

Acne Vulgaris (Buthur-e-Labaniyya): Bridging Unani and Modern Medical Perspectives — A Review Article

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Abstract :

Acne vulgaris, referred to in classical Unani literature as Buthur-e-Labaniyya (Arabic: pinhead-like eruptions resembling drops of milk), is one of the most common chronic disorders of the pilosebaceous unit, affecting the majority of adolescents worldwide and often persisting into adulthood. Unani scholars such as Ibn Sina, Zakariya Razi, Rabban Tabri and Akbar Arzani attributed the condition to derangement of humoral balance (Su-i-Mizaj), accumulation of Madda-e-Sadeediya (suppurative material), and obstruction of the sebaceous glands (Ghudud-e-Duhniyya) under the influence of excessive body heat and disturbed Balgham (phlegmatic humour). Modern dermatology, in contrast, explains the disease through follicular hyperkeratinization, increased sebum production, colonization by *Cutibacterium acnes*, inflammation, hormonal (androgenic) influence, and genetic predisposition. Both systems describe a comparable clinical progression, from comedones to papules, pustules, nodules and cysts, and both emphasise dietary correction, evacuation of morbid material or offending agents, and topical as well as systemic therapy. This review compiles the historical, epidemiological, etiopathogenic, clinical, preventive and therapeutic aspects of acne vulgaris as described in Unani and modern medical literature, and highlights the scope for an integrative approach that combines the humoral, dietary and detoxification principles of Unani medicine with the evidence-based pharmacological and procedural options of modern dermatology.

IndexTerms - Acne Vulgaris; Busoor-e-Labaniya; Unani Medicine; Sebaceous Gland (Ghudud-e-Duhniyya); *Cutibacterium acnes*; Balgham; Integrative Dermatology.

I. INTRODUCTION

The Unani System of Medicine is an age-old system of medicine which believes in the theory of Akhlat (humours). There are four types of humours, i.e. Dam (Blood), Balgham (Phlegm), Safra (Yellow bile) and Sauda (Black bile); any derangement in the quantity and quality of these four humours leads to disease. Diseases described in Unani medicine are of two types, either Maddi or Ghayr Maddi. The disease discussed here is called Pimples in English, Buthur-e-Labaniyya in Arabic, and Muhasa & Keel in Urdu. Under the name Buthur-i-Labaniyya, acne vulgaris is described, pathologically analysed, and treated in Unani literature. In Arabic, the words "Buthur" and "Laban" imply "boil" and "milk" respectively; the lesion is named for its resemblance to a drop of milk ^[1].

According to Unani literature, Busoor-e-Labaniya are described as white, pin-head sized cutaneous eruptions that typically appear on the nose and forehead, characterised by an appearance resembling small droplets of milk. Upon gentle compression, a whitish, greasy, semi-solid substance similar to coagulated oil is expressed from the lesions; these features are regarded as characteristic of Busoor-e-Labaniya in classical Unani texts ^[2].

These lesions commonly develop during adolescence and are most frequently distributed over the face, neck, shoulders and upper back. They are typically characterised by a red, firm and indurated base, reflecting the inflammatory nature of the lesion. When these eruptions mature, gentle compression results in the discharge of a small amount of pus along with a central keratinous plug (comedonal core), termed Keel ^[3].

Acne vulgaris is a chronic inflammatory disorder of the pilosebaceous unit in which follicular blockage, due to abnormal keratinisation, results in comedone formation. The blocked follicles subsequently become inflamed, producing acne lesions that may heal with scarring. It commonly appears during adolescence because hormonal changes at puberty stimulate the sebaceous glands, resulting in excessive sebum production. Although acne is generally associated with teenagers, it may continue into adult life or occasionally develop for the first time in adulthood. Besides causing visible skin lesions, acne can lead to permanent scarring and significantly affect an individual's self-esteem and quality of life ^[8].

2. HISTORICAL BACKGROUND

Unani physicians such as Ibn Sina (Avicenna), Zakariya Razi (Rhazes), Rabban Tabri, Akbar Arzani, Ibn Hubl, and Dau'd Antaki discussed the etiopathogenesis and clinical features of Busoor-e-Labaniya in their classical treatises. According to Ibn Sina, the main cause of this condition is Ma'da Sadeediya (suppurative or viscous material), formed when the latent vapours (Latif Bukharat) of the body move towards the skin's surface under favourable conditions; upon reaching the skin, these vapours condense and transform into viscous, suppurative material that cannot be resolved or expelled efficiently, leading to eruptions ^[6]. Hakeem Azam Khan (1315 A.D.) and other scholars also emphasised Maa'da Sadeediya as the primary pathological factor. The imbalance of body humours, especially the phlegmatic humour (Khilt-e-Balgham), is believed to lead to the formation of viscous pus causing these eruptions. Rabban Tabri vividly described the formation and rupture of pustules, explaining how pus and other morbid materials are expelled through the skin, and Kabeeruddin noted that recurrent pustules might leave scars, sometimes resulting in permanent hair loss in affected areas ^[3].

Zakariya Razi, in Al-Hawi, specifically addressed the occurrence of acne on the face and nose, while Ibn Sina's Al-Qanoon fit Tibb laid down a detailed explanation of the etiopathogenesis linked to Madda-e-Sadeediya and Bukharat (vapours). These scholars also highlighted environmental and dietary factors affecting the disease's progression ^[4].

According to Hakeem Mohammed Hasan Qarshi, the condition is characterised by eruptions that are red or white in colour, with size varying from a Dana-e-Khashkhash (poppy seed) to a pea ^[5].

In modern medicine, the term Acne Vulgaris originates from the Greek word "acme", meaning point, peak or the prime of life, and the Latin "vulgaris", meaning common — reflecting its high prevalence during adolescence, a period marked by hormonal surges and follicular inflammation ^[7].

3. EPIDEMIOLOGY

The prevalence of acne in adolescents is reported to be between 28.9% and 93.3%. It usually begins after ten years of age and lasts for 5–10 years, and may persist into adulthood. Its prevalence is reported equally in males and females. Globally, 650 million people are affected by acne, and according to the WHO, the specific prevalence of acne vulgaris was 9.4%, higher than that of any other skin disease ^[9].

Acne vulgaris is among the most prevalent dermatological disorders, affecting nearly all adolescents to varying degrees. It generally begins between 12 and 14 years of age. Females often develop acne earlier than males due to earlier puberty. Peak disease severity usually occurs between 16–17 years in females and 17–19 years in males. Although acne commonly improves after adolescence, a proportion of patients continue to experience persistent disease into adulthood ^[10].

Acne vulgaris is a chronic inflammatory disorder of the pilosebaceous unit characterised by the development of both inflammatory and non-inflammatory lesions. It commonly affects the face, chest, shoulders, and upper back due to the high density of sebaceous glands in these regions. Approximately one-fifth of patients experience severe acne that can result in permanent scarring. A positive family history significantly increases the likelihood of developing acne, suggesting a strong genetic predisposition; studies indicate that if both parents have acne, the risk in their offspring is substantially higher ^[11].

4. ETIOPATHOGENESIS

4.1 Unani Concept

According to the Unani system of medicine, Busoor-e-Labaniyya develops due to derangement of humoral balance (Su-i-Mizaj), defective composition (Su-i-Tarkeeb), and separation of continuity (Tafarruq-i-Ittisal). These abnormalities result in the formation and accumulation of Fasid Madda (morbid material). When the body's natural faculty (Tabiyat) fails to eliminate these waste products through normal channels, they are diverted towards the skin, leading to inflammatory eruptions known as Buthur. Under the influence of excessive body heat (Ifrat-e-Hararat), Lateef Bukharat condense into purulent material called Madda-e-Sadidiyya, which accumulates beneath the skin and obstructs the pores, eventually producing Busoor-e-Labaniyya ^[12].

Some Unani scholars attribute the disease to excessive production and retention of thick, viscous morbid material within the Ghudud-e-Duhniyya (sebaceous glands). Obstruction of glandular ducts prevents normal drainage, causing accumulation of whitish, oily material resembling milk. This retained material induces inflammation of the glands and surrounding tissue, resulting in papules and pustules. These lesions are more frequently observed during adolescence, when increased body heat facilitates the movement of morbid material towards the skin surface ^[1].

4.2 Modern Concept

In modern medicine, the pathogenesis of acne vulgaris is multifactorial and involves the following mechanisms:

1. Follicular Hyperkeratinisation: — The earliest event in acne development is abnormal keratinisation within the hair follicle. Increased proliferation and reduced shedding of keratinocytes lead to obstruction of the follicular opening, resulting in the formation of a microcomedone, the precursor for all acne lesions.
2. Increased Sebum Production: — Sebaceous gland activity increases during puberty under the influence of androgenic hormones, especially dihydrotestosterone (DHT). Excessive sebum production creates an ideal environment for bacterial colonisation and contributes to follicular blockage.

3. Colonisation by *Cutibacterium acnes*: — *Cutibacterium acnes* (formerly *Propionibacterium acnes*) is an anaerobic Gram-positive bacterium that normally inhabits sebaceous follicles. In acne, excessive sebum promotes bacterial proliferation; the organism produces lipases, proteases, and inflammatory mediators that degrade sebum triglycerides into free fatty acids and stimulate local inflammation.
4. Inflammation: — Inflammation plays a central role in acne pathogenesis. Bacterial antigens activate Toll-like receptors on immune cells, leading to release of pro-inflammatory cytokines such as IL-1, IL-8, IL-12, and TNF- α . Rupture of the follicular wall releases keratin, bacteria, and sebum into the surrounding dermis, resulting in papules, pustules, nodules, and cyst formation ^[13].
5. Hormonal Influence :— Androgens originating from the testes, ovaries, and adrenal glands stimulate sebaceous gland activity. In many patients, sebaceous glands exhibit increased sensitivity to normal circulating androgen levels rather than markedly elevated hormone concentrations; mild elevations of free testosterone and reduced sex hormone-binding globulin may contribute to acne in some females.
6. Genetic Factors :— Genetic predisposition plays a significant role in acne susceptibility. Family history and twin studies indicate that inherited factors influence sebaceous gland activity, androgen responsiveness, and inflammatory reactions ^[10].

4.3 Other Contributory Causes

- Living in a hot climate.
- Excessive exposure to sunlight.
- Consumption of heavy-to-digest foods.
- Menstrual irregularities or suppression of menstruation in girls.
- Pregnancy.
- Puberty (adolescence).
- Impaired digestion and blood impurities.
- Plethora (excess accumulation of blood in the body).
- Constipation.
- Suppression of bleeding from haemorrhoids.
- Onset of adolescence.
- Excessive consumption of sweet and oily/fatty foods.
- Hormonal imbalance.
- Excessive intake of hot and spicy foods. ^([15] [16] [17] [18])

5. CLINICAL MANIFESTATIONS:

5.1 Unani Classification

The Unani system of medicine classifies Busoor-e-Labaniya into six progressive stages, reflecting the severity of Balgham-induced lesions:

- Stage 1 — Microcomedones/Whiteheads: Small, milky pimples caused by Balgham accumulation, resembling milk droplets or solidified ghee (Muhasa), typically on the face.
- Stage 2 — Blackheads: Open comedones darkened by oxidation and debris, often on the forehead, cheeks, and nose, resulting from trapped Fasid Madda.
- Stage 3 — Papules/Acne Papulosa: Inflamed, red lesions with mild pain, caused by *C. acnes* activity and humoral imbalance, indicating progression of Balgham pathology.
- Stage 4 — Pustules/Acne Pustulosa: Pus-filled lesions from secondary infections, often staphylococcal, reflecting advanced Madda-e-Sadidiya accumulation.
- Stage 5 — Nodules/Acne Indurata: Hard, persistent lesions formed from dried pus, indicating chronic inflammation and Balgham solidification.
- Stage 6 — Cysts/Acne Cystica: Severe, fluctuating lesions, including acne conglobata (sinus sores on the chest and back) and acne fulminans (ulcerated lesions with systemic symptoms like fever and malaise).

Scarring, including erythematous, hyperpigmented, and depressed types, results from the interplay of Tabiyat (natural faculty) and the viscosity of morbid matter, with solidification being the least favourable outcome, as noted by Hippocrates. Lesions are exacerbated by environmental factors (e.g., humidity, temperature) and poor digestion, which increase Balgham production, necessitating holistic interventions to address both symptoms and underlying causes.

5.2 Modern Classification

Acne vulgaris presents as polymorphic lesions, categorised into non-inflammatory and inflammatory types ^[7]:

Non-Inflammatory Lesions:

- Microcomedones: Precursor lesions caused by sebum and keratin accumulation within follicles.
- Open Comedones (Blackheads): Darkened due to melanin oxidation and debris, typically 5 mm or larger, commonly on the nose and forehead.
- Closed Comedones (Whiteheads): Flesh-coloured or white, 0.1–3 mm, with 75% progressing to inflammatory lesions.

Inflammatory Lesions:

- Papules: Small (<5 mm), inflamed nodules with erythema, often painful.
- Pustules: Pus-filled lesions with a yellow or white core, indicating bacterial involvement.
- Nodules: Hard, deep-seated lesions resulting from follicular breakdown and intense inflammation.
- Cysts: Large, fluctuating lesions prone to rupture, leading to abscesses and scarring. Severe variants like acne conglobata (sinus-forming sores) and acne fulminans (ulcerated lesions with systemic symptoms like fever and joint pain) are rare but debilitating.

6. UNANI TREATMENT:

6.1 Principles of Treatment

The principles of treatment in Unani medicine are ^[19]:

- Treatment of the underlying cause.
- Tanqiya (elimination of morbid material of the body and Dimagh/brain).
- Improvement of digestion (Islah-e-Meda) and correction of hepatic insufficiency (Islah-e-Jigar).
- Local application of Muhallil (anti-inflammatory), Mujaffif (desiccant), and Jali (detergent) drugs for cleansing.
- Avoiding Haar (hot) and Sakheel-Ghiza (heavy food items).
- In Ghalba-e-Khoon (excess of blood), Fasd (venesection) and Hijama (cupping) are recommended.
- In Fasad-e-Dam (impurities of blood), Musaffiyat (blood purifiers) are recommended.

6.2 Ilaj bil Ghiza (Dietotherapy):

Simple Shorba (gravy), chapati, and Barid (cold) vegetables are advised. Fruits such as apple, pear, pomegranate and orange, and vegetables such as Turayi, Kaddu, Palak and Shalgham should be given. Radi (waste), Fasid (putrefied), Baadi (flatulent), oily and sweet food items, oily and jaggery-based items, Maash (black gram), Gobhi (cauliflower), Matar (peas), Sharab (alcohol), and meat should be avoided ^{[7], [15]}.

6.3 Ilaj bil Tadbeer (Regimenal Therapy)

In cases of Ghalba-e-Khoon (predominance of blood), Fasd (venesection) of the cephalic vein (Sar ki Fasd) is recommended to reduce excess blood. Tanqiya-e-Badan (systemic evacuation) is carried out with Matbooq-e-Aftimoon to eliminate morbid humours from the body ^[16]. Tanqiya-e-Balgham (evacuation of phlegmatic humour) is performed to remove excess Balgham and restore humoral balance ^[17]. Facial steam therapy, applied twice daily, helps cleanse the skin, open the pores, and facilitate the removal of accumulated morbid material ^[3].

6.4 Ilaj bil Dawa (Pharmacotherapy)

Classical formulations for local application ^[4]:

- Maghz-e-Ghonchi Safed mixed with Roghan Kunjad, applied at night and washed off in the morning.
- Kharbaq (2 parts) + Bekhe Sosan (1 part) with Sirka.
- Shunez with Sirka.
- Saleekha mixed with Shahad (honey).
- Murdar Sang + Sibr Saqtoori, with Roghan Gul and Sirka.

Systemically, Musaffiyat (blood purifiers), Muhallilat (anti-inflammatory agents), Mujaffif (desiccants), and liver correctives are used ^{[16], [2], [3]}.

7. Prevention

Prevention of Buthur-e-Labaniyya (acne vulgaris) involves maintaining proper skin hygiene, a balanced diet, and healthy lifestyle habits. Regular cleansing of the skin helps remove excess sebum and impurities that may obstruct the sebaceous ducts ^{[2], [4]}. In Unani medicine, light and easily digestible foods are recommended, while hot, spicy, oily, and heavy diets should be avoided, as they may promote the formation of morbid humours ^{[2], [20]}. Correction of digestive disturbances such as Su-e-Hazm (indigestion) and Qabz (constipation) is also emphasised ^[12].

8. Modern Treatment

The management of acne vulgaris is based on the severity of the disease. Mild acne is generally treated with topical agents such as benzoyl peroxide, azelaic acid, and topical retinoids (tretinoin, adapalene, and tazarotene). Moderate acne often requires topical or oral antibiotics, while severe acne may need oral isotretinoin and selected surgical procedures ^[20].

8.1 General Measures

- Gentle cleansing of the skin twice daily.
- Avoid excessive use of cosmetics.
- Refrain from squeezing or picking acne lesions.
- Maintain regular bowel habits and consume a balanced diet rich in fruits and vegetables.
- Provide psychological support and counselling when required.

8.2 Pharmacological Treatment

Topical retinoids normalise follicular keratinisation and reduce comedone formation. Benzoyl peroxide and azelaic acid possess antimicrobial activity against *Cutibacterium acnes*. Topical antibiotics such as clindamycin and erythromycin are effective for mild to moderate inflammatory acne. Oral antibiotics, including doxycycline, minocycline, macrolides, clindamycin, trimethoprim-sulfamethoxazole, and quinolones, are indicated for moderate to severe or treatment-resistant cases.

8.3 Hormonal Therapy

Hormonal therapy is considered a second-line option for females with hyperandrogenism or hormonally mediated acne. Common agents include combined oral contraceptives, anti-androgens, estrogens, low-dose glucocorticoids, and GnRH agonists.

8.4 Procedural Treatment

Procedural interventions such as comedone extraction, chemical peels, intralesional corticosteroids, dermabrasion, microneedling, cryotherapy, laser and light therapies, dermal grafting, and soft tissue augmentation are mainly reserved for severe acne and acne scars.

9. Integrative Perspective

A comparative reading of Unani and modern medical literature shows that both systems converge on the same underlying process, though described in different conceptual language. What Unani scholars describe as obstruction of the Ghudud-e-Duhniyya (sebaceous glands) by thick, viscous, milk-like material closely parallels the modern description of follicular hyperkeratinisation and sebaceous blockage that produces the microcomedone^{[1], [13]}. Similarly, the Unani concept of Madda-e-Sadeediya accumulating beneath the skin under excessive body heat and disturbed Balgham finds a functional counterpart in the modern account of increased sebum production, colonisation by *Cutibacterium acnes*, and the resulting inflammatory cascade of cytokines that produce papules, pustules, nodules and cysts^{[6], [12], [13]}.

Both systems also describe an almost identical clinical progression, from comedones (Stage 1–2/microcomedones) to papules, pustules, nodules and cystic lesions, and both recognise scarring as a consequence of chronic or severe disease^{[3], [7]}. In management, the Unani emphasis on dietary correction (avoidance of heavy, oily, sweet and hot foods), systemic evacuation (Tanqiya) of morbid humours, and use of Musaffiyat (blood purifiers) mirrors the modern emphasis on lifestyle measures, correction of hormonal and bacterial contributors, and systemic pharmacotherapy^{[7], [15], [16], [20]}. Likewise, topical Unani formulations aimed at Muhallil (anti-inflammatory), Mujaffif (desiccant) and Jali (detergent) action serve a purpose comparable to modern topical retinoids, benzoyl peroxide and antimicrobial agents^{[4], [19], [20]}.

This convergence suggests that an integrative approach — combining Unani principles of dietary regulation, humoral correction and systemic detoxification with the evidence-based pharmacological and procedural options of modern dermatology — may offer a more holistic strategy for the management and prevention of acne vulgaris, addressing both the visible lesions and the underlying constitutional and lifestyle factors described across both systems.

IV. RESULTS AND DISCUSSION:

Acne vulgaris, known in Unani medicine as Buthur-e-Labaniyya or Busoor-e-Labaniya, is a chronic disorder of the pilosebaceous unit that has been recognised and described in detail since antiquity by scholars such as Ibn Sina, Zakariya Razi, Rabban Tabri and Akbar Arzani, and continues to be extensively studied in modern dermatology. While Unani medicine attributes the disease to humoral derangement, accumulation of morbid material, and obstruction of the sebaceous glands, modern medicine explains it through follicular hyperkeratinisation, excess sebum production, bacterial colonisation, inflammation, hormonal influence and genetic predisposition. Both systems describe a comparable staged clinical course and share overlapping principles of management, including dietary correction, evacuation or elimination of the causative/offending material, and topical and systemic therapy. Given this considerable conceptual overlap, an integrative approach drawing on the strengths of both Unani and modern medicine holds promise for more comprehensive and holistic management of acne vulgaris, and merits further systematic and clinical evaluation.

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