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Unani perspective on polycystic ovarian syndrome: A traditional approach to modern ailment

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Abstract

Polycystic Ovarian Syndrome (PCOS) is a multifaceted disorder commonly characterized by menstrual irregularities, hirsutism, and obesity, often linked to the presence of multiple cysts in the ovaries. The global incidence of PCOS (5–6%) is rising rapidly due to changes in lifestyle and increased stress levels, particularly affecting adolescents and women of reproductive age. Approximately 20% of infertility cases are attributed to ovulatory dysfunction caused by PCOS. In the Unani system of medicine, PCOS is referred to as Marz Akyas Khusyutur Rehm, an Arabic term for this condition. Classical Unani physicians have described it under disorders involving amenorrhea, obesity, phlegmatic diseases, and uterine dysfunctions. According to Unani theory, PCOD is primarily caused by an imbalance of khilt -e-Balgham (phlegm), leading to key symptoms such as amenorrhea, oligomenorrhea, and obesity. It is believed that the predominance of phlegm results in cyst formation, hormonal imbalance, and reproductive dysfunction. Unani medicine interprets PCOS through the lens of Sue-Mizaj (derangement of temperament), especially Sue-Mizaj Barid Yabis (cold and dry temperament), which negatively impacts ovarian function and ovulation. Unani treatment emphasizes correcting the mizaj (temperament) using a combination of: Ilaj Bil Ghiza (diet therapy), Ilaj Bil Dawa (pharmacotherapy), and Ilaj Bil Tadbeer (regimental therapy). These therapeutic approaches aim to restore normal menstrual cycles, enhance fertility, reduce obesity, and improve overall health. Integrating traditional Unani principles with modern clinical knowledge offers a holistic and promising approach to managing PCOS.

Keywords: Polycystic ovarian syndrome (PCOS), Marz Akyas Khusyutur Rehm, Sue-Mizaj Barid Yabis, hormonal imbalance, Ilaj Bil Tadbeer, Ilaj Bil Da'wa, temperament theory

Introduction

Polycystic Ovarian Syndrome (PCOS) is a common endocrine disorder characterized by oligoovulation or anovulation, clinical or biochemical signs of hyperandrogenism, and the presence of multiple small ovarian cysts [3]. The presentation of PCOS can vary significantly both between individuals and over time in the same individual. It is the most prevalent endocrinopathy among women of reproductive age, affecting approximately 4% to 12% of this population (Asunción, 2000; Diamanti-Kandarakis, 1999; Farah, 1999; Knochenhauer, 1998) [3]. Several lifestyle factors, including a sedentary routine, increased consumption of junk food, and emotional or behavioural stressors (e.g., competitive pressure and social insecurities), can disrupt the hypothalamic-pituitary-ovarian (HPO) axis, contributing to the development and progression of PCOS. Ovarian Changes in PCOS include Enlarged ovaries with an increased ovarian volume (>10 cm³), Increased stromal tissue, Presence of more than 12 small follicular cysts (2–9 mm in diameter), often arranged peripherally around the ovarian cortex (giving a "string of pearls" appearance). Clinical Features of PCOS are Abdominal obesity – reported in nearly 50% of patients, Menstrual irregularities – observed in 70%, manifesting as oligomenorrhea, amenorrhea, or dysfunctional uterine bleeding (DUB), Infertility, Hirsutism and acne – present in about 70% of cases, Virilism – rare, but may occur in severe androgen excess. Management requires individualized treatment, based on the patient's primary complaints, such as menstrual disturbances, infertility, obesity, or hirsutism. The main goal is to correct underlying biochemical and hormonal imbalances, while also addressing lifestyle and psychosocial aspects. Patient education and counselling play a pivotal role in long-term disease management. The Unani system of medicine offers a holistic and natural approach to managing PCOS, focusing on balancing the body's temperament (Mizaj) and restoring harmony among the four humours (Akhlat).

Ilaj Bil Ghiza (Diet therapy) – Customized dietary plans to restore balance and promote metabolism, Ilaj Bil Dawa (Pharmacotherapy) – Use of natural herbal formulations aimed at detoxification and hormonal regulation, Ilaj Bil Tadbeer (Regimental Therapy) – Lifestyle modifications and traditional therapies like cupping, massage, and physical activity. Unani medicine not only aims to relieve symptoms, but also works to eliminate the root cause by improving overall health. It is considered a safer and sustainable alternative to modern hormonal therapies, with minimal side effects, and has been practiced effectively for centuries.

Pathophysiology: [1, 2, 3, 7]

Exact pathophysiology of PCOS is not clearly understood. It may be discussed under the following heads:

- Hypothalamic - pituitary compartment abnormality
- Androgen excess
- Anovulation
- Obesity and insulin resistance
- Long-term consequences

1. Hypothalamic-Pituitary Compartment in PCOS

- In PCOS, there is an increased pulse frequency of GnRH (Gonadotropin-releasing hormone), which results in elevated LH (Luteinizing hormone) levels. Leptin (a hormone secreted by fat cells and ovarian follicles), insulin resistance, and hyperandrogenaemia contribute to this mechanism.
- GnRH preferentially stimulates LH secretion more than FSH (Follicle-stimulating hormone).
- FSH levels remain unchanged or are not significantly increased, primarily due to the negative feedback from chronically elevated oestrogen and inhibin secreted by the follicles.
- Free oestradiol levels increase as a result of decreased levels of sex hormone-binding globulin (SHBG). This creates a positive feedback loop enhancing LH secretion.
- The LH to FSH ratio is elevated in PCOS.

2. Androgen Excess

Excess androgen production in PCOS is often due to dysregulation of the enzyme P450c17, which plays a key role in androgen synthesis in both the ovaries and adrenal glands. The main sources of excess androgens include:

A. Ovarian Production

The ovaries produce excess androgens due to:

- Increased stimulation of theca cells by high LH levels.
- Hyperfunction of the P450c17 enzyme.
- Defective conversion (aromatization) of androgens to oestrogen.
- IGF-1 (Insulin-like Growth Factor-1) mediated stimulation of theca cells.

B. Adrenal Production

The adrenal glands produce excess androgens due to:

- Stress
- Hyperfunction of P450c17 enzyme
- Elevated prolactin levels (seen in about 20% of cases)

C. Systemic metabolic alteration

Hyperinsulinemia

- Stimulates theca cells to produce more androgens.
- Increases free IGF-1 levels, further promoting androgen

production.

- Inhibits hepatic synthesis of Sex Hormone-Binding Globulin (SHBG), resulting in higher free androgen levels.

Clinical features of insulin resistance include

- BMI ≥ 25 kg/m²
- Acanthosis nigricans
- Waist-to-hip ratio > 0.85

Hyperprolactinemia

- Seen in about 20% of PCOS cases.
- May occur due to increased GnRH pulsatility or dopamine deficiency.
- Elevated prolactin stimulates adrenal androgen production.

3. Anovulation

Due to low FSH levels, ovarian follicles fail to mature fully and get arrested at various stages (2–10 mm in diameter). This results in:

- Decreased oestradiol levels
- Increased inhibin secretion
- Excess LH stimulates theca cells, causing them to enlarge and produce more androgens
- Reduced FSH leads to impaired aromatization of androgens to oestrogens

This hormonal imbalance creates a hyperandrogenic rather than estrogenic environment within the follicle. Without sufficient estrogenic support:

- Follicular growth, maturation, and ovulation are impaired
- Multiple follicles undergo atresia, increasing stromal tissue (ovarian hyperthecosis)
- LH levels remain constantly high without the mid-cycle surge needed for ovulation

4. Obesity and Insulin resistance

Central obesity is a major contributing factor in PCOS. It

- Increases androgen production
- Decreases SHBG (Sex Hormone-Binding Globulin) levels, raising free androgen levels
- Leads to insulin resistance and hyperinsulinemia, further stimulating androgen production

Genetic component: Around 50% of first-degree relatives of PCOS patients may also have the condition.

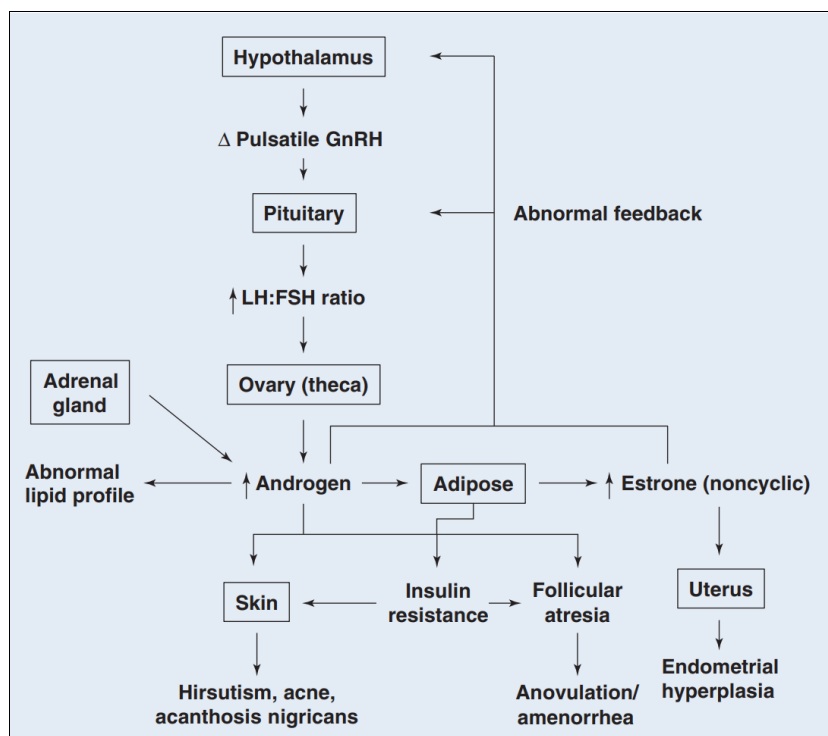
Cause of insulin resistance:

- Likely involves mutations in the insulin receptor gene
- Reduced insulin receptor function in target tissues
- Increased central (abdominal) fat is a significant contributing factor

5. Long-term consequences:

In women with PCOS, long-term effects include:

- Excess androgens (mainly androstenedione) are converted into estrone (E1) in peripheral tissues
- Lower SHBG levels increase free estrone
- Continuous, unbalanced exposure to estrone without progesterone creates a chronic hypoestrogenic state
- This may result in endometrial hyperplasia, increasing the risk of endometrial abnormalities



Signs and Symptoms: [1, 3]

Women with PCOS often present with a wide range of symptoms resulting from hormonal and metabolic imbalances. These may include menstrual irregularities, infertility, signs of androgen excess, and other endocrine-related issues. Most symptoms typically begin to appear within a few years after puberty.

Menstrual Dysfunction

Menstrual problems in PCOS may vary and include:

- Amenorrhea
- Oligomenorrhea
- Menometrorrhagia, which may be accompanied by anaemia

Hyperandrogenism

This condition is marked by elevated levels of male hormones (androgens), which may lead to:

- Hirsutism (excess hair growth on the face/body)
- Acne
- Androgenic alopecia

Other Endocrine Dysfunction

- Insulin Resistance
- Acanthosis Nigricans.
- Impaired Glucose Tolerance and Type 2 Diabetes Mellitus
- Dyslipidemia
- Obesity
- Obstructive Sleep Apnoea

Unani concept

In the Unani system of medicine, Polycystic Ovarian Disease (PCOD) is referred to as Marz Akyas Khusyur Rehm, which is an Arabic equivalent of the modern term. Unani physicians have described this condition under various categories, including amenorrhoea, obesity, phlegmatic disorders, and liver dysfunctions [8, 9, 14].

According to Unani philosophy, the root cause of PCOD lies in the predominance of khilt-e-balgham (phlegm) within the body. Classical Unani texts mention that when the liver develops a mizaj barid (cold temperament), it becomes inefficient in converting chyme (partially digested food) into pure blood. Instead, it produces an abnormal form of phlegm called balgham mayi, which is thicker and more viscous. This form of phlegm tends to accumulate and solidify, leading to the formation of cysts, particularly in the ovaries [10, 11]. Other symptoms of PCOD such as amenorrhoea, oligomenorrhoea, and obesity are also linked to this excessive presence of phlegm. It is believed that an imbalance of phlegm disrupts the natural hormonal and metabolic processes, resulting in menstrual irregularities and weight gain. Unani scholars further emphasize that the early years of adulthood-especially during adolescence-are naturally dominated by a phlegmatic temperament. Therefore, disorders associated with phlegm, such as PCOD, are more likely to manifest during this stage of life [8, 9, 10, 14].

Rhazes also observed a link between PCOD symptoms and hormonal irregularities. He associated menstrual irregularities such as oligomenorrhoea, amenorrhoea, DUB (Dysfunctional Uterine Bleeding), and symptoms like obesity, acne, hoarseness of voice, and infertility with polycystic ovarian disease and excess male hormones (hyperandrogenism) [13, 14].

Hippocrates (460-370 BC) was among the first to document the presence of excessive facial and body hair (hirsutism) in females experiencing prolonged amenorrhoea, obesity, and infertility; [8, 14]. Similar findings were later supported by the physician Galen.

Hirsutism: Hirsutism is recognized in Unani medicine as a complication that arises from prolonged amenorrhoea. It often presents alongside various masculine characteristics such as hoarseness of voice, male-type body contour, acne, and excessive hair growth on the body [7, 8, 9, 14]. The pathophysiology of hirsutism has been thoroughly described

by prominent Unani scholars such as Ibn Sina and Ismail Jurjani. The pathophysiology of hirsutism was explained by Ibn Sina and Ismail Jurjani. According to their explanation, the root cause of hirsutism lies in the alteration of a woman's natural temperament. Normally, women possess a cold and moist temperament. However, when amenorrhoea persists for a prolonged period, this balance is disrupted, leading to a transformation of temperament toward that of men - which is hot and dry. This shift is attributed to the "ehteraq" (conversion or detonation) of normal balgham (phlegm), which is cold and moist, into sauda (black bile), which is hot and dry in nature^[13, 14]. This transformation not only disturbs the internal equilibrium of a woman's body but also causes the accumulation of unwanted materials. These are excreted through the skin, resulting in conditions like busoore labnia (acne) and thick excessive body hair^[8, 9, 10, 14]. Moreover, sauda (black bile) can also manifest in the form of hyperpigmentation, such as acanthosis nigricans, further indicating hormonal imbalance^[12]. Ibn Sina, Ismail Jurjani, and Al-Razi observed that the development of masculine features is particularly common among obese women with well-developed musculature and prominent blood vessels. These women, according to Unani scholars, have a physical temperament closely resembling that of men^[8, 9]. In such cases, the progression of PCOD may lead to additional complications including infertility, insulin resistance, metabolic syndrome, and other endocrine disorders^[14, 17].

Diagnosis

Polycystic Ovary Syndrome (PCOS), also referred to as Hyperandrogenic Anovulation (HA) or Stein-Leventhal Syndrome, is among the most prevalent endocrine disorders affecting women of reproductive age. While several studies suggest that PCOS is largely a genetic disorder^[1, 7], others view it as primarily a metabolic dysfunction, due to its potential reversibility through lifestyle and medical interventions. The condition was first officially described in 1935 by American gynaecologists Dr. Irving F. Stein, Sr. and Dr. Michael L. Leventhal, which led to its earlier designation as Stein-Leventhal Syndrome. However, historical records trace the earliest known case to 1721 in Italy, and cystic changes in the ovaries were first documented in 1844.

Currently, two widely accepted diagnostic criteria are used to define PCOS:

NIH: [3, 7, 18]

In 1990, a consensus workshop sponsored by the National Institutes of Health (NIH) and the National Institute of Child Health and Human Development (NICHD) established the first widely accepted diagnostic criteria for PCOS. According to this definition, a diagnosis requires all three of the following:

- Oligo-ovulation or anovulation (infrequent or absent ovulation),
- Clinical and/or biochemical signs of hyperandrogenism (such as hirsutism, acne, or elevated androgen levels),
- Exclusion of other related disorders that could cause menstrual irregularities or excess androgens (e.g., congenital adrenal hyperplasia, androgen-secreting tumours, Cushing's syndrome).

This definition emphasizes both reproductive and hormonal

abnormalities and serves as a foundation for understanding the syndrome's complexity.

Rotterdam: [3, 7, 19]

In 2003, a consensus workshop jointly sponsored by the European Society of Human Reproduction and Embryology (ESHRE) and the American Society for Reproductive Medicine (ASRM) in Rotterdam expanded the diagnostic criteria for Polycystic Ovary Syndrome (PCOS). According to the Rotterdam criteria, PCOS is diagnosed when any two out of the following three features are present, after excluding other possible causes:

- Oligo-ovulation and/or anovulation
- Clinical and/or biochemical signs of hyperandrogenism (Such as hirsutism, acne, or elevated androgen levels)
- Polycystic ovaries observed on gynaecological ultrasound (Typically defined as the presence of 12 or more follicles in each ovary measuring 2–9 mm in diameter, and/or increased ovarian volume)

Investigations: [1, 2]

1. Ultrasound is diagnostic of PCOS.

- It confirms the enlarged ovaries, their size and increased stroma.
- Ovarian volume will be more than 10 mm³.
- It shows 12 or more small follicles each of 2–9 mm in size placed peripherally.
- It rules out ovarian tumour.
- It shows endometrial hyperplasia if present.

2. Hormonal study

- LH level is elevated and/or the ratio LH: FSH is > 2:1.
- Raised level of oestradiol and estrone - The estrone level is markedly elevated.
- SHBG level is reduced.
- Hyperandrogenism-mainly from the ovary but less from the adrenals. Andro-stenedione is raised.
- Raised serum testosterone (> 150 ng/dl) and DHEA-S may be marginally elevated.
- Insulin Resistance (IR): Raised fasting insulin levels > 25 µIU/ml and fasting glucose/insulin ratio < 4.5 suggests IR (50%).
- Levels of serum insulin response > 300 µIU/ml at 2 hours post glucose (75 gm) load, suggests severe IR.
- Prolactin is mildly raised in 15% cases.
- 17-a-hydroxyprogesterone in the follicular phase. 300 ng/dL suggests adrenal hyperplasia due to 21-hydroxylase deficiency.
- Urinary cortisol, 50 µg/24 h.

3. Thyroid function tests in obese woman.

4. Laparoscopy is reserved for therapeutic purpose, now that the diagnosis can be confirmed on ultrasound findings. Laparoscopy reveals enlarged bilateral ovarian cysts.

Treatment: [1, 2]

The primary goals of PCOS treatment are:

- To manage and cure menstrual irregularities
- To treat hirsutism (excess facial and body hair)
- To address infertility issues
- To prevent the long-term complications of metabolic syndrome (X syndrome) later in life.

1. Weight Management

- Losing even 5% of body weight can significantly improve mild hirsutism and restore hormonal balance.
- Weight loss helps reduce insulin levels, lower testosterone, and increase the production of sex hormone-binding globulin (SHBG), thereby improving overall hormonal health.

2. Lifestyle Modifications

- Cigarette smoking must be avoided as it affects hormonal levels. Quitting smoking can:
- Lower oestrogen (E2) levels
- Reduce DHEA and androgen levels, contributing to hormonal balance

3. Hormonal Therapy

- Oral Combined Pills (OC): Help regulate menstrual cycles
- OC with Cyproterone Acetate or Spironolactone: Used to manage hirsutism and androgen excess
- Ketoconazole (200 mg daily): Helps reduce testosterone secretion

Surgery

Surgery is reserved for those in whom

- Medical therapy fails
- Hyperstimulation occurs
- Infertile women
- Previous pregnancy losses

Surgery comprises laparoscopic drilling or puncture of not more than four cysts in each ovary either by laser or by unipolar electrocautery.

However, many of the above-mentioned treatments, especially hormonal therapies and surgical interventions, may have associated side effects such as weight gain, mood disturbances, metabolic changes, and long-term reproductive complications. Due to these concerns, a growing number of patients are now turning towards Unani medicine, which emphasizes holistic healing, natural remedies, and lifestyle modifications with minimal side effects. Unani interventions aim to correct the underlying imbalance of humours (Akhlat), purify the blood, and restore reproductive health using herbal formulations, detoxification methods (Ilaj Bil Tadbeer), and dietary regimens. This natural and individualized approach has shown promising outcomes in managing symptoms of PCOS safely and effectively.

Unani System of Medicine: Treatment Categories for PCOS

In Unani medicine, the treatment of PCOS is categorized into four major approaches:

1. Ilaj Bil Tadbeer (Regimental therapy): [10, 11, 14]

This method involves lifestyle modification, which plays a key role in restoring balance and overall health. It includes:

- Regular physical activity such as brisk walking and exercise
- A controlled diet and sufficient, quality sleep
- For obese patients, weight reduction is highly recommended. This can be effectively supported by:
 - Hammam Yabis (steam bath)

- Dalak (therapeutic massage)
- Additionally, to stimulate menstruation, Hijama (wet cupping) is performed on the calf muscles of both lower limbs. This practice is believed to divert the flow of blood towards the uterus, encouraging menstrual flow.

2. Ilaj Bil Giza (Diet therapy): [8, 11, 13, 14, 20]

Nutritional management is an essential aspect of Unani treatment for PCOS. Recommendations include:

- A light, easily digestible, and nutritious diet
- Inclusion of fibrous foods, especially green leafy vegetables and fresh fruits
- Adequate intake of fluids is also emphasized to maintain internal balance

Avoidance of

- Cold and dry foods
- Late-night or stale meals
- Heavy and spicy foods

3. Ilaj bid dawa: [8, 9, 14, 20]

Unani scholars, particularly Rhazes, recommended the regular induction of menstruation, especially in women exhibiting masculine features suggestive of PCOD. Treatment is aimed at:

- Correcting the altered temperament (Mizaj)
- Managing menstrual irregularity
- Using Unani medicines (single or compound drugs)
- Applying herbal formulations topically to reduce:
 - Excessive hair growth
 - Hyperpigmentation

4. Ilaj Bil Yad (Surgical Treatment): [8, 9]

This approach involves Fasd (venesection), particularly of the Rage Safin (saphenous vein), to redirect the blood flow towards the uterus and induce menstruation

Usool-e- Ilaj (Principles of Treatment) [10, 13, 20]

The Unani system outlines following core principles for treating PCOS:

- **Induction of Menstruation:** Using Mudire Haiz (emmenagogue) drugs to stimulate and regulate menstrual flow.
- **Correction of Temperament (Tadeel -e-Mizaj):** Involves the use of mundij (maturative) and mushil balgham (phlegm-expelling) drugs to restore the body's natural balance.
- **Weight Management:** Emphasis on reducing excess body weight as it plays a crucial role in restoring hormonal balance and improving symptoms.
- **Use of Specific Unani Medications:** Tailored herbal formulations and single or compound drugs are prescribed to target the underlying humoral imbalance and associated symptoms.

Mudire Haiz (Emmenagogue) Drugs: [10]

Single Drugs

Abhal, Badyan, Post Amaltas, Persiawa Shan, Asgand, Aspand, Habbe Balsan, Habbe Qillt, Habbe Qurtum, Rewand Chini, Tukhm Kasoos, Khashkhash, Glue Teesu, Karafs, Elwa, Heeng, Jausheer, Asaroon, Turmus, Tukhm Gazar, zafran, zanjabeel, ood saleb, musali siyah, sarphunka.

Tadeel Mizaj (Correction of temperament): [10, 13, 20]

- a) **Mundij:** Mavez Munaqqaa, Badiyan, Aslusoos, Persia wa Shan, Anjeer Zard
- b) **Mushil:** Ayarij Faiqrah, Turbud, Habun Neel with Arqe Badiyan.
- c) **Tabreed:** Khameera Gaouzaban Sada wrapped in Warqe Nuqra.

Weight Reduction [9, 13]

Weight management is a key component in the treatment of PCOS and includes the following herbal interventions:

- Dawae Luk Sagheer with Arqe Badiyan
- Safoof Muhazzil with Arqe Zeera
- Itrifal Sagheer taken at bedtime

Specific Drugs

a) Insulin Sensitizers:

These herbs help improve insulin sensitivity and reduce insulin resistance, a key factor in PCOS pathology: [12, 21]

- Darchini (Cinnamon)
- Rewand,
- Abhal,
- Mushktramashi,
- Zafran,
- Asgand

b) Natural Remedies for Hirsutism: [20, 22]

These herbs are traditionally used to reduce excessive hair growth (hirsutism), a common symptom of PCOS:

- Nagarmotha
- Amba Haldi
- Methi
- Pudina
- Soya
- Neem
- Kalonji

Conclusion

Polycystic Ovarian Syndrome (PCOS) remains a complex and multifactorial disorder that demands a holistic and patient-centred treatment approach. While conventional treatments like hormonal therapy and surgical interventions are often effective, they may lead to undesirable side effects and long-term complications. The Unani system of medicine offers a holistic and natural approach to managing conditions such as PCOS through its fourfold treatment plan: Ilaj Bil Tadbeer (regimental therapy), Ilaj Bil Giza (diet therapy), Ilaj Bil Dawa (medicinal therapy), and Ilaj Bil Yad (surgical therapy). Unlike modern medicine, which often comes with side effects, Unani therapy emphasizes lifestyle modifications, natural diets, and herbal formulations that aim to restore balance in the body with minimal adverse effects. The use of regimental methods like hijama, dietary regulation, emmenagogue herbs, and traditional techniques reflects the comprehensive and individualized care that Unani medicine provides. This has led many patients to turn towards Unani treatments as a safer, effective, and traditional alternative in the management of PCOS and related menstrual disorders.

Conflict of Interest

Not available.

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References

1. Konar H. DC Dutta's Textbook of Gynaecology. 6th ed. New Delhi: Jaypee Brothers Medical Publication (P) LTD; p. 459-462.
2. Hawkins and Brownie. Shaw's Textbook of Gynaecology. 17th ed. Elsevier LTD; 2011. p. 432-4.
3. Hoffman L, Schorge JO, Schaffer JI, Halvorson LM, Bradshaw KD, Cunningham FG. Williams Gynaecology. 2nd ed. McGraw-Hill Professional; 2012. p. 460-4.
4. Kollmann M, Martins WP, Raine-Fenning N. Terms and thresholds for the ultrasound evaluation of the ovaries in women with hyperandrogenic anovulation. Hum Reprod Update. 2014;20(3):463-4. doi:10.1093/humupd/dmu005. PMID: 24516084.
5. MediQ Learning, LLC. USMLE-Rx. 2014. "Stein-Leventhal syndrome, also known as polycystic ovary syndrome (PCOS), is a disorder characterized by hirsutism, obesity, and amenorrhea because of luteinizing hormone-resistant cystic ovaries."
6. Fauser BC, Diedrich K, Bouchard P, Domínguez F, Matzuk M, Franks S, *et al.* Contemporary genetic technologies and female reproduction. Hum Reprod Update. 2011;17(6):829-47. doi:10.1093/humupd/dmr033. PMC 3191938. PMID: 21896560.
7. Mirza S, Naaz SA, Alim SM. Management of Polycystic Ovarian Syndrome (Keesa-e-Khusyatur Rehm): Unani Perspective. JTD, Deoband, District Saharanpur, India. Deptt. Amraz-e-Niswan wa Atfal, AKTC, AMU, Aligarh, India. Unani Medical Officer, Bharatpur Govt. Of Rajasthan, India. [Journal information missing]
8. Ibn Sina. Al Qanoon Fil Tib. Kantoori GH, Urdu translator. New Delhi: Idarae Kitabul Shifa; 2010. p. 1065-70, 1445-7.
9. Jurjani AH. Zakheerae Khwarzam Shahi. Khan AH, Urdu translator. Vol VI & VIII. New Delhi: Idarae Kitabul Shifa; 2010. p. 27-8, 606-9.
10. Hamdani KH. Usoole Tibb. New Delhi: Khoumi Council Baraye Farogh Urdu Zaban; p. 398.
11. Kermani BDNI. Kulliyate Nafisi. Kabeeruddin, Urdu translator. Vol I & II. New Delhi: Idarae Kitabul Shifa; p. 269-70.
12. Wallace AM, Sattar. The Changing Role of the Clinical Laboratory in the Investigation of Polycystic Ovarian Syndrome. J Clin Biochem Rev. 2007 Aug;28:79-92.
13. Razi ABZ. Al Hawi Fil Tib. Vol IX. New Delhi: CCRUM; 2001. p. 77-86, 90-1, 99-100, 102-3, 106-8, 110-1, 115-6.
14. Firdose KF, Shameem I. An approach to the management of poly cystic ovarian disease in Unani system of medicine: A review. [Journal information missing]
15. Rumaiza J, Razana MCN, Shifka WF. UNANI PERSPECTIVE OF POLYCYSTIC OVARIAN SYNDROME (MARZE-AKYAS-E-KHUSYATUR-REHM): A LITERATURE REVIEW. Institute of Indigenous Medicine, University of Colombo. [Journal information missing]
16. Grant P. Spearmint Herbal Tea has Significant

- Antiandrogen Effects in Polycystic Ovarian Syndrome- A Randomized Controlled Trial. *Phytother Res.* 2010;24:186-8.
17. Legro RS, Brzyski RG, Diamond MP, Coutifaris C, Schlaff WD, Casson P, *et al.* Letrozole versus Clomiphene for Infertility in Polycystic Ovary Syndrome. *N Engl J Med.* 2014;371:119-29.
 18. Lucidi RS. Polycystic Ovarian Syndrome. *eMedicine.* 2011 Oct 25. Available from: <https://emedicine.medscape.com/article/256806-overview> [Accessed 2011 Nov 19].
 19. Azziz R. Diagnosis of Polycystic Ovarian Syndrome: The Rotterdam Criteria Are Premature. *J Clin Endocrinol Metab.* 2006 Mar;91(3):781-5. doi:10.1210/jc.2005-2153. PMID: 16418211.
 20. Khan A. Al Akseer. Kabeeruddin, Urdu translator. New Delhi: Idarae Kitabus Shifa; 2011 Jan; p. 797-801.
 21. Firdose KF, Begum W, Shameem I. Clinical Evaluation of Qillat Tams and its Management with Unani Formulation. *Int Res J Med Sci.* 2013;1(11):1-8.
 22. Farzana A, Mubeen U, Tabasum H, Rehman H. Physiological perspective of Hirsutism in Unani Medicine: An Overview and Update. *Int J Herbal Med.* 2013;1(3):79-85.

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