

A REVIEW THE USE OF UNANI TREATMENT IN CASE OF ANAEMIA IN FEMALE

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ABSTRACT

Anaemia is a common nutritional deficiency disorder & global public health problem which affects both developed and developing world with major consequences for human health and their social and economic development. It is characterized by decreased amounts of RBCs or haemoglobin level below 11 gram/dl. Iron deficiency anaemia is the commonest nutritional deficiency among pregnant and non-pregnant women. Main cause of the Iron deficiency anaemia due to poor absorption of iron and increase the demand of the Iron. In Classical literature mentioned that *Su-e-Mizaj Barid wa Ratab* (Deranged cold and wet temperament) leads to the development of feature of Iron deficiency anemia, which they have described as *Soo-ul-Qiniya* (Anaemia). It affecting the women and described its aetiopathology as alteration in the constituents of blood and added that size of RBCs become small (microcytosis) and their red substance decreased (hypochromic) with increased fibrous material in the blood.

KEYWORDS: *Soo-ul-Qiniya, Faqr-ud-am.***INTRODUCTION**

Anaemia is a hematological condition characterized by the reduction in the concentration of haemoglobin accompanied by reduced number of circulating RBCs. Hb concentration of less than 11g/dl (7.45mmol/L) and a hematocrit of less than 33% is defined as anemia in pregnancy.^[1] According to WHO estimates upto 41.8% pregnant women in world are anaemic.^[2] According to National Family Health Survey (NFHS-4th) (2015-2016) prevalence of anemia among women age 15 to 49 years is 53%.^[3] Anaemia prevalence has barely changed in 10 year between (NFHS 3rd) to(NFHS 4th) decreasing from 55% in 2005-06 to 53% in 2015-16.^[4] According to WHO anemia classified as mild degree (Hb 9-11g/dl) moderate (7-9mg/dl) severe (4-7g/dl).⁵ In woman anaemia may become underlying cause of maternal mortality and perinatal mortality.^[6] Anaemia also result in an increased risk of premature delivery and low birth weight.^[7,8] Iron deficiency anemia (IDA) is the most common type of anemia in pregnant woman responsible for 95 % of the anaemia's during pregnancy. About half of the global maternal deaths due to anaemia occur in south Asian country which is caused by insufficient dietary intake and absorption of iron and iron loss.^[1] In megaloblastic anaemia, DNA replication is affected due to derangement of red cell maturation with production of abnormal precursors known as megaloblasts which can be due to deficiency of folate or vitamin B12^[11]. In

physiological anaemia there is disproportionate increase in plasma volume, RBC volume and haemoglobin mass during pregnancy.^[9] Numerous Iron containing modern medicine are available in all over the market and this contained one or more iron salts. Oral administration of that medicines is effective and inexpensive but long-term treatment may cause heart burn, nausea, upper gastric discomfort, constipation and diarrhea.^[2]

India contributes to about 80 % of majority ratio, in India the prevalence of anaemia in high because of dietary intake, poor iron (< 20 mg /dl) and folic acid intake (< 70 mg/day).^[9]

Poor bioavailability of iron (3-4 % only) in phytate and fiber rich Indian diet & Chronic blood loss due to infection such as malaria & hook worm infestations.^[3,9]

The exact description of iron deficiency anemia is not available in ancient Unani literature but Razi (Raze 841-926AD) and Abul Hasan Ahmad bin Mohammad Tabri (10th century AD) have mentioned that *Soo-e-Mizaj Barid wa Ratab* (Deranged cold and wet temperament) leads to the development of feature of iron deficiency anemia, which they have described as *Soo-ul-Qiniya*.^[11] Kabiruddin (1950 AD) simulated *Soo-ul-Qinya* with that of *Faqr-Dam*, *Qilit-ud-Dam* etc. He further described *Khizra* (chlorosis) as type of *Soo-ul-Qinya*, affecting the women and described its etiopathology as alteration in

the constituents of blood and added that size of RBCs become small (microcytosis) and their red substance decreased (hypochromic) with increased fibrous material in the blood.^[12]

In classical Unani literature Jurjani states that faculty dietary habits & imbalance (deficient iron nutrients) in the cause of anaemia & he recommends that proper diet & digestion in the key to balance the humours & health. If the anaemia is left untreated it may lead to *Istesqa*.^[20]

Razi mention that anaemia occurs due to altered temperament of liver resulting in pica and edema & recommended treatment with *Muqawiyat Jigar Advia* & Goat's liver.^[19]

Ibn Sina expressed that excess of Sauda produces anaemia by stagnating between liver & stomach and there by interfering with the normal production of blood & other humours.^[11]

According to the Unani physicians Ibn Sina, Ismail Jurjani, Ibn Hubal Baghdadi & Hakim Azam Khan blood is considered to be the vital fluid of human body which is formed in the liver. Due to derangement of the liver functions & weakness of hepatic faculties or sometimes due to associated disease the resultant formation of blood in normal for nourishment there by leading to anaemia.^[11,12]

The clinical features of Iron deficiency anaemia appear to have recognized in the earliest times.

Ibn Sina described a disease Sual Qinya which is quite similar to iron deficiency anaemia with manifestation like pedal edema, puffiness of face & peri orbital area, pallor, dyspnoea, inflammation cracked lips and lethargy etc.^[11]

In late 1920s early 1930s a distinct form of anaemia was identified which corresponds to the Iron deficiency anaemia as we know today.^[7]

Types of Anaemia

There are several types & classification of anaemia. The occurrence of anaemia is due to the various red cell defects such as production defect.

- Production defect (anaplastic anaemia).
- Maturation defect (megaloblastic anaemia).
- Defect in haemoglobin synthesis (Iron deficiency anaemia).
- Genetic defect of haemoglobin maturation (Thalassaemia).
- Due to the synthesis of abnormal haemoglobin (Haemoglobinopathies).
- Sickle cell anaemia & thalassaemia.
- Physical loss of red cells chaemolytic anaemia.^[9]

Causes

- The low dietary intake of iron,

- Low intake of folic acid and food stuffs that promote iron absorption.
- Poor bioavailability of iron is the major factor responsible for very high prevalence of anaemia.^[21,22]
- Poor iron stores at birth.^[22]

Treatment

Prophylactic includes

- Avoidances of frequent child-births.^[2,3]
- Supplementary Iron therapy.^[3]
- Dietary prescription like foods rich in Iron are liver, meat, egg, green, vegetables, green peas, figs, beans, whole wheat & jaggery.^[10]
- Adequate treatment should be instituted to eradicated hookworm infestation, dysentery Malaria, Bleeding piles, & Urinary tract infection.^[3]

Curative treatment

- Iron therapy.
- Oral therapy
- Parental Therapy.^[3]

Usool-e-Ilaj

- To remove the underlying cause.
- Improvement of digestion and appetite.
- Correction of nutritious diet.
- Medication to improve the quality of blood.^[12,19]

Unani treatment

- Safoof-e-Khabsul Hadeed.^[15] Constituents of *Safoof-e-Khabsul Hadeed* are Poste Haleela zard (Terminalia chebula), Poste Baleela (Terminalia ballerica), Amla (Emblca officinalis), Filfil Daraz (Piper longum), Sonth (Zingiber officinalis), Gudh (Jaggery) each 12 grams.^[16,17]
- Jawarish Amla 7 grams twice a day.^[15]
- Qurs-e-Gulnar 2 BID.^[15]
- Jawarish Amla 7 grams twice a day with water and Qurs-e-Kushta-e-Faulad 2 Qurs morning & evening, up to 2 months.^[15]
- Jawarish Anarain 5 to 7 gram with normal water twice a day.^[15]
- Sharbat-e-Anar 10 to 20 ml with normal water twice a day.^[15]

CONCLUSION

Anaemia is the important global health risk factor faced by the pregnant women and non- pregnant women nowadays. Anaemia should be diagnosed earlier and treated to get a healthy generation. Unani medicine is one of the great hopes in the treatment of the Anaemia. There are so many medicines that have been mentioned in classical Unani literature to treat the anaemia so a proper clinical trial is needed for establishing the efficacy of Unani treatment of Anaemia.

REFERENCES

1. Sharma J.B. Text book of obstetrics, haematological disorders during pregnancy (1st edition), 2014; 483.
2. De Benoist B *et al* eds worldwide prevalence of anaemia 1993-2005, WHO global database on anaemia Geneva, world health organisation, 2008.
3. Controlling chronic anaemia in women in India (DHS in news July) Demographic (DHS programme health survey), 2017; 289.
4. National family health survey (NFHS4) (16) published by international institute of population sciences, deonar Mumbai, 2015; 289.
5. Okeke PU (2011) anaemia in pregnancy is it persisting public health problem in Porto NoVo Cape Verde? Research journal of medical sciences, 2011; 5(4): 193-199.
6. Ezzati M, Lopez AD, doges A, Vander HS, Murray CJ selected major risk factor and global and regional burden of disease lancet, 2002; 360: 1347-60.
7. Agarwal KN (1984) the effects of maternal iron deficiency on placenta and foetus. In Jolliffe DB, Jolliffe FEP editors, advances in international maternal child health, oxford clarendon press, 1984; 4: 26-35.
8. Aggarwal RMD, Tripathi AM, Aggarwal KN cord blood haemoglobin. Iron and serum ferritin status in maternal anaemia acts paedialer second, 1983; 74: 545-8.
9. Dutta D.C. Text book of obstetrics (sixth edition). New central book agency (P) LTD Calcutta India, 2004; 262.
10. Huda N, Mishra DS Singh JP. Clinical evaluation of an ayurvedic preparation for treatment of iron deficiency anaemia in patients. J homeop ayurv Med, 2014; 3(4).
11. Kantoori S.G.H H. Tariuma Qanoon vol 3rd part 2 (original author shaikh ali bin Abdullah ibn-e-sina) munshi Nawal Kishore Kanpur, 1303; 47-53.
12. Kabeeruddin H.M. Tariuma Kabeer Sharah-e-Asbab (vol 2nd). (original author, Nafis Bin Euz Kirmani) Hikmat book depot. Hyderabad, 1950; 669-688.
13. Ghani N. (YNM) Khazinul advia Lucknow Munshi Naval Kishore press YNM, 163,187,189,482, 485,932,933.
14. Kabeeruddin Makhzanul Mufradat New Delhi Idara kitab ul shifa, 2007; 49-50.
15. Hakeem MA Bustan ul mufradat New Delhi idara kitabul shifa, 2002; 84: 90,91,180.
16. Ibn Baitar AL (YNM) Jami al Mufradat Al Advia wa Aghzia (Urdu translation) vol 1 New Delhi CCRUM, 128; 131.
17. Muzzfar H. kitabul mufradat wa khawasul advia kashmiri bazar Lahore, 1965; 182,183,160,161.
18. Antaki D. Tazkira ul albab part 1 New Delhi CCRUM ministry of health and family welfare govt of India, 2008; 421,422.
19. Razi ABZ. Al Hawi –Fil-Tib, Vol 3th. New Delhi: CCRUM, 2001; 151-68.
20. Jurjani I Zakheera -e-Khawarzam Shahi (Urdu Translation by Khan AH) Matba Nami munshi Naval Kishore Lucknow, 1878; 109.
21. Anaemia in pregnancy. In: Ratnam SS, Bhasker Rao K, Arul Kumaran S, editors. Obstetrics and gynaecology for postgraduates, Vol 1. Madras: orient Longman, 42-53.
22. Nutrition in Pregnancy. In: Gopalan C, Kaur S, editors. Women and nutrition in India, Special Publication No. 5. New Delhi: Nutrition Foundation of India, 153-93.
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