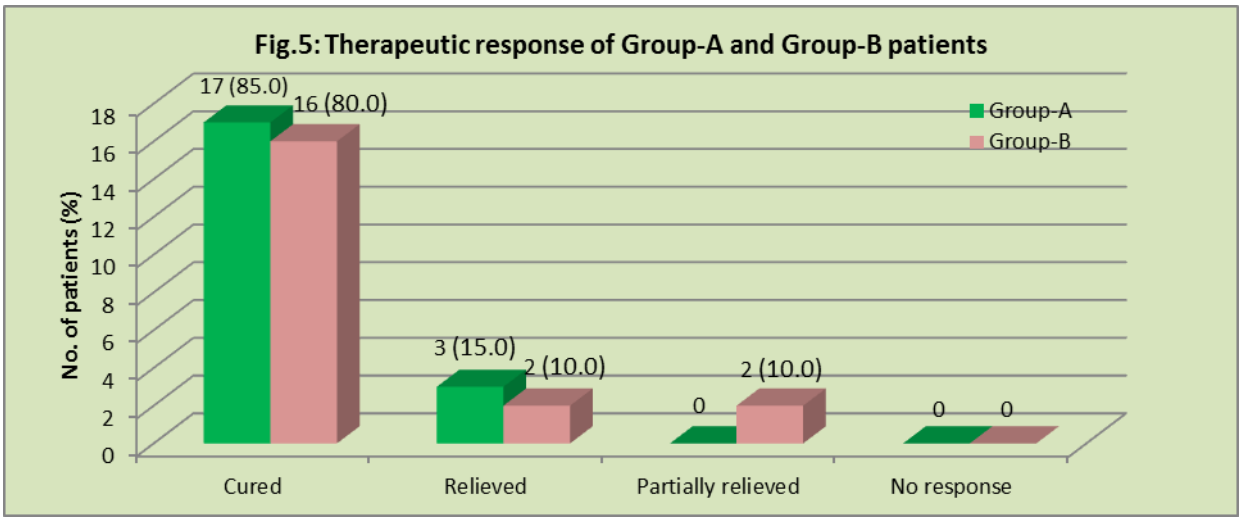
The observations show the remission of pelvic examination findings in Group A patients: the percentage of remission of cystocele 93.3%, rectocele 100%, vaginal laxity 66.7%, loose muscle tone 70%. In the above observation, the highest response was observed in rectocele i.e.100%.



The observations show the remission of pelvic examination findings in Group B patients: the percentage of remission of cystocele 100%, rectocele 100%, and vaginal laxity 66.7%, loose muscle tone 50%. In the above observation, the highest responses were observed in cystocele & rectocele i.e.100%.

Table 5: Showing Therapeutic response in Group A and Group B patients.

No.	Response	Group A		Group B	
		No. of patients	Percentage	No. of patients	Percentage
1	Cured	17	85.0	16	80.0
2	Relieved	3	15.0	2	10.0
3	Partially relieved	-	-	2	10.0
4	No response	-	-	-	-
	Total	20	100.0	20	100.0

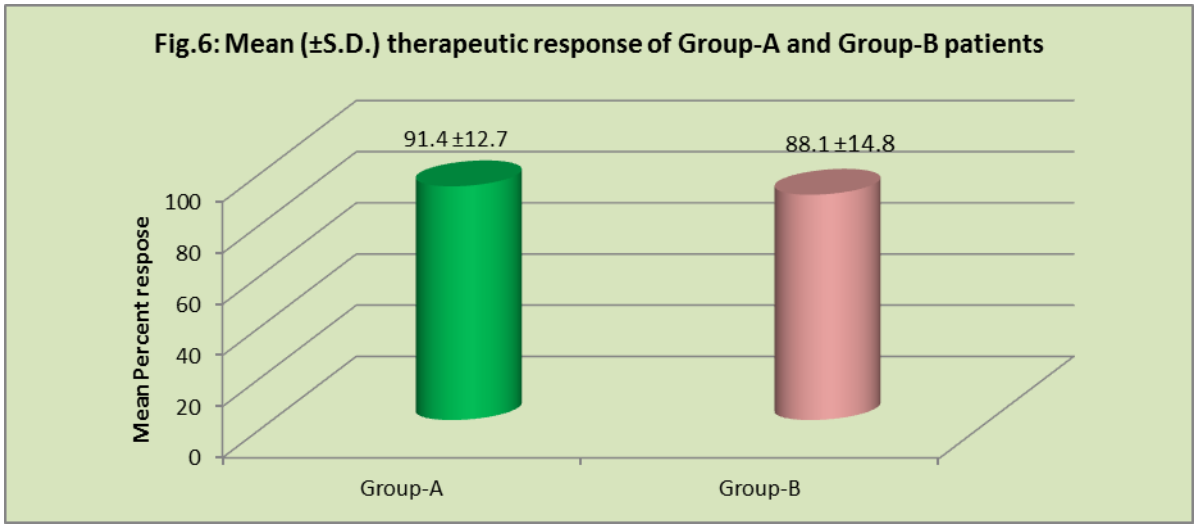


This observation shows the therapeutic response in Group A & Group B patients. In this present study in group A out of 20 patients 17(85%) has been cured, and remaining 3(15%) of patients were get relieved by their symptoms but prolapse was not totally cured. In group B out of 20 patients 16(80%) has been cured, 2(10%) of patients were get relieved by their symptoms, and 2 (10%) were partially relieved by their symptoms but prolapse was not totally cured.

Table 6: Showing Mean (±SD) Response in Group-A and Group-B patients.

Parameter	Group-A (Mean ± SD)	Group-B (Mean ± SD)	P < 0.05
Mean response	91.4 ±12.7	88.1 ±14.8	Not Significant

It means both groups have same efficacy in the treatment outcome.



This observation shows the therapeutic response in comparison between Group A & Group B. In group A the Mean ± SD value is 91.4 ±12.7, and in group B Mean ± SD value is 88.1 ±14.8. T test is applied for the response. The p value is < 0.05 response of both Group A &B were observed to be almost equal but in comparison, the response of Group A is slightly better than group B.

CONCLUSION

Table 1: Pelvic examination findings: In group A 15 patients has cystocele, 5 patients has rectocele, 14 patients have vaginal laxity, and 14 patients has loose muscle tone. In group B ,14patients has cystocele, 3 patients have rectocele,9 patients have vaginal laxity ,6 patients have loose muscle tone. It has been observed that highest number 15(75%) patients out of 20 registered have cystocele, and lowest number that is 3(15%) patients out of 20 has rectocele.

Table 2: HB% Percentage: Distribution of patients according to HB% was done to assess the general health condition. High percentages of patients are seen with HB % in between 10-12% that is 14(70%) in group A and 17 (85%) in group B. After treatment there was slight increase in group A that is from 14 patients to 18 patients are seen with HB% in between 10-12%. In group B there was slight decrease in that is from 17 patients to 16 patients are seen with HB% in between 10-12%.

Table 3 Remission of symptoms: In group A 20 patients were suffered from mass per vagina, 11 patients were suffered from lower abdominal pain, 15 patients were suffered from low back ache, 13 patients were suffered from white discharge, 7 patients suffered from stress urinary incontinence and 8 patients suffered from constipation. After treatment, the percentage of remission of mass per vagina is 100%, lower abdominal pain is 100%, low back ache is 73.3%, white discharge is 100%, stress urinary incontinence is 100 %, constipation is 62.5%, the highest response were observed in mass per vagina, lower abdominal pain, white discharge and stress urinary incontinence i.e. 100%. In group B 20 patients were suffered from mass per vagina, 13 patients were suffered from lower abdominal pain, 20 patients were suffered from low back ache, 15 patients were suffered from white discharge, 3 patients suffered from stress urinary incontinence and 11 patients suffered from constipation. After treatment, the percentage of remission of mass per vagina is 100%, lower abdominal pain is 92.3, low back ache is 70%, white discharge is 66.7%, stress urinary incontinence is 66.7 %, constipation is 90.0%, the highest response was observed in mass per vagina i.e.100%.

Table 4: Remission of pelvic examination finding: In group A 15 patients has cystocele, 5 patients have rectocele, 14 patients have vaginal laxity, 14 patients have loose muscle tone. After treatment the percentage of remission of cystocele 93.3%, rectocele 100%, vaginal laxity 66.7%, and loose muscle tone 70%. The highest responses were observed in rectocle i.e. 100%. In group B, 14patients has cystocele, 3 patients have rectocele, 9 patients have vaginal laxity, 6 patients have loose muscle tone. After treatment the percentage of remission of cystocele 100%, rectocele 100%, vaginal laxity 66.7%, loose muscle tone 50%, the highest response was observed in cystocele & rectocele i.e.100%.

Therapeutic response of drugs

In present study the maximum number of patients complained of mass per vagina is the first-place other complaints include lower abdominal pain, low back pain, white discharge, stress urinary incontinence, and constipation. The drugs which were selected for the joshanda, sufoof, humool and douch is described scientifically according to the chemical constituents and mode of action are as follows.

A. Mazu: The principal chemical constituent of galls is

tannin and tannic acid 50-60% and about 3% of gallic acid. Oak-bark contains up to 16% tannic acid to which it owes its effect. Allepo galls contain 50-60% of tannin. Chinese galls yield as much as 70% tannic acid. It acts as Astringent, haemostatic, anti-inflammatory for local inflammations like sore throat, nasal catarrh, Gonorrhea. Tannic acid in its pure form and gallic acid derived from the nut galls are valuable styptics, acid derieved from the nut galls are valuable styptics, astringents, useful in internal hemorrhages.

B. Mayeen: Tamarixgallica consists of tannin (50%) eg. ellagic acid and gallic acid, Major chemical constituents of tamarix were tamarixin, tamarixetin, troupin, 4-methylcoumarin, 3, 3'-di-0-methylellagic acid and quercetol (methyllic ester). The numerous polyphenols were also present in tamarix like anthocyanins, tannins, flavonones, isoflavonones, resveratrol and ellagic acid. It also constituted antioxidants like carotenoids and essential oils. It is used as Astringent, anti-inflammatory, anti-microbial laxative, stimulant, Expectorant, detergent and diuretic

C. Mocharas. The gum contains 8.9 % mineral matter and a large proportion of catechol, tannin, along tannic, gallic, and catechu tannic acids. The gum yielded DL-Valin and Indicamine. Aucubin was isolated from the gum. It is used Astringent, Expectorant, diuretic, tonic, stimulant, anti-inflammatory, styptic and demulcent.

D. Gul-e-dhawa. The main chemical constituents are Organic: Tannin, phenols, steroids, terpeunoids, carbohydrates and resins. Inorganic: Iron, calcium, potassium, magnesium, aluminium. It acts as Qabiz, Habis ud dam, Mubbarid and Mujaffif.

E. Aqaqia. The pod of babul tree contains about 22.44% Tannin. It also contains calcium, potassium and magnesium. Extract of gum is styptic, tonic, and astringent.

F. Samg-E-Arabi: The gum contains Arabic acid, combined with calcium, magnesium and potassium; it also contains small quantity of mallic acid sugar 14%, and 3-4% ash. It acts as Astringent, Demulcent, Aphrodisiac, Nutritive and Expectorant, Antibiotic.

G. Beekh-E-Azkhar: Distillation of the fresh plant yields Lemon grass Oil, verbena oil, and Indian molisa oil. Plant contains small amounts of methyl Heptenone and turpines. It acts as Stimulant, diuretic, purgative, anti-inflammatory, anti- microbial and sedative.

H. Bekh-E-Karafs: It contains Sulphur, it also contains sapoila Poisonous principal a lecoside apiin, a volatile essential oil, albumin, mucilage and salts. It acts as Antianxiety, antirheumatic, appetizer, carminative, Diuretic, nervine, and stimulant.

I. Bekh-E-Kasini: The chief chemical constituents are carbohydrates, proteins. Iron, calcium, potassium, magnesium. It acts as Mudir-e-baul, Musaffi-e-Dam, Muhhail –e- Warm, Musaqqit-e-janeen, Mufattit-e-sudad.

J. Post-E-Anar: The fruit rind (dried) contains up to 26, stem bark 10-25, root bark 28 and leaves 11 % tannin. The rind gave an ellagitannin, punicalagin, punicalin and ellagic acid. Rind of fruit acts as astringent, stomachic, digestive. Used for diarrhea, dysentery, colitis, dyspepsia and uterine disorders.

K. Katha Sufaid: Cutch (the concentrated extract) contains tannins 2-20%, catechin 25-33%, phlobatannins including catechutannic acid 20-50%; flavonoids including quercetin, quercitrin, fisetin; gums, resins, pigments. Cutch from wood is acts as powerful astringent, antidiarrheal, homeostatic; used for treating excessive mucous discharges, hemorrhages, relaxed conditions of gums, throat and mouth, stomatitis, irritable bowel.

L. Gul-E-Surkh: It contains_volatile essential oil, fat, resin malic, tartaric and tannic acids. red rose petals contain an aromatic volatile oil, a glucoside quercitrin, gallic acid. It acts as mildly astringent, aperients, carminative, refrigerant, muqawi-e-qalb-o-dimag, muqawi-e-badan, and musakkin-e-hiddat-e-safra.

M. Turbud Sufaid: It contains a resin known as turpethin yielded by the root bark which is a glucoside. Roots alone are rich in the purgative principle. It expels balgham and sauda, it purifies stomach and uterus, it is used in brain diseases

Aspghol: The chemical constituents are organic: Proteins, tannin, glycosides, fixed oils, and carbohydrates, Mucilage. Inorganics: Iron, zinc, potassium, and sodium. Seeds are cooling, demulcent, mildly astringent, emollient, laxative, and diuretic.

N. Samg-E-Arabi: The gum contains Arabic acid, combined with calcium, magnesium and potassium, it also contains small quantity of mallic acid sugar 14%, and 3-4% ash. It acts as Astringent, Demulcent, Aphrodisiac, Nutritive and Expectorant, Antibiotic.

O. Gheekwar: Organic: carbohydrates, proteins and tannins, Inorganic: Iron, calcium, Potassium magnesium and sodium. It acts as carminative, tonic, digestive, anti-inflammatory.

P. Ashok Chal: The stem bark contains glycoside, flavonoids, tannins, saponins, alcanes, esters, and primary alcohols. The alcoholic extracts present in the bark have showed a significant action against wide range of bacteria. It acts as Astringent, antiseptic, antitoxic, sedative, styptic.

Q. Supaari: Areca nut contains several alkaloids of the

pyridine group, such as arecoline, arecaine, arecodine, arecaidine, guvacine, isoguvacine, choline, etc.; ß-sitosterol and leucocyanidins. Its water extracts yield catechu, which contains tannins, catechin, gallic acid the nut also contains vitamin A, thiamine, riboflavin, niacin and ascorbic acid. Powdered nuts are prescribed in diarrhoea and urinary disorders. In combination with other astringent and styptic herbs, arecanut is used as a major constituent in confections of Indian medicine for gynaecological disorders.

R. Barg-E-Hina: Leaves yield a coloring matter henna dye 12-15%, Hanno-tannic acid, a kind of tannin and an olive-green resin soluble in ether and alcohol. other constituents are gallic acid, glucose. It acts as astringent, detergent, and deodorant.

S. Barg-E-Bakaeen: It contains a bitter alkaloid named "margosine" in long wide needles. Leaves also contain a small quantity of bitter substance of a similar character but much more soluble in water. It acts Munjiz, resolvent, blood purifier, Astringent, Emmenagogue.

SUMMARY

The pelvic organ prolapse is the worldwide problem that affects the quality of life of Millions of women. Genital prolapse in women is not a condition to modern times, modern diet, or modern living It is a distressing weakness that has probably being with us since very early times when human being first adopted the upright posture. It can be defined as falling or downward displacement of uterus from normal position along with vaginal walls. Further uterine prolapse is always associated with anterior vaginal wall prolapsed (cystocele and urethrocele). Sometimes posterior vaginal wall prolapsed (rectocele and /or enterocele). The present study was aimed to improve the prolapse quality of life of women and to minimize the surgical intervention, to treat the prolapse with Unani medicine. After the careful study of parameters of the uterine prolapse and keeping in view of complaints and complications, research medicines were selected, formulated and divided into two groups. Group A and Group B. Treatment was given as OP/IP basis in each group .special coded medicine has been formulated, prepared and given to the patients for 10 days course in each cycle, and has been repeated for next 3 cycles. All selected drugs are safe, easily available, with little side effects.

The drug's efficacy is better and patient tolerated well to the route of administration without overwhelming side effects. The response of drugs was monitored after administration of drugs for 10 days course of treatment. Subjective parameters show almost 100% remission after treatment, and there was improvement in objective parameters. After 3 cycles of treatment with pretest and posttest evaluation results were analyzed statistically for significant improvement of subjective and objective parameters. The results were analyzed by T test, Chi square test, and standard deviation test and tabulated.

In this present study in group A out of 20 patients 17(85%) has been cured, and remaining 3(15%) of patients were get relieved by their symptoms but prolapse was not totally cured. In group B out of 20 patients 16(80%) has been cured, 2(10%) of patients were get relieved by their symptoms, and 2 (10%) were partially relieved by their symptoms but prolapse was not totally cure.

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