

A Comprehensive Review of Qubā (Tinea) in Unani System of Medicine with Special Reference to Dermatophytosis

Dr. Mohd Saad Yusuf^{1*}, Dr. Md. Najibur Rahman², Prof. Dr. Shahnawaz Akhtar³, Dr. Shagufta Parveen Hussain⁴, Dr. Md. Shamim Akram⁵

¹PG Scholar, Dept of Moalajat, Govt. Tibbi College and Hospital (GTCH), Patna

²Associate Professor cum HoD-Moalajat, Govt. Tibbi College and Hospital (GTCH), Patna

³Professor cum Medical Superintendent, Govt. Tibbi College and Hospital (GTCH), Patna

⁴PG Scholar, Dept of Mahiyatul Amraz, Govt. Tibbi College and Hospital (GTCH), Patna

⁵PG Scholar, Dept of Moalajat, Govt. Tibbi College and Hospital (GTCH), Patna

DOI: <https://doi.org/10.36347/sajb.2025.v13i08.015>

| Received: 24.06.2025 | Accepted: 19.08.2025 | Published: 21.08.2025

*Corresponding author: Dr. Mohd Saad Yusuf

PG Scholar, Dept of Moalajat, Govt. Tibbi College and Hospital (GTCH), Patna

Abstract

Review Article

Background: Qubā, a cutaneous disorder described in Unani medicine, corresponds to Tinea (dermatophytosis) in modern dermatology. It is characterized by annular, scaly, and itchy lesions, often recurring and distressing to patients. Classical Unani scholars including Ibn Sina, Al-Razi, and Jurjani attributed Qubā to humoral imbalance, particularly the predominance of *Balgham* (phlegm) and *Saudā* (black bile), combined with poor hygiene, dietary indiscretions, and environmental factors. In modern medicine, dermatophytosis is understood as a superficial fungal infection caused by dermatophytes such as *Trichophyton*, *Microsporum*, and *Epidermophyton* species, with increasing prevalence worldwide. **Objective:** This review aims to analyze the concept of Qubā in Unani medicine, compare it with dermatophytosis in modern dermatology, and evaluate the therapeutic approaches of both systems. **Methods:** Relevant information was extracted from classical Unani texts (*Al-Qanun fi al-Tibb*, *Kitab al-Hawi*, *Zakhira Khwarazm Shahi*, etc) and compared with modern dermatological literature obtained from PubMed, Scopus, and Google Scholar. **Results:** Unani physicians described Qubā as presenting with circular patches, scaling, and itching, which correlate with clinical features of dermatophytosis. Diagnostic methods in Unani medicine were mainly clinical, while modern diagnosis employs KOH microscopy, fungal culture, and dermoscopy. Unani treatment adopts a holistic approach: *Ilāj bil-Tadbīr* (regimenal therapy such as lepa and hammam), *Ilāj bil-Ghizā* (dietary modification avoiding oily and damp foods), and *Ilāj bil-Dawā* (local and systemic use of drugs like *Sibr* [Aloe vera], *Hina* [Lawsonia inermis], and *Nees* [Azadirachta indica]). Modern management relies on topical and systemic antifungals, though recurrence and resistance are common. **Conclusion:** Qubā, as conceptualized in Unani medicine, closely parallels dermatophytosis. Unani holistic management provides promising complementary strategies that may enhance long-term outcomes when integrated with conventional antifungal therapy.

Keywords: Qubā, Tinea, Dermatophytosis, Unani Medicine, Humoral Theory.

Copyright © 2025 The Author(s): This is an open-access article distributed under the terms of the Creative Commons Attribution 4.0 International License (CC BY-NC 4.0) which permits unrestricted use, distribution, and reproduction in any medium for non-commercial use provided the original author and source are credited.

INTRODUCTION

Skin diseases are a significant global health problem due to their chronicity, recurrence, and psychosocial impact. Among them, dermatophytosis (Tinea) is one of the most prevalent superficial fungal infections, affecting approximately 20–25% of the world population at any given time. [1]. It is caused by keratinophilic fungi such as *Trichophyton*, *Microsporum*, and *Epidermophyton* species that colonize keratinized tissues including skin, hair, and nails. [2] Clinically, it presents as annular, scaly,

erythematous lesions with itching, central clearing, and active margins. Although antifungal agents such as azoles and allylamines remain the mainstay of treatment, recurrence, treatment failure, and antifungal resistance have become major challenges in recent years. [3] In Unani medicine, this condition is described as Qubā. Eminent Unani physicians such as Ibn Sina (Avicenna), Al-Razi (Rhazes), and Jurjani elaborated its concept and considered it a disease caused by deranged temperament of the skin (Sue Mizaj Jild) with accumulation of morbid humors, particularly *Balgham* (phlegm) and *Saudā* (black bile). [4–6] The clinical

descriptions in classical literature—circular patches associated with itching, scaling, and discoloration—closely correspond to the modern clinical features of dermatophytosis. Importantly, Unani physicians also highlighted the influence of dietary habits, environmental conditions, and personal hygiene in disease causation, which reflects their holistic approach. Unani treatment of Qubā is based on three fundamental principles: *Ilāj bil-Tadbīr* (regimenal therapy), *Ilāj bil-Ghizā* (dietotherapy), and *Ilāj bil-Dawā* (pharmacotherapy). Local applications such as *lepa* (pastes), *hammam* (bathing), and vinegar-based formulations, along with systemic use of herbal and mineral drugs like *Sibr* (Aloe vera), *Hina* (Lawsonia inermis), and *Nees* (Azadirachta indica), are frequently recommended. [7] In contrast, modern dermatology largely depends on pharmacological interventions, without sufficient focus on dietary and lifestyle regulation. Considering the rising global burden of dermatophytosis and the limitations of antifungal therapy, the Unani perspective of Qubā provides valuable insights into a comprehensive and sustainable approach. This review aims to present the Unani understanding of Qubā, correlate it with modern dermatophytosis, and discuss its management from both perspectives.

Etiology (Asbāb) of Qubā (Tinea)

In Unani medicine, Qubā is primarily attributed to an imbalance of humors (Akhlaat) and derangement of the temperament (Mizaj) of the skin. The main causative factors mentioned by Unani physicians include:

1. **Humoral Imbalance:** Ibn Sina stated that Qubā arises due to predominance of Balgham (phlegm) and Saudā (black bile), which cause thick, viscid, and cold morbid matter to accumulate in the skin, leading to circular, scaly lesions. [4] Jurjani described it as a localized cutaneous manifestation of morbid humors, particularly when Balgham combines with Dam (blood), resulting in erythema and itching. [6]
2. **Dietary Factors:** Excessive intake of damp, oily, cold, and indigestible foods (Ghiza Ratba wa Barida), such as fish, milk, and sour substances, are considered predisposing factors. [4]
3. **Environmental Factors:** Al-Razi emphasized the role of hot and humid climate, unhygienic surroundings, and excessive sweating in aggravating skin disorders including Qubā. [5]
4. **Lifestyle and Personal Hygiene:** Improper bathing, use of dirty clothing, overcrowding, and neglect of skin care were highlighted as important contributors. [6]
5. **Transmission:** Though classical Unani scholars did not explicitly describe fungal contagion, they acknowledged the transmissible nature of Qubā through close contact and sharing of personal items [4]

Modern Correlation

In modern medicine, dermatophytosis is caused by fungi belonging to the genera *Trichophyton*, *Microsporum*, and *Epidermophyton*. Important risk factors include hot and humid climate, poor hygiene, overcrowding, tight clothing, immunosuppression, and comorbidities such as diabetes mellitus. [1,2] The overlap between Unani and modern etiological concepts underscores the significance of humoral imbalance (internal susceptibility) and environmental triggers (external susceptibility) in disease manifestation.

Clinical Features (A'lāmāt) of Qubā (Tinea)

Qubā is one of the well-recognized cutaneous diseases described in Unani medicine. Its clinical picture has been extensively elaborated by eminent physicians like Ibn Sina, Al-Razi, and Jurjani, who emphasized its annular shape, itching, and scaling as hallmark signs. In modern medicine, Qubā is equated with dermatophytosis (tinea), caused by dermatophytes affecting keratinized tissues (skin, hair, nails).

Unani Description of Clinical Features

Lesion Morphology:

Ibn Sina described Qubā as “Da’ira Shakal” (circular or ring-shaped patches), often qashiri (scaly) and associated with hikka (itching). [4]

The lesions are often slightly raised with well-defined margins, sometimes with central clearing, making them distinguishable from other skin diseases [6]

Color and Humoral Correlation:

Jurjani stated that the color of lesions varies with humoral predominance:

- Damvi Mizaj (sanguine temperament) → reddish patches.
- Balghami Mizaj (phlegmatic) → whitish lesions with oozing.
- Saudawi Mizaj (melancholic) → dark or blackish lesions with chronicity. [6]

Itching and Irritation:

Severe or moderate itching (hikka shadida) is considered a constant symptom. Scratching often leads to excoriation and sometimes secondary infection. [5]

Distribution:

Classical texts note that Qubā commonly affects the face, scalp, neck, trunk, and sometimes extremities [4,8] In children, Qubā of the scalp is particularly emphasized, corresponding to tinea capitis. [6]

Progression and Chronicity:

Lesions usually begin as small papules or macules, which enlarge centrifugally to form annular, ring-like patches. Multiple lesions may coalesce into irregular plaques, often with a tendency to relapse or persist chronically. [6]

Modern Correlation (Dermatophytosis / Tinea)

Modern dermatology describes tinea as a superficial fungal infection caused by dermatophytes (Trichophyton, Microsporum, Epidermophyton). Clinical features vary by site of infection:

General Features:

- Annular, erythematous, scaly lesions with central clearing and active, raised margins. [1]
- Pruritus (itching) is the most common symptom.
- Lesions may become chronic, recurrent, or widespread in immunocompromised patients. [2]

Site-Specific Variants:

- **Tinea corporis (body):** Ring-shaped erythematous patches with scaly borders.
- **Tinea capitis (scalp):** Scaling, alopecia, pustules; common in children.
- **Tinea cruris (groin):** Itchy, red, spreading lesions in warm, moist areas.
- **Tinea pedis (athlete's foot):** Interdigital maceration, scaling, fissures.
- **Tinea unguium (onychomycosis):** Thickened, brittle, discolored nails [9]

Complications:

- Secondary bacterial infections due to scratching.
- Chronic dermatophytosis resistant to antifungals.
- Psychological impact due to cosmetic disfigurement. [2,9]

Comparative Understanding

Unani physicians highlighted features like circular lesions, itching, color variation with humors, and chronicity, which remarkably parallel modern descriptions of tinea.

The holistic approach of Unani also considered constitutional temperament (Mizaj), diet, and hygiene as contributing factors, while modern dermatology emphasizes fungal etiology and host immunity.

Diagnosis (Tashkhīs) of Qubā (Tinea)

1. Unani Perspective

In Unani medicine, the diagnosis (Tashkhīs) of Qubā is largely based on clinical observation (Mu'āyana), inspection (Mushāhada), and evaluation of Mizaj (temperament). Physicians relied on visible signs, palpation, and correlation with humoral imbalance.

a. Clinical Recognition

Circular Lesions (Da'ira Shakal): Ibn Sina described Qubā as having annular lesions with scaly margins, often multiple and expanding centrifugally. [4]

Itching (Hikka): Persistent and troublesome itching is considered a cardinal diagnostic sign [6]

Scaling (Qashir): White or greyish scales over erythematous base, often aggravated in chronic cases. [5]

Color Variation: Jurjani emphasized that the hue of lesions depends on humoral predominance—reddish (Damvi), whitish (Balghami), or blackish (Saudawi). [6]

b. Differentiation from Other Cutaneous Disorders

Unani physicians differentiated Qubā from other skin conditions such as:

- **Da' al-Hasat (Psoriasis):** More generalized and thicker scaling.
- **Baras (Leucoderma/Vitiligo):** White depigmented patches, non-pruritic.
- **Judāri (Smallpox scars) and Juzām (Leprosy):** Progressive systemic signs in addition to skin lesions. [4]

c. Role of Mizaj (Temperament) in Diagnosis

The physician assessed whether the patient had Saudawi (melancholic), Balghami (phlegmatic), or Damvi (sanguine) predominance, as this guided both diagnosis and treatment selection. [6]

2. Modern Diagnostic Approach

Modern dermatology confirms tinea through a combination of clinical features and laboratory investigations.

a. Clinical Examination

- **Lesion Morphology:** Annular erythematous plaques with central clearing and raised, scaly margins. [9]
- **Distribution:** Trunk, scalp, groin, feet, or nails depending on subtype.
- **Symptoms:** Intense itching, recurrent or chronic course. [2]

b. Laboratory Tests

- **KOH Mount:** Direct microscopic examination of skin scrapings in 10–20% potassium hydroxide solution shows septate hyphae, confirming dermatophytosis. [10]
- **Fungal Culture:** Sabouraud dextrose agar culture helps identify causative dermatophyte species (Trichophyton, Microsporum, Epidermophyton). [2]
- **Dermoscopy:** Shows “peripheral scaling,” “comma hairs,” or “corkscrew hairs” in tinea capitis. [11]
- **Biopsy & Histopathology:** Rarely needed; shows fungal hyphae within stratum corneum using PAS stain.

c. Differential Diagnosis

Psoriasis: Silvery scales, well-defined erythematous plaques, Auspitz sign positive.

Eczema: Ill-defined margins, vesiculation, oozing.

Pityriasis versicolor: Hypo- or hyperpigmented macules with fine scaling.

Seborrheic dermatitis: Yellow greasy scales, especially on scalp and face. [2]

3. Comparative Understanding

Unani physicians relied on clinical signs and humoral evaluation, showing remarkable accuracy in recognizing the annular, scaly, itchy nature of Qubā centuries before fungal etiology was discovered.

Modern medicine builds on this with microscopic and cultural confirmation, ensuring precise species identification and guiding antifungal therapy.

Treatment of Qubā (Tinea) in Unani Medicine

Unani management of Qubā is based on the principle of Izālat-e-Sabab (removal of cause) and Tadeel-e-Mizāj (correction of temperament), with the aim of reducing pathogenic humors (Balgham and Saudā) and restoring cutaneous health. The treatment can be categorized into Ilāj bi'l-Tadbīr (Regimenal therapy), Ilāj bi'l-Ghizā (Dietotherapy), and Ilāj bi'l-Dawā (Pharmacotherapy).

1. Ilāj bi'l-Tadbīr (Regimenal Therapy)

Unani scholars emphasize purification, hygiene, and local applications as essential measures.

- **Tahleel wa Tanfis (Resolution and Expulsion):** Hot fomentation and gentle massage over lesions to liquefy thick morbid humors. [4]
- **Hammām (Bath therapy):** Cleansing with medicated decoctions such as Nees (Neem leaves) and Sibr (Aloe vera) to reduce itching and scaling. [6]
- **Zimād (Topical pastes):** Application of vinegar-based herbal pastes to dissolve thickened morbid matter and reduce lesions. [5]

2. Ilāj bi'l-Ghizā (Dietotherapy)

Diet is prescribed to maintain skin temperament and prevent aggravation of phlegm and black bile.

Avoid: Oily, fried, sour, excessively sweet foods; fish, curd, stale and heavy meals. [12]

Recommended: Light diet such as Yakhni (meat soup), Ma-ul-Sha'eer (barley water), Khichdi (rice + lentil porridge), green vegetables, and easily digestible cereals.

Supportive: Use of Sharbat-e-Unnab and Sharbat-e-Banafsha for systemic cooling.

3. Ilāj bi'l-Dawā (Pharmacotherapy)

A. Topical Applications (Dawā-i-Zāhiri)

Classical Unani physicians developed several ointments and topical preparations specifically for Qubā:

Name	Ingredients	Action
Marham-i-Kibrīt	Sulfur, Vinegar, Sesame oil	Antifungal, antiparasitic, detergent. [4]
Marham-i-Angubīn	Honey, Vinegar, herbal powders	Healing, antimicrobial, detoxifying. [5]
Marham-i-Nīm	Neem leaves + Coconut oil	Antifungal, anti-itching. [12]
Marham-i-Gandhak	Sulfur + Vinegar	Strong antifungal, exfoliative. [8]
Marham-i-Qubā	Sulfur, Verdigris (Tutia-e-Sabz), Hina, Vinegar, Sesame oil/Beeswax	Specific ointment for Qubā; antifungal. [13]
Marham-i-Sumbulut-Tib	Valeriana officinalis + herbal oils	Anti-inflammatory, resolvent. [13]

B. Oral Medicines (Dawā-i-Dākhilī) for Qubā

Medicine	Action (Af'āl)	Therapeutic Role in Qubā
Itrifal-e-Sanamaki	Mild Mushil (laxative)	Eliminates morbid matter from bowels, reduces systemic toxins.[4]
Sharbat-e-Banafsha / Sharbat-e-Unnab	Mubarrid (cooling), Mulattif (demulcent)	Maintains systemic balance, relieves irritation and dryness.[4]
Majoon-e-Ayarij	Strong Mushil(purgative)	Expels excess Saudā and Balgham, useful in chronic skin diseases.[5]
Qurs Musaffi Khoon	Musaffi Dam (blood purifier)	Clears blood impurities, prevents recurrent skin lesions.[13]

4. Comparative Note with Modern Medicine

Modern therapy: Topical antifungals (clotrimazole, terbinafine), systemic antifungals (itraconazole, griseofulvin).

Limitations: Recurrence, resistance, hepatic side effects.

Unani therapy: Focuses not only on antifungal effect but also on systemic detoxification, temperament correction, and recurrence prevention.

Modern Treatment of Qubā (Tinea / Dermatophytosis)

Management of dermatophytosis in modern medicine is based on eradication of the causative fungus, control of symptoms (itching, scaling, erythema), and prevention of recurrence and transmission. The treatment approach includes topical therapy, systemic therapy, adjuvant measures, and preventive strategies.

1. Topical Antifungal Therapy

Topical agents are the first-line treatment in uncomplicated, localized tinea infections.

- **Azoles (Imidazoles & Triazoles):** Clotrimazole 1%, Miconazole 2%, Ketoconazole 2%, Sertaconazole 2% creams – inhibit ergosterol synthesis in fungal cell membrane. Applied twice daily for 2–4 weeks. [9]
- **Allylamines:** Terbinafine 1% cream, Naftifine 1% cream – fungicidal; inhibit squalene epoxidase. Shorter duration therapy (once or twice daily for 1–2 weeks). [14]
- **Ciclopirox olamine 1% cream/lotion:** Antifungal + anti-inflammatory effect. [15]

Efficacy: Topical therapy achieves cure in most cases of Tinea corporis, Tinea cruris, Tinea faciei if lesions are limited. [16]

2. Systemic Antifungal Therapy

Indicated in extensive, recurrent, chronic, or nail/hair involvement.

- **Terbinafine:** Oral dose: 250 mg once daily for 2–4 weeks (for skin); 6–12 weeks (for nails). Fungicidal; effective against *Trichophyton* spp. [17]
- **Itraconazole:** Oral dose: 100 mg once daily for 2–4 weeks or 200 mg daily in pulse therapy. Broad-spectrum antifungal, useful in resistant cases. [18]
- **Fluconazole:** Oral dose: 150 mg once weekly for 2–4 weeks. Alternative for patients intolerant to other drugs. [19]
- **Griseofulvin:** Oral dose: 500–1000 mg daily for 4–8 weeks. Fungistatic; effective for skin,

hair, and nail infections, though less preferred now due to longer course. [9]

Monitoring: Systemic antifungals may cause hepatotoxicity; baseline and periodic liver function tests are recommended. [20]

3. Adjuvant and Symptomatic Therapy

- **Antihistamines:** For relief of itching. [21]
- **Keratolytic agents (Salicylic acid, Urea):** Used in hyperkeratotic lesions to enhance penetration of antifungal drugs. [22]
- **Topical corticosteroids:** Not recommended alone, but sometimes used in combination creams; however, irrational use can lead to Tinea incognito and resistance. [23]

4. Preventive Measures and Lifestyle Advice

- Maintain proper hygiene and keep skin dry.
- Avoid tight clothing and sharing of towels or personal items.
- Treat concomitant conditions such as diabetes mellitus.
- Screen and treat family members if infected. [24]

5. Recent Advances

- **Topical luliconazole 1% cream:** Once daily application, highly effective in short courses. [25]
- **Efinaconazole and Tavaborole:** Developed for onychomycosis, showing promising results. [26]
- **Combination therapy:** Systemic + topical antifungal therapy shows higher cure rates in resistant cases. [27]

Comparative Treatment of Qubā (Tinea) in Unani & Modern Medicine

Aspect	Unani Treatment	Modern Treatment
Pharmacological Agents	Sharbat-e-Unnāb, Sharbat-e-Banafsha, Arq-e-Gulab – act as Mussaffi-e-Dam (blood purifiers). [6]	Topical antifungals: Clotrimazole, Miconazole, Terbinafine, Ketoconazole. [28]
Local Applications (Marhamāt & Dawae Muzaiyya)	Marham-e-Qubā (containing Gandhak, Kafoor, Sirka, etc.), Marham-e-Kafoor, Marham-e-Sulphur, Dawae Muzaiyya (caustic agents for stubborn lesions). [4]	Systemic antifungals: Terbinafine 250 mg/day, Itraconazole 100–200 mg/day, Fluconazole 150 mg weekly, Griseofulvin 500–1000 mg/day [29]
Detoxification & Excretion	Ilaj bit Tadbeer: Fasd (venesection), Hijamah (cupping), and Munzij-Mushil therapy to expel morbid matter. [6]	Not practiced; focus on antifungal drugs [30]
Dietary Regimen (Ghiza)	Avoid: fried, spicy, salted food; Encourage: Ma-ul-Sha'eer (barley water), Yakhni (light broth), cooling diets	No specific diet prescribed; general advice to maintain hygiene and immune support. [31]
Symptomatic Relief	Roghan-e-Gul, Roghan-e-Baboona for soothing effect, Sharbat-e-Banafsha for cooling [5]	Antihistamines (cetirizine, hydroxyzine) for itching. [32]
Preventive Measures	Personal hygiene, avoiding contaminated clothes, staying in clean environment as per Tahaffuz principles [4]	Washing/drying skin, avoid sharing towels/clothes, antifungal powders for prophylaxis. [31]

Comparative Discussion: Qubā (Tinea) in Unani Medicine vs. Modern Dermatology

Aspect	Unani Medicine	Modern Dermatology
Terminology	Qubā [15]	Tinea / Dermatophytosis [14]
Etiology	Imbalance of Balgham (phlegm) and Saudā (black bile); aggravated by poor hygiene, dampness, contaminated clothes, and diet [4,5,6]	Fungal infection (Trichophyton, Microsporum, Epidermophyton spp.); influenced by humidity, overcrowding, and immunosuppression [14,23]
Pathogenesis	Humoral imbalance leading to altered skin temperament (Sue Mizaj Jild) [5,6,33]	Colonization and invasion of keratinized tissues (skin, hair, nails) by dermatophytes [14]
Clinical Features	Circular, scaly patches with intense itching (Hikka Shadida), sometimes oozing [4,6]	Annular scaly plaques with central clearing, erythematous margins, pruritus [14]
Diagnosis	Clinical observation based on mizaj and appearance of lesions [4,5,6]	KOH microscopy, fungal culture, dermoscopy, histopathology [14,23]
Treatment Approach	Ilāj bil-Tadbīr (regimenal: hammam, lepa); Ilāj bil-Ghizā (dietary regulation); Ilāj bil-Dawā (herbal and mineral drugs such as Marham-i-Qubā, Sibr, Neem, Hina) [5,6,33]	Topical antifungals (azoles, allylamines, ciclopirox, amorolfine); systemic antifungals (terbinafine, itraconazole, fluconazole, griseofulvin) [3,14,23]
Strengths	Holistic approach: corrects internal milieu, prevents recurrence, low side effects [5]	Rapid clearance of infection, standardized dosing, strong evidence base [3,14,23]
Limitations	Lack of extensive clinical trials, longer duration of therapy, variable formulations [23]	Recurrence common, resistance emerging, systemic drugs hepatotoxic [3]
Integrative Potential	Combines internal correction (tadbīr and ghizā) with herbal formulations for long-term control [5,6]	Provides acute fungal clearance through antifungals [3,23]

CONCLUSION AND FUTURE RECOMMENDATIONS

Qubā, described extensively in Unani literature, corresponds to Tinea (dermatophytosis) in modern dermatology. Both traditions recognize its chronic and recurrent nature and the significant role of environmental, constitutional, and hygienic factors in its causation and persistence.

Classical physicians such as Ibn Sina, Razi, Jurjani, and Majusi emphasized that Qubā arises from derangement of Saudā (black bile) and Balgham (phlegm), manifesting as annular, scaly, and itchy lesions resistant to short-term therapy. [4-6,33] Their management strategies combined Tanqiya (detoxification), Islah-i-Mizaj (correction of temperament), regimental measures, and pharmacological preparations like Marham-i-Qubā, Gandhak-based formulations, and oral purgatives, aiming to restore humoral balance and prevent relapse. [4-6,33]

Modern dermatology attributes Tinea to fungal infection of keratinized tissues, treated with topical and systemic antifungal agents such as azoles, allylamines, and griseofulvin derivatives [3,14,23] While effective, these therapies face challenges of drug resistance, recurrence, hepatotoxicity, and patient non-compliance, highlighting the need for safer and holistic alternatives. [3,14,23]

The comparative analysis suggests potential for integrative approaches, combining modern antifungal drugs for rapid clearance with Unani regimens for detoxification, immune modulation, and relapse prevention. Such integration could result in more sustainable and patient-friendly therapies.

Future Recommendations

Pharmacological validation of classical Unani formulations (Marham-i-Qubā, Gandhak-based ointments) through in vitro and in vivo antifungal studies. [4-6]

Clinical trials evaluating the efficacy and safety of Unani topical and oral medicines in comparison with standard antifungals. [3,14,23]

Phytochemical standardization of Unani drugs to identify bioactive compounds responsible for antifungal activity. [4-6,33]

Exploration of synergistic therapies, combining Unani and modern antifungal agents to reduce resistance and recurrence [5,23]

Promotion of preventive regimens described in Unani medicine, such as hygienic practices, dietary modifications, and strengthening of host immunity, as adjuncts to modern care [4-6].

In conclusion, Unani medicine offers a holistic and preventive framework for managing Qubā, while modern antifungals provide rapid curative options.

Integrating both could open avenues for more effective, safer, and sustainable management strategies for Tinea and other recurrent skin disorders.

REFERENCES

- Havlickova, B., Czaika, V. A., & Friedrich, M. (2008). Epidemiological trends in skin mycoses worldwide. *Mycoses*, 51(Suppl 4), 2–15.
- Ameen, M. (2010). Epidemiology of superficial fungal infections. *Clinics in Dermatology*, 28(2), 197–201.
- Dogra, S., & Uprety, S. (2016). The menace of dermatophytosis in India: The evidence that we need. *Indian Journal of Dermatology, Venereology and Leprology*, 82(3), 229–231.
- Ibn Sina. (2007). *Al-Qanun fi al-Tibb (The Canon of Medicine)* (Vols. 1–3, pp. 90–93, 98–104, 214–216, 234–251, 245–248). New Delhi: CCRUM.
- Al-Razi, Z. (1991). *Kitab al-Hawi* (Vol. 23, pp. 119–129, 210–212). Hyderabad: Dairat al-Ma'arif al-Osmania.
- Jurjani, I. (2010). *Zakhira Khwarzam Shahi* (Vol. 1, pp. 192–196, 200–203, 214–219; Vol. 4, pp. 310–315). New Delhi: Idara Kitab-us-Shifa.
- Central Council for Research in Unani Medicine. (2006). *Standard Unani Medical Terminology* (pp. 110–115). New Delhi: CCRUM.
- Kabiruddin, H. M. (2000). *Makhzanul Mufradat* (pp. 98–120, 145–147, 214–215). New Delhi: Aijaz Publishing.
- Hay, R. J., & Ashbee, H. R. (2016). Mycology. In C. Griffiths, J. Barker, T. Bleiker, R. Chalmers, & D. Creamer (Eds.), *Rook's textbook of dermatology* (9th ed., pp. 36.1–36.32, 32.1–32.45). Oxford: Wiley-Blackwell.
- Chander, J. (2018). *Textbook of medical mycology* (4th ed., pp. 36.10–36.15). New Delhi: Jaypee Brothers.
- Rudnicka, L., Olszewska, M., Rakowska, A., et al. (2008). Trichoscopy: A new method for diagnosing hair loss. *Archives of Dermatology*, 144(8), 1000–1006.
- Ghani, N. (2005). *Khazainul Advia* (Vol. 1, pp. 110–118). New Delhi: Idara Kitab-us-Shifa.
- Kabiruddin. (1935). *Bayaz-e-Kabeer* (Vol. 1, pp. 202–204; Vol. 2, pp. 132–134, 138–140; Vol. 3, pp. 85–88, 145–148). Hyderabad: Hikmat Book Depot.
- Gupta, A. K., & Cooper, E. A. (2008). Update in antifungal therapy of dermatophytosis. *Mycopathologia*, 166(5–6), 353–367.
- Sigurgeirsson, B., & Baran, R. (2014). The role of ciclopirox in antifungal therapy. *Journal of the European Academy of Dermatology and Venereology*, 28(Suppl 4), 1–8.
- Ely, J. W., Rosenfeld, S., & Seabury Stone, M. (2014). Diagnosis and management of tinea infections. *American Family Physician*, 90(10), 702–710.
- Ryder, N. S. (1992). Terbinafine: Mode of action and properties of the squalene epoxidase inhibition. *British Journal of Dermatology*, 126(Suppl 39), 2–7.
- Elewski, B. E., & Tavakkol, A. (2005). Safety and tolerability of oral antifungal agents in the treatment of fungal nail disease: A proven reality. *Therapeutics and Clinical Risk Management*, 1(4), 299–306.
- Grant, S. M., & Clissold, S. P. (1990). Fluconazole: A review of its pharmacodynamic and pharmacokinetic properties, and therapeutic potential in superficial and systemic mycoses. *Drugs*, 39(6), 877–916.
- Chattaway, F. W., & Ashbee, H. R. (2014). Adverse drug reactions of systemic antifungals. *Clinical and Experimental Dermatology*, 39(5), 482–489.
- James, W. D., Berger, T. G., Elston, D. M., & Neuhaus, I. M. (2019). *Andrews' diseases of the skin: Clinical dermatology* (13th ed., pp. 306–312). Elsevier.
- Korting, H. C., & Schöllmann, C. (2009). The significance of keratolysis in superficial fungal infections. *Mycoses*, 52(1), 16–21.
- Verma, S., & Madhu, R. (2017). The great Indian epidemic of superficial dermatophytosis: An appraisal. *Indian Journal of Dermatology, Venereology and Leprology*, 83(3), 281–288.
- World Health Organization. (2018). *Guidelines for the diagnosis, prevention and control of dermatophytosis*. Geneva: WHO.
- Khurana, A., & Sardana, K. (2017). Luliconazole: Evidence of efficacy and safety. *Indian Journal of Dermatology, Venereology and Leprology*, 83(4), 463–472.
- Gupta, A. K., & Versteeg, S. G. (2017). Efinaconazole and tavaborole for onychomycosis: A review. *Journal of Cutaneous Medicine and Surgery*, 21(2), 114–122.
- Rotta, I., Ziegelmann, P. K., Otuki, M. F., Riveros, B. S., Bernardo, N. L., & Correr, C. J. (2012). Efficacy and safety of topical antifungals in the treatment of dermatophytosis: A systematic review. *British Journal of Dermatology*, 166(5), 927–933.
- Hay, R. J., Johns, N. E., Williams, H. C., et al. (2014). The global burden of skin disease. *Journal of Investigative Dermatology*, 134(6), 1527–1534.
- Fuller, L. C. (2019). Diagnosis and management of tinea infections. *BMJ*, 364, 1438.
- Crawford, F., & Ferrari, J. (2014). Oral treatments for fungal infections of the skin of the foot. *Cochrane Database of Systematic Reviews*, 2014(4), CD003584.
- Narang, T., & Dogra, S. (2015). Superficial fungal infections: Prevention and control. *Indian Dermatology Online Journal*, 6(2), 120–122.
- Verma, S., & Heffernan, M. P. (2012). Superficial fungal infection. In L. A. Goldsmith et al. (Eds.), *Fitzpatrick's dermatology in general medicine* (8th ed., pp. 220–222). New York: McGraw-Hill.
- Majusi, A. I. A. (2010). *Kamil al-Sana'a al-Tibbiyya* (Vol. 2, pp. 402–406). New Delhi: CCRUM.