

**SCIATICA: A COMPREHENSIVE LITERATURE REVIEW FROM UNANI AND
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ABSTRACT

Background: Sciatica (*Irq al-Nasā*) is a common musculoskeletal and neuropathic condition characterized by radiating pain along the course of the sciatic nerve, often accompanied by numbness, tingling, muscle weakness, and functional impairment. It significantly affects quality of life and daily activities. Although conventional therapies provide symptomatic relief, their long-term effectiveness may be limited, leading to increasing interest in complementary and traditional systems of medicine. **Objective:** This narrative review aims to evaluate the role of Unani medicine in the management of Sciatica (*Irq al-Nasā*) by integrating classical Unani concepts with contemporary scientific evidence. **Methods:** Relevant information was compiled from classical Unani literature, the National Formulary of Unani Medicine, and peer-reviewed biomedical studies on Sciatica, *Irq al-Nasā*, and Unani therapeutic interventions. The review summarizes the etiology, pathophysiology, clinical manifestations, diagnosis, and evidence supporting Unani management strategies. **Results:** Unani management of Sciatica is based on the principles of *Ilaj bil Tadbeer*, *Ilaj bil Dawa*, and *Ilaj bil Ghiza*. Regimenal therapies, including *Dalk*, *Takmeed*, *Hijama*, *Fasd*, *Nutool*, Hammam, and *Riyazat*, along with herbal formulations possessing anti-inflammatory, analgesic, and neuroprotective properties, may help reduce pain, improve nerve function, enhance mobility, and restore functional capacity. **Conclusion:** Unani medicine represents a promising complementary approach for the management of Sciatica (*Irq al-Nasā*). The integration of classical Unani principles with contemporary evidence may provide holistic and patient-centered care. However, further well-designed randomized controlled trials and high-quality clinical studies are needed to establish its efficacy, safety, and role in evidence-based musculoskeletal and neurological practice.

KEYWORDS: Sciatica; *Irq al-Nasā*; Unani medicine; Regimenal therapy; Neuropathic pain.**1. INTRODUCTION**

The word sciatica is derived from the Greek term *ischias*, which translates to “hip pain.” Clinically, sciatica is characterized by pain radiating along the course of the sciatic nerve, affecting the buttock, posterior thigh, posterolateral leg, and the dorsal or plantar aspect of the foot.^[1] ‘*Irq al-Nasā*’, the Arabic term for sciatica, refers to a clinical condition characterized by pain radiating along the distribution of the sciatic nerve and its constituent nerve roots, often extending from the lower

back to the buttock and lower limb.”^[2,3] Sciatic pain may present unilaterally or bilaterally and can develop either abruptly following physical exertion or gradually over time. The pain is typically described as aching, sharp, burning, shooting, or tingling in nature, with intensity ranging from mild discomfort to severe pain. It commonly radiates along the distribution of the affected nerve root, extending from the buttock to the lower limb. In L5 nerve root compression, pain usually radiates to the dorsolateral aspect of the thigh and leg; L4

compression is associated with pain over the anterolateral thigh, whereas S1 nerve root involvement commonly produces pain along the posterior aspect of the thigh. Depending on the duration of symptoms, sciatica may be classified as acute, subacute, or chronic.^[4,5] Low back pain is one of the most common complaints encountered in clinical practice and often presents a diagnostic challenge because of its diverse underlying causes. Among these, sciatica is a significant condition characterized by radiating pain along the course of the sciatic nerve, frequently resulting in considerable functional impairment and reduced quality of life. The condition most commonly arises from lumbar disc herniation, spinal stenosis, or degenerative changes of the intervertebral discs, leading to compression or irritation of the lumbar nerve roots. Although the clinical presentation may vary among individuals, patients typically experience radiating leg pain accompanied by low back pain, paresthesia, numbness, and muscle weakness within the distribution of the affected nerve root.^[6,7] Sciatica is a highly prevalent musculoskeletal condition, with an estimated annual incidence ranging from 1% to 5%. Its prevalence is reported to be approximately 1.6% in the general population, while considerably higher rates, reaching up to 43%, have been observed among selected working populations.^[6] In the Unani system of medicine, *Irq al-Nasā* (sciatica) has been comprehensively described by several classical scholars, who elaborated on its etiology, pathophysiology, clinical manifestations, and therapeutic management in ancient Unani texts. The term *Irq al-Nasā* is derived from Arabic and literally refers to the sciatic nerve, which extends from the gluteal region to the ankle. Pain arising along the course of this nerve is known as *Irq al-Nasā*.^[1,3] According to *Ibn Sina* (980-1037AD), *Irq al-Nasā* is a type of arthralgia in which pain begins in the hip region and extends through the groin down to the ankle along the course of the affected nerve.^[8] Sciatica is known as *'Irq al-Nasā* and *RenganBao*, and *Langdika Dard*.^[10] It is a type of *Waja-ul-Mafasil* characterized by pain that starts in the lower back and radiates to the knee or ankle along the outer side of the lower limb.^[9,10] *Mohammad Ismaeel Jurjani* (930–994 AD) described *'Irq al-Nasā* as pain that begins at the ischial joint and radiates down the leg.^[11] *Ibn-e-Hubal Baghdadi* (d. 1213 AD) described *'Irq al-Nasā* similarly to *Razi* (865–925 AD), adding that the pain begins in the hip and radiates along the outer side of the thigh to the calf muscles.^[12] *Abu Marwan Abdul Malik Ibn Zuhri* (1092–1162 AD) stated that in *'Irq al-Nasā*, the pain may sometimes begin in the foot and spread upward to the upper part of the thigh, affecting either leg and causing mild discomfort.^[13] According to Unani scholars, *'Irq al-Nasā* develops due to an imbalance of *Akhlat* (body humours), particularly *Khilt-e-Damwi Ghaleez* (thick sanguineous humour) or *Khilt-e-Balghami Ghaleez* (thick phlegmatic humour). The accumulation of these humours in the *Mafasil-e-Warik* (hip joint) causes pain and may occasionally result in joint dislocation^[9]. According to Unani literature, *'Irq al-*

Nasā involves the accumulation of *Maddah* (morbid material), which may consist of *Khilt-e-Damwi* (sanguineous humour), *Khilt-e-Balghami* (phlegmatic humour), or *Makhloot Balgham wa Safra* (a mixture of phlegmatic and bilious humours).^[14] **Regimenal therapy** is one of the principal treatment methods in Unani medicine. It aims to eliminate morbid matter, prevent its excessive formation and spread, and restore humoral balance, which is essential for maintaining health. For the management of *'Irq al-Nasā*, Unani scholars have recommended several regimens, including *Dalk* (massage), *Hijama bil Shart* (wet cupping), *Mehjama Nariya* (fire cupping), *Hijama bila Shart* (dry cupping), *Fasd* (venesection), *Takmeed* (fomentation), *Taleeq* (leech therapy), *Zimad* (ointment), *Tila* (liniment), and *Nutool* (douching), all of which are considered beneficial in its treatment.^[15,16]

2. LITERATURE SEARCH METHODOLOGY

This review was conducted using a comprehensive narrative literature review approach. A systematic search of the published literature was performed using electronic databases, including PubMed, Google Scholar, Scopus, ScienceDirect, and CrossRef. Classical Unani literature was reviewed from standard texts such as *Al-Qanoon fi al-Tibb*, *Al-Hawi fi al-Tibb*, *Kamil-us-Sana'ah al-Tibbiyah*, *Zakhira Khwarazm Shahi*, *Sharh Asbab*, and other authentic Unani references.

The search strategy included combinations of the following keywords: "Sciatica", "Lumbar Radiculopathy", "Sciatic Nerve", "*Irq al-Nasā*", "Unani Medicine", "Regimenal Therapy", "*Ilaj bit Tadbeer*", "*Hijama*", "*Dalak*", "*Fasd*", "Leech Therapy", "Musculoskeletal Disorders", and "Low Back Pain".

Articles published in English, along with relevant Unani literature, were considered for inclusion. Review articles, systematic reviews, meta-analyses, randomized controlled trials, observational studies, and authoritative textbooks relevant to the objectives of the review were included. Duplicate records, non-peer-reviewed reports, conference abstracts without full text, and studies unrelated to the scope of the review were excluded.

The collected literature was critically analyzed and synthesized to provide an integrated overview of sciatica from both contemporary biomedical and Unani perspectives.

3. Definition: Sciatica is characterized by pain accompanied by sensory symptoms such as numbness or tingling along the distribution of the sciatic nerve. The pain commonly affects the sciatic nerve in the thigh and extends below the knee. It is generally described as pain originating in the lower back and hip that radiates along the course of the sciatic nerve. According to *Harrison's Principles of Internal Medicine*, the term sciatica refers to leg pain radiating posteriorly in the sciatic or L5/S1 nerve root distribution.^[17]

Sciatica is a term commonly used to describe radiating leg pain caused by inflammation or compression of the lumbosacral nerve roots (L4–S1), which form the sciatic nerve. It can lead to severe pain, functional limitations, and disability. Clinically, sciatica is considered a symptom or clinical condition rather than a specific diagnosis.^[18]

4. Different Nomenclatures

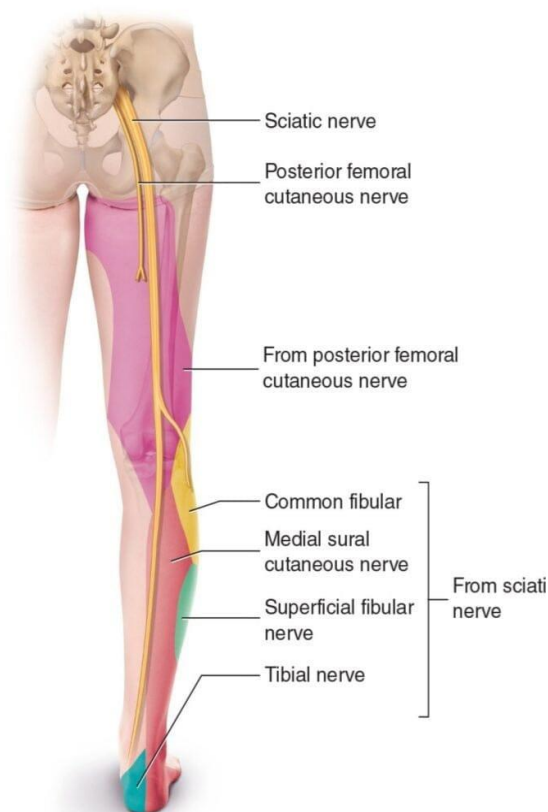
Sciatica is described by several terms in the medical literature depending on its clinical features and underlying pathology. It is commonly referred to as **radicular low back pain**, in which pain radiates from the lower back to the lower limb along the affected spinal nerve root, most often due to compression of the L5 or S1 nerve roots. The condition is also known as **lumbosacral radicular syndrome (LRS)**, characterized by radiating pain in one or more lumbar or sacral dermatomes and often associated with nerve root tension signs or neurological deficits. Another frequently used term is **radiculopathy**, which refers to pain, numbness, tingling, or muscle weakness resulting from compression of a spinal nerve root, particularly in the lumbar region. Other related terms include **nerve root pain**, **nerve root entrapment or irritation**, and **nerve root compromise**, which describe symptoms caused by irritation or compression of the spinal nerve roots due to conditions such as disc herniation, spinal stenosis, tissue swelling, or anatomical abnormalities. The term **sciatic neuralgia** is also used interchangeably with sciatica to describe pain caused by inflammation or compression of the sciatic nerve. In addition, **sciatica** itself refers to one of the most common types of radiating leg pain resulting from compression of the lower spinal nerve roots, especially **L5 and S1**.^[18,19]

5. Anatomy of the Sciatic Nerve

The sciatic nerve (*ʿIrq al-Nasā*) is the largest and thickest peripheral nerve in the human body. It originates from the lumbosacral region of the vertebral column, extends through the gluteal region and posterior aspect of the lower limb, and continues towards the foot. The nerve is formed by the ventral rami of the L4–L5 and S1–S4 spinal nerves, which together constitute the *Zafira Ajuz* (sacral plexus).^[9] The sacral plexus is located anterior to the sacrum and exits the pelvis through the *Thulma Warikiyya Azima* (greater sciatic notch), passing inferior to the *Adala Makhrootiya* (piriformis muscle) before entering the *Khit al-Wiyya* (gluteal region).^[20]

From the gluteal region, the sciatic nerve descends between the *Hadaba Warikiyya* (ischial tuberosity) and the proximal femur. Along its course, it lies in close relation to several muscles, including the *Adala Sadda Batina* (obturator internus), *Adala Murabba'a Fakhidhiyya* (quadratus femoris), *Adala Muqarriba 'Azima* (adductor magnus), and *Adala Taw'amiyya Saqiyya* (gastrocnemius). In the distal part of the thigh, the sciatic nerve typically bifurcates into two terminal

branches: the lateral popliteal (common peroneal) nerve and the medial popliteal (tibial) nerve.^[21]



6. Pathophysiology of Sciatica

Sciatica develops due to a variety of spinal and extra-spinal disorders that affect the sciatic nerve or its nerve roots. The most common mechanism is **mechanical compression** of the lumbosacral nerve roots by a herniated or prolapsed intervertebral disc, particularly at the **L4–S3** level. Neuroradiological studies indicate that nearly **90%** of sciatica cases are associated with disc pathology. Other intraspinal causes include lumbosacral strain, lumbar spinal stenosis, vertebral neoplasms, and other vertebral disorders capable of compressing or irritating the sciatic nerve.^[18,22]

A herniated disc occurs when the nucleus pulposus or annulus fibrosus protrudes beyond the normal intervertebral disc space. This condition, also referred to as a prolapsed disc, slipped disc, disc protrusion, or herniated nucleus pulposus, is one of the leading causes of low back pain with radiating leg pain in adults.^[22]

Apart from spinal lesions, the sciatic nerve may also be affected within the pelvis or after it exits the pelvis. **Intra-pelvic causes** include tumors, psoas muscle hematoma, endometriosis, tubo-ovarian abscess, uterine perforation caused by an intrauterine device, and vascular abnormalities such as abdominal aortic aneurysm. **Extra-pelvic causes** include gluteal artery aneurysm, pseudoaneurysm, gluteal abscess, tumors, and

piriformis syndrome, all of which may compress or irritate the sciatic nerve.^[18]

In addition to mechanical compression, **inflammation** plays an important role in the pathogenesis of sciatica. Increased levels of inflammatory mediators, including interleukin (IL)-1 β , IL-6, IL-8, and tumor necrosis factor (TNF)- α , have been detected in the serum, cerebrospinal fluid, and tissue samples of patients with sciatica, particularly in older adults. Furthermore, a **neuropathic component** may contribute to symptoms when the nerve root is damaged, as seen in conditions such as diabetic neuropathy.

7. Pathophysiology of 'Irq al-Nasā

According to *Abul Hasan Ali Ibn Rabban Tabri*, the development of 'Irq al-Nasā may result from derangement of *Khilt-e-Safra*, prolonged exposure to sunlight leading to drying of the hip joint fluid, and the mixing of abnormal humours with blood.^[18,23]

Zakariya Razi explained that the primary cause of 'Irq al-Nasā is the infiltration (*Nufooz*) of abnormal humours into the fluid of the hip joint. These morbid humours

may include *Ghair Tabayi Balgham*, *Safra*, *Dam*, or a mixture of *Balgham* and *Safra*. Persistence of these abnormal humours within the joint causes them to become thick and hardened, resulting in *Tahajjur-e-Mafasil* (joint hardening) and eventually 'Irq al-Nasā.^[15]

Unani literature also identifies several predisposing factors, including a sedentary lifestyle, lack of physical activity, excessive use of *Hammam*, irregular eating habits, and consumption of foods with unsuitable *Kaifiyat* (temperament).^[18]

According to *Ibn Sina*, the causes of 'Irq al-Nasā are classified into **active** and **passive** factors. He proposed that weakening of the nerve increases its susceptibility to the accumulation of morbid matter. The active causes include *Sue Mizaj Sada* (simple derangement of temperament), which rarely produces mild pain without inflammation, and *Sue Mizaj Maddi* (derangement of temperament associated with morbid matter), which may involve *Damwi* (sanguineous), *Safrawi* (bilious), *Balghami* (phlegmatic), or *Saudawi* (melancholic) humours.^[8,18]

8. Clinical Manifestations Based on the Predominant Humour^[18]

Table no. 1.

Type of Sue Mizaj (Morbid Humour)	Clinical Manifestations of 'Irq al-Nasā
<i>Sue Mizaj Damwi</i>	Severe pain radiating along the course of the sciatic nerve.
<i>Sue Mizaj Safrawi</i>	Affected area becomes warm, hot, and tender on examination.
<i>Sue Mizaj Balghami</i>	Inflammatory signs are generally absent. Skin color usually remains normal, although a dusky discoloration may occasionally be observed. Pain is persistent despite minimal inflammation.
<i>Sue Mizaj Saudawi</i>	Mild inflammation and tenderness are present. This type is comparatively more difficult to treat and has a chronic course.

9. Usool-e-Ilaj and Line of Management

The primary objective of treatment in Unani medicine is to restore the patient's normal physiological state, regardless of the underlying cause of the disease. A systematic therapeutic approach has been described for various *Amraz-e-Mafasil* (musculoskeletal disorders), including 'Irq al-Nasā (sciatica). According to classical Unani literature, the management of 'Irq al-Nasā is based on the following principles:

- **Izala-e-Sabab (elimination of the underlying cause)** by adopting appropriate therapeutic measures.
- **Correction of Sue Mizaj Maddi** (restoration of the altered temperament associated with morbid matter).
- **Ilaj bil Dawa**, using both single (*Mufrad*) and compound (*Murakkab*) formulation, and *Ilaj bit tadbeer*, *Ilaj bil ghiza*

9.1 Ilaj bit Tadbeer (Regimenal Therapy)^[24]

The following regimenal therapies have been recommended by classical Unani physicians for the management of 'Irq al-Nasā:

- **Dalak (Therapeutic Massage)**

Dalak improves local blood circulation, relieves muscle spasm, reduces stiffness, enhances flexibility, and promotes functional recovery. Medicated oils such as *Raughan-e-Baboona*, *Raughan-e-Gul*, or *Raughan-e-Suranjan* are commonly used depending on the patient's temperament and clinical condition.

- **Takmeed (Fomentation)**

Takmeed involves the application of moist or dry heat to the affected region. Heat therapy promotes vasodilation, reduces muscle spasm, improves tissue metabolism, and provides symptomatic relief from pain and stiffness.

- **Hijama (wet Cupping Therapy)**

Hijama, particularly wet cupping in selected patients, is employed to facilitate the evacuation of morbid humours, reduce local congestion, improve microcirculation, and alleviate pain. Contemporary clinical studies suggest that cupping therapy may provide short-term improvement in pain intensity and functional disability in chronic musculoskeletal disorders.

- **Fasd (Venesection)**

Fasd may be considered in carefully selected patients when there is evidence of excessive blood congestion (*Imtila*) according to classical Unani principles. The procedure should be performed only by trained practitioners after proper patient evaluation.

- **Hammam (Medicated Bath)**

Hammam therapy provides gentle heat that relaxes muscles, improves peripheral circulation, decreases joint stiffness, and enhances overall physical comfort. It is often used as an adjunctive therapy in chronic musculoskeletal disorders.

- **Riyazat (Therapeutic Exercise)**

After adequate pain control, gradual therapeutic exercises are recommended to strengthen the lumbar and paraspinal muscles, improve flexibility, restore normal posture, and reduce the risk of recurrence. Exercise also

contributes to improved physical function and quality of life.

- **Irsal-e-Alaq (Leech Therapy)**

Irsal-e-Alaq involves the application of medicinal leeches to the affected area. It is believed to improve local blood circulation, reduce inflammation and congestion, relieve pain, and promote tissue healing. Recent studies suggest that leech therapy may provide symptomatic relief and improve functional outcomes in selected patients with chronic musculoskeletal disorders.

9.2 *Ilaj bil Ghiza* (Dietotherapy)

Dietary management emphasizes the consumption of *Barid Ratab Aghziya* (cold and moist foods), which are considered beneficial in restoring humoral balance and reducing the pathological condition.^[24,25]

9.3 *Ilaj bil Dawa* (Pharmacotherapy)^[24]

Table no. 2.

Unani Drug	Botanical Name	Mode of Administration/Use
Asal-e-Baladur	<i>Semecarpus anacardium</i>	Local application as Tila; described as an alternative to Amal-e-Kai
Khardal	<i>Brassica nigra</i> Linn.	3 g with Sharab (wine) for 3 days
Pudina + Qust	<i>Mentha arvensis</i> Linn. + <i>Saussurea hypoleuca</i> Spreng.	Local paste application
Asaroon	<i>Valeriana hardwickii</i> Wall.	Internal use
Ayarij	<i>Aloe barbadensis</i> Mill.	Internal use
Bozidaan	<i>Orchis latifolia</i> Linn.	Internal use
Suranjan	<i>Colchicum luteum</i> Linn.	Internal use
Guggul	<i>Commiphora mukul</i>	Internal use
Haleela Zard	<i>Terminalia chebula</i> Retz.	Internal use
Rae	<i>Brassica nigra</i> Linn.	Internal use
Sonth	<i>Zingiber officinale</i> Roscoe	Internal use
Cheeta Lakdi	<i>Plumbago zeylanica</i> Linn.	Internal use
Saater	<i>Zataria multiflora</i> Boiss.	Internal use
Anisoon	<i>Pimpinella anisum</i> Linn.	Internal use
Ajwain	<i>Ptychotis ajowan</i> DC.	Internal use
Harmal	<i>Peganum harmala</i> Linn.	Internal use
Qust (Koth)	<i>Saussurea hypoleuca</i> Spreng.	Internal use
Shahem-e-Hanzal	<i>Citrullus colocynthis</i> Schrad.	Internal use
Ghariqun	<i>Agaricus alba</i> Linn.	Internal use
Bach	<i>Acorus calamus</i> Linn.	Internal use
Kali Zeeri	<i>Carum carvi</i> Linn.	Internal use
Farfiyun	<i>Euphorbia resinifera</i> Berg	Internal use
Zarawand Mudahraj	<i>Aristolochia rotunda</i> Linn.	Internal use
Majaith	<i>Rubia cordifolia</i> Linn.	Internal use
Zoofa Khushk	<i>Hyssopus officinalis</i> Linn.	Internal use
Long	<i>Syzygium aromaticum</i> (L.) Merr. & L.M. Perry	Internal use
Jintiyana	<i>Gentiana lutea</i> Linn.	Internal use
Hasha	<i>Thymus serpyllum</i> Linn.	Internal use
Taj	<i>Cassia lignea</i>	Internal use
Pudina	<i>Mentha arvensis</i> Linn.	Internal use
Jueda	<i>Teucrium polium</i> Linn.	Internal use
Ushq	<i>Dorema ammoniacum</i> D. Don	Internal use

Jaosheer	<i>Ferula galbaniflua</i> Boiss.	Internal use
Parsi-yoshan	<i>Adiantum capillus-veneris</i> Linn.	Internal use
Baheroza	<i>Pinus longifolia</i> Roxb.	Internal use
Tukhm Karafs	<i>Apium graveolens</i> Linn.	Internal use
Sakbeenaj	<i>Ferula persica</i> Willd.	Internal use
Anzaroot	<i>Astragalus sarcocolla</i> Dymock	Internal use
Hulba	<i>Trigonella foenum-graecum</i> Linn.	Internal use
Beekh-e-Kibr	<i>Capparis spinosa</i> Linn.	Internal use
Habbur-Rashad	<i>Lepidium sativum</i> Linn.	Internal use

Compound Unani Formulations for Oral Administration in the Management of 'Irq al-Nasā.^[24]

Table no. 3.

Compound Formulation	Mode of Administration
Habb-e-Mus'hil	Oral
Habb-e-Suranjan	Oral
Habb-e-Zehab	Oral
Majoon Suranjan	Oral
Matbookh	Oral
Majoon Kuchla	Oral
Polyherbal powder (Ali Ibn Abbas Majusi)	Contains <i>Sana-e-Makki</i> (30 g), <i>Suranjan</i> (15 g), <i>Sheetraj Hindi</i> (11 g), and <i>Zafran Khalis</i> (1.75 g); ingredients are powdered, mixed with an equal quantity of sugar, and administered orally.

10. DISCUSSION

The present narrative review emphasizes the potential role of Unani medicine as a complementary therapeutic approach in the management of Irq al-Nasā (Sciatica). Unani medicine adopts a holistic treatment strategy that integrates regimenal therapies, pharmacotherapy, and dietary modifications to alleviate pain, improve functional mobility, and restore the underlying humoral imbalance considered responsible for the development of the disease. This comprehensive approach extends beyond symptomatic management and aims to address the root cause of the disorder according to Unani principles.

Evidence from both classical Unani literature and contemporary scientific studies suggests that various regimenal interventions, including Dalk (massage), Takmeed (fomentation), Hijama (cupping therapy), Taleeq (leech therapy), Hammam (medicated bath), and Riyazat (therapeutic exercise), may contribute to the management of sciatica by improving local blood circulation, reducing inflammation, relieving muscle spasm, promoting nerve function, and enhancing mobility. Similarly, several medicinal plants commonly prescribed in Unani medicine have demonstrated anti-inflammatory, analgesic, antioxidant, and neuroprotective properties in experimental and clinical studies, providing scientific support for their traditional use in the treatment of musculoskeletal and neuropathic disorders. These findings indicate that Unani medicine may serve as a beneficial adjunct to conventional conservative management, particularly for individuals with chronic or recurrent sciatica.

However, despite encouraging findings, the available scientific evidence remains limited and does not permit definitive clinical conclusions. Most published studies are constrained by small sample sizes, methodological limitations, inadequate randomization and blinding, short follow-up durations, and variability in treatment protocols. Moreover, robust randomized controlled trials evaluating comprehensive Unani interventions for Irq al-Nasā are still scarce. Future research should therefore prioritize well-designed multicentre clinical trials, standardization of regimenal procedures and herbal formulations, and the use of validated clinical, functional, and radiological outcome measures. Generating high-quality evidence through rigorous scientific research will facilitate the integration of Unani medicine into evidence-based management of sciatica and strengthen its contribution to contemporary integrative healthcare.

11. CONCLUSION

A review of both classical Unani literature and contemporary medical literature indicates that the understanding of 'Irq al-Nasā (Sciatica) has evolved over time. Initially, the condition was primarily regarded as a disorder of the hip joint; however, advances in anatomical and clinical knowledge have established it as a disorder involving the sciatic nerve. In contemporary medicine, sciatica is commonly attributed to pathological conditions that compress or irritate the lumbosacral nerve roots, resulting in inflammation and characteristic radiating pain.

From the Unani perspective, 'Irq al-Nasā refers not only to the sciatic nerve but also to the disease affecting it. Classical Unani scholars have generally described 'Irq

al-Nasā as a subtype of Waja-ul-Mafasil, with its pathogenesis explained on the basis of humoral imbalance and the accumulation of morbid matter. Despite differences in the conceptual framework, both Unani and modern medicine recognize the characteristic clinical presentation of the disease and emphasize timely diagnosis and appropriate management to relieve symptoms and improve functional outcomes. Integrating the classical principles of Unani medicine with contemporary scientific understanding may provide a broader perspective for the effective management of patients with sciatica.

Conflict of interest; None.

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