

INTERNATIONAL JOURNAL OF UNANI AND INTEGRATIVE MEDICINE



E-ISSN: 2616-4558
P-ISSN: 2616-454X
www.unanijournal.com
IJUIM 2024; 8(3): 20-24
Impact Factor (RJIF): 6.3
Peer Reviewed Journal
Received: 01-07-2024
Accepted: 06-08-2024

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A comprehensive review of *Taqashshur-al-jild* (Psoriasis) in the light of Unani medicine

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DOI: <https://doi.org/10.33545/2616454X.2024.v8.i3a.292>

Abstract

Psoriasis is an auto-immune, chronic inflammatory papulosquamous skin disease characterized by well-defined, sharply demarcated erythematous plaques covered in whitish, silvery scales. It is primarily caused by variations in the normal growth and differentiation of the skin's epidermis. Psoriasis is a global disease. Prevalence varies between nations from 0.1 percent to 11.8 percent. Unani physicians have vividly described psoriasis not as a separate disease, actually as part of a group of diseases that share a close clinical resemblance with psoriasis. One such disease as mentioned in classical Unani texts is *Baraş Aswad*, which is characterized by dryness of skin and the development of scales on the skin which shares lot of resemblance with scales of fish. Psoriasis, also known as *Qūbā Mutaqashshira*, is characterized by rough skin, intense itching, and peeling of large round scales resembling fish scales (*Faloos-i-Māhī*). Recently, Unani physicians coined the term *Taqashshur-al-Jild*. The Psoriasis Area Severity Index (PASI) Scale, as well as certain specific investigations, are used for the diagnosis and evaluation of the condition.

Keywords: Psoriasis, Qūbā Mutaqashshira, Khushūnat, Baraş Aswad, *Taqashshur-al-Jild*

Introduction

Psoriasis is derived from the Greek words "psora" (itching) and "iasis" (condition). The term "Psora" was coined by the renowned Greek physician Hippocrates (460-377 BC) [1]. Psoriasis is a chronic, papulosquamous, inflammatory skin disorder that manifests as well-defined erythematous plaques with sharp borders. These plaques are covered with white, silvery scales [2]. It is a chronic, non-contagious, and disabling disease that significantly reduces patients' quality of life. Psoriasis can affect any age group [3]. Plaque Psoriasis is the most common type of psoriasis, accounting for nearly 90% of cases. It can be defined as an inflammatory proliferative disorder of the skin, with significant genetic and environmental influences [4,5]. Psoriasis is not mentioned as a separate disease entity in Unani Medicine, but almost all Classical Unani literature describes various diseases with scales and itching. Baraş Aswad is a common skin disease that causes dry skin and scales that resemble fish scales by eminent and world-renowned Unani physicians such as Ibn Sīnā [6], *Naftis ibn 'Iwaḍ Al-Kirmānī*, [7], *Ibn Hubal Baghdādī*, [8] *Jamāluddīn Aqsarā'ī* a [9] and *Zakariyyā Rāzī* [10-12] characterized the condition known as *Baraş Aswad*, which is very similar to Plaque Psoriasis.

Etiology

Unani physicians believe that Baraş Aswad is caused by an imbalance in the quantity and quality of body humors, specifically Sawdā (black bile), Mādda Raḍḍiyya (morbid matter), and skin sensitivity [6, 10, 13]. The disease's progression is influenced by both external (Asbāb Baironi) and internal (Asbāb Andruni) factors. According to Ibn Zuhr, excessive accumulation of abnormal Sawdā' in the skin can impair nutrition, cause skin malfunction, and prevent the skin from excreting abnormal Sawdāwī Khilṭ. Skin tissues decompose into dead scales, which fall off. [13] In his book *Kāmil al-Ṣanā'a al-Ṭibbiyya*, 'Alī ibn 'Abbās Majūsī, (Haly Abbas) discussed how the body's *Ṭabī'iyat* (Physis) expels viscous humour (*Khilṭe Ghlaeez*) from the internal organs towards the skin when *Balgham Mirāri* (bilious phlegm) and blood mixed.

This humour then accumulates within the skin, resulting in scaling and chronic, severe itching. This abnormal condition can occasionally occur from *Ḍu'f jild* (skin weakness) when the *Ṭabī'yyat* (Physis) tries to expel wastes that are *Akhlāte Ghallīza* towards the skin. Due to *Ḍu'f Dāfi'-i-yah* (weakness of the expulsive power), it cannot expel and resolve waste humours. So, waste humours build up here and cause the skin to dry, scaly, and itchy^[14, 15].

Epidemiology

The prevalence varies by region, but is approximately 2% worldwide. According to the World Health Organization (WHO), the prevalence of psoriasis varies by country, ranging from 0.09% to 11.43%. Thus, Psoriasis is a global health problem, affecting nearly 100 million people worldwide. The prevalence of Psoriasis in India ranges between 0.44% and 2.8%. The prevalence of psoriasis in Kashmir valley has been reported to be around 2.4%. Psoriasis is twice as common in men as in women. The majority of patients typically present in their third or fourth decade of life^[16].

Pathogenesis

According to Ibn Zuhr, excessive accumulation of abnormal *Sawdā'* in the skin can impair nutrition, cause skin malfunction, and prevent the skin from excreting abnormal *Sawdāwī Khilṭ*. Skin tissues decompose into dead scales, which fall off.^[13] In his book *Kāmil al-Ṣanā'a al-Ṭibbiyya*, 'Alī ibn 'Abbās Majūsī, (Haly Abbas) (930-994 AD) discussed how the body's *Ṭabī'yyat* (Physis) expels viscous humour (*Khilṭe Ghlaez*) from the internal organs towards the skin when *Balgham Mirāri* (bilious phlegm) and blood mix. This humour then accumulates within the skin, resulting in scaling and chronic, severe itching. This abnormal condition can occasionally occur from *Ḍu'f jild* (skin weakness) when the *Ṭabī'yyat* (Physis) tries to expel wastes that are *Akhlāte Ghallīza* towards the skin. Due to *Ḍu'f Dāfi'-i-yah* (weakness of the expulsive power), it cannot expel and resolve waste humours. So, waste humours build up here and cause the skin to dry, scaly, and itchy^[14, 15].

Classification

Chronic plaque psoriasis

Psoriasis vulgaris, a chronic, inflammatory skin disease, is characterized by erythematous plaques with distinct borders and whitish scales^[2]. This type constitutes nearly 90% of all cases of psoriasis, making it the most common. Erythematous, scaly patches or plaques frequently appear on extensor surfaces. This manifestation is by far the most prevalent. Other Types of Psoriasis include: Guttate Psoriasis^[2, 4, 17, 18], Flexural Psoriasis^[19], Rupiod, Elephantine and Ostraceous Psoriasis^[4] Erythrodermic Psoriasis^[20] Pustular Psoriasis^[21] Scalp Psoriasis^[2, 4], Nail Psoriasis,^[2, 4, 22] Palmo Plantar Psoriasis^[2, 4].

Symptoms

Psoriasis can manifest in a variety of clinical forms, but the most common are persistent, symmetric, erythematous, well-defined, dry red scaly papules or plaques. The scales are numerous, loose, dry, and silvery. They can be white or micaceous^[4].

Signs

Koebner's phenomenon / ISO morp hic response

He Koebner's phenomenon refers to the appearance of new

Psoriatic lesions in stable skin regions in Psoriatic patients following injury. It is an all-or-nothing phenomenon that happens more frequently while the disease is in remission, i.e., if Psoriasis occurs in one site of injury, it will occur at all sites^[5]. The first to describe it was Heinrich Koebner in 1878. Koebner's phenomenon is brought on by skin injuries that affect both the Epidermis and Dermis.

Membrane of Berkley

When all of the scales have been removed, the stratum Mucosum (basement membrane) is visible as a crimson, moist surface with red dots that represent dilated capillaries.^[23]

Auspitz sign

Many bleeding sites are caused by the ripping of the capillaries at the tips of the protruding papillae and the continued scratching^[19].

Wornoff's Ring

The cause of a surrounding area of hypopigmentation is typically unknown, but experimental studies suggest that prostaglandin E2 deficiency is the responsible. This condition is uncommon and usually associated with treatment, most commonly with topical corticosteroids or UV radiation^[24].

Signe de la tache de bougie/ candle grease sign

Even from non-scaling lesions, candle grease can be seen when a Psoriatic lesion is scratched with the tip of a dissecting forcep^[2, 4, 19].

Grattage Test: When scales are removed from psoriatic lesions, pinpoint bleeding occurs, which is a well-known dermatological sign named after Heinrich Auspitz. The Grattage test is used to determine the Auspitz sign^[25] According to the Unani Concept and classification of disease, *Baraṣ e Aswad* is a *Maraḍ-i-Murakkab* (compound disease) that develops due to impaired *Khilṭe Sawdā'* (black bile) and weakened *Quwwat-i-Dāfi'-i-yah* of the skin. This eventually results in *Waram* (inflammation), *Yubūsat wa Khushūnat* (dryness) and *Taqashshur* (Scaling) of the skin^[11, 26].

Risk Factors^[27-33]

- Genetic Factors Environmentl Factors Stress Cold Weather Trauma.
- Skin Infections e.g.; Beta Haemolytic streptococci.
- Obesity.
- Smoking.
- Alcohol.
- HIV.
- Diet rich in calories.

Complications: Psoriasis patients are more likely to develop cardiovascular disease, insulin resistance, and diabetes mellitus due to elevated levels of pro-inflammatory cytokines such as tumour necrosis factor and other inflammatory reactions, oxidative stress, and endothelial dysfunction. These patients are also more likely to develop Systemic Arterial Hypertension and Vascular disease because there is a link between high blood pressure and the severity of psoriasis. Other complications associated with Psoriasis include Ocular manifestations, Inflammatory

Bowel Disease (IBD), Non-Alcoholic Steato Hepatitis (NASH), Osteoporosis, Lymphoma, Obesity and Psychological Comorbidities [34-41].

Differential diagnosis of psoriasis

Common disorders associated with plaque psoriasis include atopic dermatitis, nummular dermatitis, lichen simplex chronicus, pityriasis rosea, pityriasis rubra pillaris, and tinea. Other conditions that fall under the Psoriasis differential diagnosis include Pityriasis Rosea, Nummular Eczema, Seborrheic Dermatitis, and Secondary Syphilis. Cutaneous lymphoma of T cells, Tinea Ungum, Discoid Lupus Erythematosus (DLE), Leprosy or Hansens Disease, Acute Generalised Exanthematous Pustulosis (AGEP) [5, 19, 42-44].

Diagnosis: Clinical factors may be used to diagnose Psoriasis; seldom is a skin biopsy required [20, 46].

Beta Haemolytic streptococci detection in Guttate Psoriasis requires throat swabbing [46].

If the condition is asymmetrical, take skin scrapings or nail clippings for fungal culture [46].

Rheumatoid factor testing and radiography are helpful in assessing arthritis [46].

If the patient is obese and at risk for metabolic syndrome, check their fasting blood sugar, cholesterol and Triglycerides [46].

Total Haemogram, liver function and renal function screening are used until systemic treatment respectively [46].

Pro Collagen peptide 3 (earlier than methotrexate) [46].

Fasting triglycerides and cholesterol (Previous to oral retinoids) [46].

Some Scales used for Assessing the Severity of Psoriasis:

The Psoriasis Area and Severity Index (PASI) is a widely used scale for assessing the severity of psoriasis. Based on the assessment of the affected area as well as the severity of lesions, the PASI generates a single score ranging from 0 to 72. The four parts of the body that receive separate scores are the head, arms, trunk, and legs. The grade, which goes from 0 to 6, is derived from the estimated percentage of the skin area affected. Each area's expected severity is translated into a grade that runs from 0 to 6. Three, clinical symptoms are used to determine the severity within each area: Erythema (Redness), Induration (Thickness) and Desquamation (Scaling). On a scale of 0 to 4, severity parameters range from none to maximum. Then, for each skin segment, the sum of the three severity criteria is determined, multiplied by the area score for that section, and finally multiplied by the weight of that particular section (0.1 for Head, 0.2 for Arms, 0.3 for Body and 0.4 for Legs). [47].

Treatment [4, 5, 47-49]

Psoriasis is primarily treated with topical pharmacotherapy (topical corticosteroids, dithranol, vitamin D analogues, calcineurin, salicylic acid, coal tar, and biologic therapies (emollients). In terms of systemic therapy, treatment options include Folic Acid Antagonists (Methotrexate), Calcineurin Inhibitors, Retinoid like Acitretin, Phototherapy including Psoralen and Ultraviolet Light (PUVA), Ultraviolet B Light, and Biologic Agents. All of the aforementioned drugs work well, but they have various side effects such as hypopigmentation, skin thinning, burning, itching, and skin

irritation.

Management of Psoriasis in Unani Medicine [6-12].

Uşūl-i-'Ilāj (Principles of Treatment)

Nudj-wa Tanqiya'-i- Akhlāṭ Ghair Ṭabī'a (Concoction and expulsion of abnormal humors).

Tahlīl-i-Awrām (resolution).

Tasfiya al-Dam (blood purification)

Indimāl-i-Zakhm (Cicatrization).

Taskhīn Jild (Demulcefication).

Tarṭīb-i-'Umūmī-wa- Maqāmī (general and local moisturization) and the use of *Jālī* (Detergent) drugs.

'Ilāj-e-Taqaashshur-al-Jild

- **Izalae-e-Sabab:** Treat and remove the underlying cause.
- **Tanqiya'-i- Mādda:** It is recommended to administer a decoction of the herbs *Halayla Zard Musaffa, Kishmish Munaqqa, Maghze Faloos Khayar Shambar, Ma'jūn Najah, Itrīfāl Shahtara* and *Tiryāq Farooque* (1.75 gms) along with *Sharbat Aslussoos* (35 gms). [13, 14, 50].
- **Muṣaffī-i-Dam:** *Shahtara, Haldi, Post-i-Neem, Babchi, Mundi, Charaita, Ushba, Chobchini, Gulle Surkh, Sandal Safed, Surkh* [51].
- **Compound Drugs:** *Ma'jūn-i-Ushba, Khamīra-i-Sandal, Sharbat-i-Unnab, Sharbat-i-Murakkab.* 'Araq-i-Shahtara, 'Araq-i-Ushba, *Sharbat-i-Banafsha, Sharbat-i-Nilofar, and Ḥabb-i-Musaffī Khoon.* [8, 10, 11, 12, 13, 14, 15].
- **Adwiya Murakkab Maqāmī** (Topical Therapy): *Ṭilā'* of *Roghane Gul, Sirka* and *Murdār Sung.* Local application of *Ṭilā'* composed of *Haldi, Hinna, Murdār Sung, Zaravand, Post Anar, Sirka, Sharāb* and *Roghane Gull. Marham Da-al-Sadaf, Marham Gulabi, Marham Basliqoon, Marham Ahmar,* and paste of *Tukhme Jarjeer, Tukhme Mooli,* and *Kundur* with *Sirka* may be applied locally on the affected parts of the body. *Roghane Gundum, Roghane Banafsha, Roghane Nilofer, Roghane Chalmogra, Roghane Kameela, Roghane Badam, Roghane Khardal, Roghane Hindi* and *Mom Safaid* are also beneficial in *Taqashshur al Jild.* [6, 12, 52, 53].

Conclusion

Psoriasis is an autoimmune, chronic inflammatory skin disease characterized by well-defined, sharply demarcated red papules covered in whitish silvery scales. It is primarily caused by variations in the normal growth and differentiation of the skin's epidermis. Psoriasis's underlying cause is still unknown. Previously, it was thought to be primarily a keratinocyte-related disease

However, only recently has the auto-immune nature of disease been discovered. Psoriasis can affect anyone, but it is most common among people aged 50 to 69. The age of onset typically follows a bimodal distribution, peaking around 20-30 years old and then again around 50-60 years old. Psoriasis is a global disease. Prevalence varies by country, ranging from 0.1% to 11.8%. The majority of cases occur in adulthood, which can have a negative impact on patients' social and occupational functioning. The disease has a significant impact on patients' quality of life. Thus, psoriasis is a major global health concern. Despite the fact that several treatment modalities are available, identifying an explicit type of treatment option remains challenging. Thus, various alternative treatment options available in the

Unani system of medicine can help.

Conflict of interest

None.

Acknowledgement

The authors are highly thankful to all the writers whose papers are referred to for the references. Also thankful to the staffs and management of NRIUMSD, Hyderabad and RRIUM, Srinagar, for providing materials and for their cooperation and engagement during the whole process of writing this review article.

References

- O'Neill T, Silman AJ. Historical background and epidemiology. *Baillieres Clinical Rheumatology*. 1994 Jun;8(2):245-261.
- Kamiya K, Kishimoto M, Sugai J, Komine M, Ohtsuki M. Risk factors for the development of psoriasis. *International Journal of Molecular Sciences*. 2019 Sep 5;20(18):4347.
- World Health Organization. Global Report on Psoriasis. Available at: <https://apps.who.int/iris/handle/10665/204417>. [Accessed 8 Jan 2024].
- Griffiths CEM, Burns T, Breathnaeh S, Chalmer R. *Rook's Textbook of Dermatology*. 8th ed, Vol-1. USA: John Wiley and Sons Ltd; 2016:20.1-20.60.
- Goldsmith LA, Katz SI, Gilchrist BA, Paller AS, Leffel DJ, Wolff K. *Fitzpatrick's Dermatology in General Medicine*. 8th ed. Medical Publication Division McGraw Hill; p. 197-221.
- Ibn Sina. *Al Qanoon Fil Tib (Arabic Version)*. Vol-4. New Delhi: Institute of History of Medicine and Medical Research; 1408 Hijri: 405-406, 409-10, 405-16.
- Nafees. *Mo'alajate Nafeesi (Arabic)*. Vol-4. Lucknow: Matba Munshi Naval Kishore; 1324 Hijri: 531-532.
- Hubul I. *Kitabul Mukhtarat Fil Tib (Urdu Translation)*. Vol-4. New Delhi: CCRUM, Ministry of Health and Family Welfare; c2007. p. 104-105.
- Jamaluddin Aqsarai (Arabic). Vol-3. Lucknow: Matba Musnhi Navl Kishore; YNM: 476-477.
- Razi AMBZ. *Kitabul Fakhir Fil Tib (Arabic Version)*. Part 1, Vol 1. New Delhi: CCRUM, Ministry of Health and Family Welfare; 2005:28-46.
- Razi AMBZ. *Alhavi Fil Tib (Urdu Translation)*. Vol-23. Aligarh Muslim University: Saba Publishers Aligarh; c1994. p. 21-23, 61-62, 73.
- Razi AMBZ. *Kitabul Mansoori (Urdu Translation)*. New Delhi: CCRUM, Ministry of Health and Family Welfare; c1991. p. 200, 207.
- Ibn Zuhr AMAM. *Kitabul Taisir Fil Mudawat wat Tadabir*. 1st ed. (Urdu Translation by Central Council for Research in Unani Medicine). New Delhi; c1986. p. 31.
- Majoosi. *Kamil us Sana (Urdu Translation)*. Vol-1 & 2. New Delhi: Idara Kitab-ul-Shifa; 2010:252, 431-433.
- Ibn al Quff. *Kitabul Umda Fil Jarahat (Urdu Translation)*. Vol-1,2. New Delhi: CCRUM, Ministry of Health and Family Welfare; 1986:174-175, 102-107, 234, 236, 268, 271-272, 273, 274, 292, 293.
- Masood Q, Hassan I, Sameem Farah, Khan D, Majid Imran, Singh G, Bhat T, Afshan A, Shafi M. Psoriasis in Kashmir Valley: A clinic epidemiological study. *JK Science*. 2011;13:80-83.
- Murphy GF. *Dermatology for Clinicians: A Practical Guide to Common Skin Conditions*. WB Saunders Company; p. 74-76.
- Ran D, Cai M, Zhang X. Genetics of psoriasis: a basis for precision medicine. *Precision Clinical Medicine*. 2019 Jun 24;2(2):120-130.
- Behl PN, Aggrawal A, Srivastava G. *Practice of Dermatology*. 9th ed. New Delhi: CBS Publishers and Distributors; c2002. p. 254-256.
- Boyd AS, Menter A. Erythrodermic psoriasis: Precipitating factors, course, and prognosis in 50 patients. *Journal of the American Academy of Dermatology*. 1989 Nov;21(5):985-991.
- Tuschida Y, Hayashi R, Ansai O, Nakajima M, Ognizewa M, Kawai T, Yoloyama R, Deguchi T, Hama N, Shinkuma S, Abe R. Generalized pustular psoriasis complicated with bullous pemphigoid. *International Journal of Dermatology*. 2019 Mar;58(3):308-309.
- Manhart R, Rich P. Nail psoriasis. *Clinical and Experimental Rheumatology*. 2015 Sep-Oct;33(5):93-98.
- Valia RG, Valia AR. *Textbook of Dermatology*. 3rd ed. Vol-1. Mumbai, India: Bhalani Publishing House; pp. 1025-1055.
- Sainani GS, *et al*. *API Textbook of Medicine*. 6th ed. Association of Physicians of India, Mumbai; c1999, 1198-1199.
- Madke B, Nayak C. Eponymous signs in dermatology. *Indian Dermatology Online Journal*. 2012 Sep-Dec;3(3):159-165. DOI: 10.4103/2229-5178.101810.
- Jurjani I. *Zakhira Khawarazm Shahi*. Vol-2. New Delhi: Idara Kitabus Shifa; 2010:7-21.
- Harden JL, Krueger JG, Bowcock AM. The immunogenetics of psoriasis: a comprehensive review. *Journal of Autoimmunity*. 2015 Nov;64:66-73.
- Prieto-Perez R, Cabaleiro T, Dauden E, Ochoa D, Roman M, Santos FA. Genetics of psoriasis and pharmacogenetics of biological drugs. *Autoimmune Diseases*. 2013;2013:613086.
- Belanger A, Padilha de Oliveira C, Maheux M, Pouliot R. Plaque psoriasis: Understanding risk factors of this inflammatory skin pathology. *Journal of Cosmetics, Dermatological Sciences and Applications*. 2016 Jan;6(2):67-80.
- Bolognia JL, Jorizzo JL, Rapini RP. *Dermatology*. 4th ed. Vol-1. UK: Mosby Elsevier; 2018:138-160.
- Bressler MY, Pathak N, Rotblat D, Tamez R. Acute HIV infection presenting with diffuse plaque psoriasis treated with highly active antiretroviral therapy. *International Journal of Dermatology*. 2021 Nov;17(11):13.
- Baros G, Duran P, Vera I, Bermudez V. Exploring the links between obesity and psoriasis: A comprehensive review. *International Journal of Molecular Sciences*. 2022 Jul;23(14):7499. DOI: 10.3390/ijms23147499.
- Wolters M. Diet and psoriasis: experimental data and clinical evidence. *British Journal of Dermatology*. 2005 Oct;153(4):706-714.
- Menter MA, Ryan C. *Psoriasis*. 2nd ed. New York: Taylor & Francis Group; 2014:3.
- Mala P, Bhattacharjee J, Bhattacharya GC, Ghosh S, Sarker G, Pal R. Association between psoriasis, diabetes mellitus, hypertension, obesity. *Clinical Epidemiology and Global Health*. 2015 Jan;3(3):132-

- 136.
36. Salihbegovic EM, Hadzegrahic N, Sulgaic E, Kurtalic N, Sadic S, Zejerovic A, Mujacic A. Psoriasis and high blood pressure. *Medical Archives*. 2015 Feb;69(1):13-15.
 37. Aikatarni I, Christos L, Zouboulis C. Links and risks associated with psoriasis and metabolic syndrome. *Psoriasis (Auckland)*. 2015;5:125-128.
 38. Maitray A, Bhandary AS, Shetty SB, Kundu G. Ocular manifestations in psoriasis. *International Journal of Ocular Oncology and Oculoplasty*. 2016;2(2):123-131.
 39. Mehmood F, Helliwell P. Psoriatic arthritis: A review. *European Medical Journal*. 2016;3(1):114-117.
 40. Gelfand JM, Shin DB, Neimann AL, Wang X, Margolis DJ, Troxel AB. The risk of lymphoma in patients with psoriasis. *Journal of Investigative Dermatology*. 2006 Oct;126(10):2194-2201.
 41. Russo PAJ, Ilchef R, Cooper AJ. Psychiatric morbidity in psoriasis: A review. *Australasian Journal of Dermatology*. 2004 Aug;45(3):155-159.
 42. Silverberg NB. Typical and atypical clinical appearance of atopic dermatitis. *Clinical Dermatology*. 2017 Jul-Aug;35(4):354-359.
 43. Gaul A, Pau Charles I, Abeck D. Topical corticosteroids in dermatology: from chemical development to galenic innovation and therapeutic trends. *Journal of Clinical Experimental Dermatology Research*. 2015 Feb 28;6(269):2-5.
 44. Runge M, Greganti M. *Netter's Internal Medicine*. 2nd ed. 2011:233.
 45. Hunter JAA, Savin JA, Dahl MV. *Clinical Dermatology*. 3rd ed. USA: Blackwell Science; 2002:48-62.
 46. Burge S, Matin R, Wallis D. *Oxford Handbook of Medical Dermatology*. 1st ed. UK: Oxford University Press; 2011:178-194.
 47. Khanna N. *Illustrated Synopsis of Dermatology and Sexually Transmitted Diseases*. 5th ed. Delhi: Elsevier Health Sciences; 2016:44-45.
 48. Warren RB, Griffiths CE. Systemic therapies for psoriasis: Methotrexate, steroids, and cyclosporine. *Clinical Dermatology*. 2008 Sep-Oct;26(5):438-447.
 49. Habif TP. *Clinical Dermatology*. 3rd ed. London: Mosby; 2011:121-131.
 50. Khan MA, Azam Q, Akmal. *Matba Siddiqui, India*; 1898:1115.
 51. Qarshi HM. *Jami ul Hikmat*. Vol-2. New Delhi: Idara Kitabus Shifa; 2011:1005.
 52. Siddiqui AH, Cormane RH. Dermatologic origins and developments down to the early twentieth century. *Journal of Investigative Dermatology*. 1976 Feb;66(2):122-125.
 53. Holuber K. Psoriasis 100 years ago. *Dermatologica*. 1990;180(1):1-4.

How to Cite This Article

Haque SUL, Avid M, Ahmad J, Rehman R, Zahoor U, Babu C, Shahid R. A comprehensive review of *Taqashshur-al- jild* (Psoriasis) in the light of Unani medicine. *International Journal of Unani and Integrative Medicine* 2024; 8(3): 20-24.

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