

SCABIES (JARAB): A COMPARATIVE REVIEW OF MODERN MEDICAL AND UNANI PERSPECTIVES ON ETIOPATHOGENESIS, CLINICAL FEATURES, AND MANAGEMENT

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Abstract: Scabies, known as Jarab in the Unani system of medicine, is a highly contagious and intensely pruritic skin infestation caused by the mite *Sarcoptes scabiei*. Despite the availability of effective modern therapeutic options, the disease continues to pose a significant clinical and public health challenge because of persistent transmission, frequent reinfestation, treatment failure, and the emergence of drug resistance. This review presents a comparative account of scabies from both modern medical and Unani perspectives, covering its historical evolution, epidemiology, etiopathogenesis, clinical manifestations, classification, diagnosis, differential diagnosis, complications, and management. In modern medicine, the disease is attributed to a delayed hypersensitivity reaction to the mite, its eggs, and faecal pellets, and is managed with scabicide agents such as lindane, permethrin, and ivermectin, together with antihistamines and hygienic measures. Classical Unani physicians, from Mohammad bin Tabri to Azam Khan, progressively described Jarab as arising from the retention of Akhlat-e-Faseda (morbid humours), particularly Fasad-e-Dam (impure blood), and outlined its management through Tanqiya-e-Badan (evacuation of morbid humours), Tasfiya-e-Dam (blood purification), and appropriate topical and systemic medicines. Both systems independently converge on the importance of personal hygiene, simultaneous treatment of close contacts, and prevention of reinfestation as central to disease control. Integrating the historical and humoral insights of Unani medicine with the diagnostic precision and pharmacological advances of modern medicine may offer a more comprehensive approach to the understanding and management of scabies.

IndexTerms – Scabies, Jarab, *Sarcoptes scabiei*, Unani medicine, Akhlat; Humours.

1. INTRODUCTION

Scabies is a contagious skin disease caused by the mite *Sarcoptes scabiei* and is commonly associated with poor living conditions and overcrowding. The disease is also frequently encountered in hospitals and nursing homes, where close person-to-person contact facilitates its transmission.^[1] Clinically, scabies is characterized by intense pruritus and the presence of characteristic burrows, with lesions predominantly involving the interdigital spaces, flexural areas, and genital region.^[2]

Recognizing its substantial global health burden, the World Health Organization designated scabies as a Neglected Tropical Disease in 2017, highlighting the need for strengthened public health measures, including timely diagnosis, effective treatment, and improved preventive strategies to reduce its global impact.^[3]

In the Unani system of medicine, scabies is known as Jarab, a communicable skin disorder characterized by severe itching and various eruptive skin lesions. Classical Unani literature attributes its development to the retention of Akhlat-e-Faseda (morbid humours), particularly Fasad-e-Dam (impure blood), and advocates Tanqiya-e-Badan (elimination of morbid humours), Tasfiya-e-Dam (blood purification), appropriate topical and systemic medications, and personal hygiene as the fundamental principles of management.^{[14][15][19]}

Despite the availability of effective therapeutic options, scabies continues to pose a significant clinical and public health challenge because of persistent transmission, frequent reinfestation, treatment failure, and the emergence of drug resistance. A comprehensive understanding of the disease from both modern and Unani perspectives may help bridge traditional knowledge with contemporary scientific evidence and support the development of more holistic management

strategies. Therefore, the present review aims to critically evaluate scabies (Jarab) from both modern and Unani perspectives, with particular emphasis on its etiopathogenesis, clinical manifestations, prevention, and management.

2. HISTORICAL EVOLUTION OF THE CONCEPT OF JARAB IN UNANI MEDICINE

Scabies has been recognized since ancient times and has been described extensively in the Unani system of medicine under the name **Jarab**. Classical Unani physicians made significant contributions to understanding the disease by documenting its causes, clinical manifestations, and principles of treatment. In Persian and Urdu literature, Jarab is also referred to as **Kar** and **Kharish**, respectively.^[19]

Among the earliest Unani physicians, Mohammad bin Tabri, in his treatise **Moalijat-e-Bugratia**, is regarded as one of the first scholars to describe the organism responsible for Jarab. His observations marked an important step in the early understanding of the disease and laid the groundwork for subsequent Unani scholars.^[15]

Ismail Jurjani further expanded the concept of Jarab by explaining that the disease develops as a result of putrefied blood, which is naturally driven towards the surface of the body by the body's own defensive mechanism. This description reflects the classical Unani belief that the body attempts to expel harmful substances through the skin.^[19]

Building upon these concepts, Ibn-e-Hubal Baghdadi (1091–1162 AD) considered **Mayiyat** (excessive fluidity) and **Balgham-e-Maleh** (salty phlegm) to be the principal factors responsible for the development of **Jarab-e-Ratab**.^[20] Similarly, Ibn-e-Zohar (1094–1162 AD) attributed the disease to **Khilt-e-Fasid** (deranged humours) and emphasized that its clinical manifestations differ according to the humour predominantly involved.^[21]

Ibn Rushd (1126–1198 AD) observed that heavy rainfall during the summer season was associated with the occurrence of severe itching among people living in the affected region. He also mentioned the use of topical sulphur as a therapeutic measure, a remedy that continues to hold clinical relevance even today.^[22]

Several centuries later, Akbar Arzani (1722 AD) described scabies under the Persian name **Kar** and presented its characteristic clinical features in detail. He also referred to a pathogenic organism known as **Heeban**, describing it as resembling the eggs of an ant and noting its presence particularly in chronic cases of Jarab.^[13]

The understanding of Jarab was further enriched by Azam Khan (1831–1902), who provided a comprehensive account of the disease, including its causes, clinical features, and detailed principles of treatment.^[23]

Collectively, these classical descriptions illustrate the gradual evolution of the Unani concept of Jarab over several centuries. Although the explanations were based on the prevailing humoral theory of their time, they demonstrate careful clinical observation and established the foundation for the traditional Unani approach to the diagnosis, prevention, and management of scabies. These concepts continue to influence contemporary Unani practice and provide valuable insights for integrative approaches to the disease.

3. EPIDEMIOLOGY

Scabies is a globally prevalent infestation affecting individuals of all ages, ethnicities, and socioeconomic groups. Its prevalence varies considerably, ranging from 4% to 100% in some developing countries. An infested individual usually harbors 3–50 egg-laying female mites, although the mite burden is substantially higher in crusted scabies. Transmission occurs primarily through close physical contact with an infested person or household members, while indirect transmission via contaminated fomites is most evident in crusted scabies because of its highly contagious nature. Consequently, individuals in close contact with affected patients are at increased risk of infestation. Studies have reported approximately 6,000 mites per gram of debris collected from bed linens, floors, curtains, and nearby furniture of patients with crusted scabies. Furthermore, live mites have also been recovered from dust samples collected from bedroom floors, upholstered chairs, and sofas in the homes of patients with ordinary scabies.^[4]

Several significant scabies pandemics have been reported in recent history. The most recent occurred between the mid-1960s and the early 1970s. Although the widespread outbreak eventually subsided, scabies has continued to occur intermittently, often as localized outbreaks. These smaller outbreaks are commonly seen among close contacts, particularly within households, nursing homes, and other institutional settings.^[5]

The prevalence of scabies tends to fluctuate in a cyclical pattern in many populations, with outbreaks often peaking every 15–20 years. This pattern has been attributed to the concept of herd immunity, which suggests that transmission

becomes more likely as a new generation of individuals with little or no immunity accumulates, making the population more susceptible to infestation.^[6]

The burden of scabies is particularly high in resource-limited communities. For example, a prevalence of 8.8% has been reported among residents of a Brazilian slum. Certain groups are at an increased risk of developing severe or atypical forms of the disease, including immunocompromised individuals, particularly those with HIV/AIDS, and patients with inherited disorders of keratinization. Scabies also occurs more frequently during the cooler months of the year, possibly because people spend more time in close contact indoors, thereby increasing opportunities for transmission.^[7]

4. ETIOPATHOGENESIS

4.1 MODERN PERSPECTIVE

Scabies is a skin infestation caused by the human itch mite, *Sarcoptes scabiei* var. *hominis*, which belongs to the family **Sarcoptidae** and class **Arachnida**. This mite is highly adapted to humans and rarely infests other hosts. It is tiny, pearly white, translucent, eyeless, and oval-shaped, with four pairs of short, stubby legs. The adult female measures about 0.4 × 0.3 mm, while the male is slightly smaller, making both mites almost impossible to see with the naked eye.

Although the mite depends on humans for survival, it can remain alive for up to 3 days away from the host under normal conditions and up to 7 days in mineral oil preparations. Scabies mites cannot fly or jump; they spread mainly through close skin-to-skin contact.^[4]

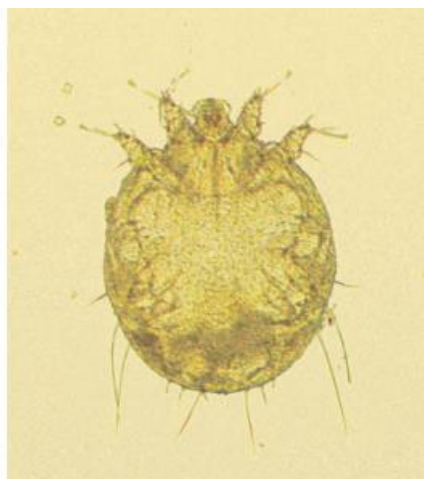


Fig.1

Fig.1 The adult female acarus (scabies mite)

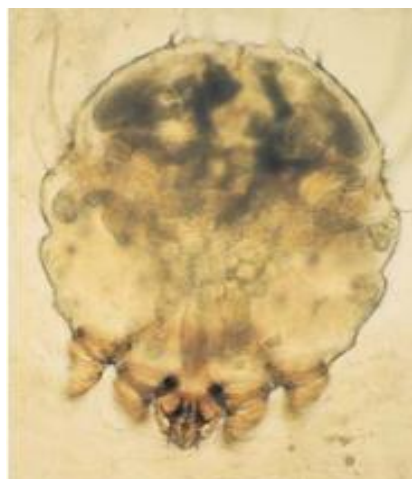


Fig.2

Fig.2 Scabies mite seen on microscopic examination of skin surface biopsy

Life Cycle of *Sarcoptes scabiei* var. *hominis*

The life cycle of *Sarcoptes scabiei* var. *hominis* is completed entirely on human skin. Following copulation, which occurs in shallow molting pockets on the skin surface, the fertilized female burrows into the **stratum corneum**, creating a slightly sloping tunnel at a rate of approximately **2 mm per day**. As she advances through the burrow, she deposits **2–3 eggs daily** throughout her lifespan of about **30 days**, after which she dies within the burrow.

The eggs hatch within **3–7 days**, releasing six-legged larvae that emerge from the burrow and migrate to the skin surface. The larvae then form shallow molting pockets in the superficial layer of the skin, where they undergo further development through nymphal stages. Within **14–21 days (2–3 weeks)** after the eggs are laid, they mature into adult mites. Adult male mites generally remain on the skin surface and enter the female's burrow or molting pockets for mating. After copulation, the male dies, while the fertilized female excavates a new burrow, thereby initiating another life cycle.^{[4][6][8]}

4.2 UNANI PERSPECTIVE ^[9]

The foundation of the Unani system is the four humour theory, which was developed by Hippocrates (460–377 BC). The fundamental cause of Jarab is a disturbance in the quantity or quality of one of the four humors dam(blood), Safra (yellow bile), Balgham (phlegm) or Sawda (black bile) which might result in the following causes.

1) Fasād -e-Akhlāt

It may be in various forms which result due to abnormality in normal akhlāt, these are.

Fasād -e-dam due to ihtiraq (derangement of blood because of burning):

Nearly all Unani physicians, including Tabri, Majoosi, Maseehi, Razi, and Ibn e Sina, have proposed that fasad-e-khoon (deranged blood) is the cause of Jarab. Some Unani scholars believe that severe itching will result if fasad-e-khoon is caused by Ratoobat-e-galeeza (thick consistency of blood) and also contains some Hiddat (heat). If ufoonat-e-dam (putrefaction of blood) causes fasad-e-khoon, it will result in Jarab-e-ratab, and if it is combined with Balgham-e-maaleh galeez, (thick salty phlegm) it will create intense itching and a burning sensation. According to Razi, fāasid ghiza (impure diet) which includes namkeen (salty), tursh (sour), hot and spicy dishes, and old wine is the main contributor to Jarab.

2) Unhygienic conditions:

Almost every Unani physician somewhere agreed that unhygienic condition can be considered as one of the commonest cause for any dermatological disease. Mohd Ayyub Israeli has very efficiently described the pathological picture of Jarab. He further says that madda-e-Jarab gets putrified when it gets accumulates beneath the skin for prolonged time and when body impurities mixes with madda-e-Jarab, microbes are produced, and result in itchy eruptions which appear on the body.

3) Microbes:

As far as the microbial theory and microbe of Jarab is concerned, the disease was keenly observed and delineated by the Arab physician Ahmad bin Mohd Tabri (980 AD) in his book Moalajat-e-Buqratiya. He described that Jarab is produced by an insect similar to lice.

4) Environmental Factor

According to Ibn Sina, the favourable season for spread of Jarab is khareef season (autumn season). Ibn e Rushd has described Jarab with reference to Hippocrates in his glorious book Kitab ul kulliyat that heavy rain fall in the summer season leads to manifestation of intense type of itching.

5. CLINICAL MANIFESTATIONS

5.1 MODERN PERSPECTIVE ^{[1][4][5][6][17]}

Scabies presents with characteristic symptoms and skin lesions that result primarily from a delayed hypersensitivity reaction to the mite, its eggs, and fecal pellets. The clinical features vary depending on the duration of infestation and the immune status of the affected individual.

1. Pruritus

- Intense itching is the hallmark symptom of scabies and is typically worse at night.
- During primary infestation, pruritus usually develops 4–6 weeks after exposure.
- In previously infested individuals, symptoms may appear within 1–2 days due to prior sensitization.
- Some individuals remain asymptomatic despite infestation and may act as carriers.

2. Primary Skin Lesions

- The burrow is the pathognomonic lesion of scabies.
- It appears as a thin, raised, grayish-white, linear or serpiginous tunnel measuring approximately 1–10 mm in length.
- Burrows are formed by the fertilized female mite as it tunnels through the stratum corneum to lay eggs.
- The burrow often terminates in a small papule or vesicle, and occasionally the mite can be seen as a tiny dark dot at its advancing end.



Fig.3 Scabies: Several thread like burrows



Fig.4 Scabies: Vesicles and Burrows

3. Secondary Skin Lesions

- Persistent scratching results in excoriations, eczematization, scaling, crusting, oozing, and prurigo-like papules.
- Secondary bacterial infection may further aggravate the lesions.



Fig.5 Scabies Secondary Lesion

4. Distribution of Lesions

- Lesions are usually symmetrical.
- Commonly affected sites include:
 - Interdigital web spaces
 - Sides of the fingers and hands
 - Flexor aspects of the wrists
 - Elbows
 - Anterior axillary folds
 - Areolae in women
 - Lower abdomen
 - Buttocks and gluteal folds
 - Penis, scrotum, and labia
 - Knees, ankles, and feet
- In healthy adults, the head and neck are usually spared.
- In infants, elderly individuals, and immunocompromised patients, lesions may also involve the face, scalp, palms, and soles.

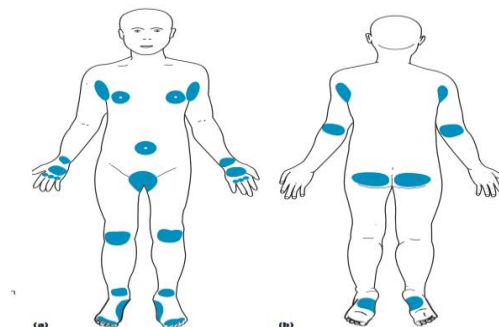


Fig.6 Diagrams showing sites of predilection for scabies infestation on (a) the front of the trunk and limbs, and (b) the back of the trunk and limbs.

5. Severe Clinical Forms

- Clinical severity depends largely on the host's immune status.
- Crusted (Norwegian) scabies occurs mainly in elderly, debilitated, and immunocompromised individuals. It is characterized by widespread hyperkeratotic and crusted plaques with a very high mite burden.
- Palms, soles, and nails are commonly affected, with nail thickening and dystrophy.
- Children may develop indurated nodules in intertriginous areas, while persistent erythematous nodules are frequently observed on the genitalia.



Fig.7



Fig.8

Fig.7 Crusted scabies. Hyperkeratotic plaques populated with thousands of mites

Fig.8 Severely crusted eruption due to scabies in an immunocompromised Child.

5.2 UNANI PERSPECTIVE ^{[10][11]}

According to classical Unani literature, **Jarab** is primarily characterized by **Hikka (intense itching)**, which is considered its most prominent clinical feature. The itching is persistent and becomes more severe with repeated scratching. Initially, the disease presents with **small eruptions (Basoor/Qurooh)** that gradually spread over the affected skin.

The appearance of these lesions varies according to the predominance of the **morbid humour (Khilt-e-Fāsid)**. In **Safrāwī Jarab**, the lesions are erythematous and are associated with intense itching and a burning sensation. **Saudāwī Jarab** is characterized by dark or blackish eruptions with a chronic and prolonged course, whereas **Balghamī Jarab** presents with pale or whitish eruptions that often contain serous or purulent fluid.

Persistent scratching may lead to **excoriations, burning, crust formation, and oozing** from the affected areas. In long-standing cases, the lesions may become **thickened, dry, and chronic**, while some patients may develop watery or purulent discharge from the eruptions. The lesions commonly involve the **interdigital spaces of the fingers**, although other parts of the body may also be affected, and generalized involvement can occur in severe cases. If left untreated, continued scratching and the persistence of morbid humours may result in **secondary ulceration and chronic skin changes**.

6. CLASSIFICATION OF SCABIES

6.1 MODERN PERSPECTIVE ^{[4][8][12]}

Scabies can be classified into the following clinical variants:

1. Classical (Typical) Scabies

The most common form of scabies, characterized by intense nocturnal pruritus, burrows, papules, and excoriations. Lesions typically involve the interdigital web spaces, wrists, axillae, areolae, lower abdomen, buttocks, and genitalia, while the face and scalp are usually spared in healthy adults.

2. Scabies in Clean Individuals (Scabies of the Clean)

This variant occurs in individuals with good personal hygiene. Patients usually have fewer lesions, which may occur at atypical sites, but experience disproportionately severe pruritus, making diagnosis more challenging.

3. Scabies Incognito

This form develops following the inappropriate use of topical or systemic corticosteroids, which suppress the inflammatory response and alter the classical appearance of lesions, often delaying diagnosis.

4. Nodular Scabies

Nodular scabies is considered a persistent hypersensitivity reaction to scabies antigens. It is characterized by persistent erythematous or reddish-brown pruritic nodules, most commonly affecting the scrotum, penis, and vulva. These nodules frequently persist even after successful eradication of the mites and may not contain live mites.

5. Genital Scabies

Genital scabies is characterized by pruritic inflammatory papules and nodules involving the penis and scrotum in males and the vulva in females. These lesions are highly suggestive of scabies and are considered clinically important diagnostic features.

6. Crusted (Norwegian) Scabies

Crusted scabies is a severe hyperinfestation caused by an impaired host immune response. It commonly affects elderly, debilitated, neurologically impaired, or immunocompromised individuals, including organ transplant recipients and patients receiving immunosuppressive therapy. It presents with extensive hyperkeratotic plaques, thick crusts, heavy scaling, nail dystrophy, and an extremely high mite burden. Lesions frequently involve the hands, scalp, face, trunk, palms, soles, and nails, while pruritus may be minimal or absent despite extensive disease.

7. Animal (Zoonotic) Scabies

This transient form occurs following close contact with infested animals. Patients develop pruritic papules resembling classical scabies; however, burrows are usually absent, and the condition is generally self-limiting because animal mites cannot complete their life cycle on human skin.

6.2 UNANI PERSPECTIVE

Classification of Jarab According to kaifiyat ^{[10][11][13][14][18]}

Jarab is classified into two types on the basis of Kaifiyat (properties) and the Nature of lesion

1. Jarab-e-Raṭab

In this type, the skin eruptions contain watery fluid or pus. On scratching, a yellowish or blackish-red fluid oozes from the lesions

2. Jarab-e-Yābis

In this type, no fluid or pus is discharged from the lesions on scratching. However, continuous scratching may produce dry red macules, and scab formation may occur.

Classification of Jarab According to Akhlat (Humours) ^[14]

Jarab is classified into three types on the basis of Akhlat (humours) in Sharḥ Asbāb

1. Jarab-e-Safrāwī

This type develops due to the predominance of Safrā (yellow bile). The eruptions are reddish in colour and are associated with intense itching, pain, and burning sensation.

2. Jarab-e-Balghamī

This variety is caused by the predominance of Balgham-e-Shor (salty phlegm). The skin eruptions are whitish in colour and are filled with watery fluid.

3. Jarab-e-Saudāwī

This type occurs due to the predominance of Saudā (black bile) in the blood. The eruptions are blackish in colour, while itching and pain are mild. The disease usually has a prolonged course

Classification of Jarab According to the Shape of Lesions ^[15]

In *Moalijat-e-Buqratiya*, Ahmed bin Mohammed Tabri classified Jarab into the following types.

1. Jarab-e-Dūdī

This type is caused by an organism resembling Sibyān (head lice). The lesions are large and associated with severe pain on scratching. They are closely arranged and may merge together to form a single large lesion.

2. Jarab-e-Nārī

In this type, the eruptions are bright red in colour. Although itching is present, it is not painful. On palpation, the affected area gives a sensation of hot vapours rising from the skin.

3. Jarab-ul-Kalb

This type presents with large eruptions that spread throughout the body and merge with one another, resembling Daad (ringworm). Some Unani physicians have stated that it occurs in both children and adults, with eruptions appearing behind the ears and accompanied by fluid discharge.

4. Jarab-e-Juzāmī

Jarab-e-Juzāmī is a form of Jarab-e-Saudāwī. It is characterized by large eruptions distributed over the body with the discharge of pus or blackish fluid.

5. Jarab Mutaqashuf

This type is characterized by deep and dry lesions associated with itching and irritation. It mostly resembles Khushk Khuji.

6. Jarab Muqmah

In this type, the lesions vary in shape and size, but their roots are deeply established.

7. Jarab Mutadaquq

This type is characterized by rough-surfaced lesions accompanied by itching and pain.

8. Jarab-e-Mabsūt

This type presents with large lesions that are deeply rooted and associated with itching and exudation.

7. DIAGNOSIS ^[5]

The diagnosis of scabies is primarily based on the identification of burrows, which are pathognomonic of the disease. Burrows appear as greyish-white, slightly raised, linear tracks measuring 1–4 mm in length and are typically found at the characteristic sites of infestation. Their number varies according to the severity of infestation and the patient's hygiene.

A definitive diagnosis is confirmed by demonstrating the mite, eggs, or fecal pellets through microscopic examination of skin scrapings, extraction of the mite from a burrow, or cyanoacrylate skin surface biopsy. As burrows may be difficult to detect, a compatible clinical presentation together with a history of itching among close contacts or family members strongly supports the diagnosis and justifies treatment when scabies is suspected. Differential diagnosis should be considered in all cases.

8. DIFFERENTIAL DIAGNOSIS ^[1]

- Pediculosis
- Atopic dermatitis
- Flea bites
- Seborrheic dermatitis
- Dermatitis herpetiformis
- Contact dermatitis
- Nummular eczema

- Syphilis
- Other insect infestation

9. COMPLICATIONS ^[8]

1. Eczematization: It is common in infants and young children. Involved areas of the extremities and trunk show erythema, oedema, vesiculation, oozing and crusting. The face is commonly involved in infants.

2. Secondary infection: Secondary bacterial infection (strepto-or staphylococcal) may occur in case of untreated scabies. The existing lesions turn into pustules and even bullae which when they burst are covered with yellowish crusts. Scratching results in excoriations.

3. Id eruption.

4. Urticaria.

5. Contact dermatitis to antiscabetic drugs.

10. MANAGEMENT

10.1 MODERN PERSPECTIVE

First Line

- Clothing, underwear, and towels used in the 48 hours before treatment must be laundered.
- Following a warm bath or shower, lindane lotion should be applied to all skin surfaces below the neck (can be applied to the face if area is infested); it should be washed off 8 to 12 hours after application. Repeat application 1 week later is usually sufficient to eradicate infestation.
- Pruritus generally abates 24 to 48 hours after treatment, but it can last up to 2 weeks; oral antihistamines are effective in decreasing postscabetic pruritus.
- Topical corticosteroid creams may hasten the resolution of secondary eczematous dermatitis. If the patient is a resident of an extended care facility, it is important to educate the patients, staff, family, and frequent visitors about scabies and the need to have full cooperation in treatment. Scabicide should be applied to all patients, staff, and frequent visitors, whether symptomatic or not; symptomatic family members of staff and visitors should also receive treatment.

Second Line

- Permethrin 5% cream is also effective with usually one treatment; it should be massaged into the skin from head to soles of feet; remove 8 to 14 hours later by washing. If living mites are present after 14 days, treat again.

Third Line

- A single dose (150-200 mcg/kg in 6-mg tablets) of ivermectin, an antihelminthic agent, is as effective as topical lindane for the treatment of scabies. It is the best treatment for generalized crusted scabies.

10.2 UNANI PERSPECTIVE

Principles of Treatment (Usool-e-Ilaj / Line of Treatment) ^[16]

According to Unani medicine, the management of Jarab is based on the following principles:

1. Identify and eliminate the underlying cause responsible for the disease.
2. Perform Fasd (venesection) in cases of excess Dam (blood).
3. Administer Musaffiyat (blood-purifying drugs) orally.
4. Use Gandhak (sulphur)-based formulations as part of the treatment.
5. Apply Musakkin (soothing) and Munawwim (anaesthetizing) agents locally in patients with intense itching.
6. Maintain personal hygiene throughout the course of treatment.
7. Keep the bed linen and fomites of the infected individual separate to prevent transmission.

TREATMENT (Ilaaj) ^[9]

Izala-e-Sabab

Treat and remove the cause which is responsible for Jarab(scabies).

1. Tanqiya-e-Khilt-e-Fasida (for evacuation of morbid humours)

- For the purpose of evacuation of morbid blood humours Venesection is advised. After that decoction of Chiraita (Swertia chirayita Roxb.) Sarphoka (Tephrosia purpurea Linn.), Gul-e-mundi (Sphaeranthus indicus Linn.), Shahtra (Fumaria indica Pugsley) and Unnab (Ziziphus jujuba Mill.) along with Sharbat Unnab 25 ml BD is advised.
- For the purpose of evacuation of morbid bilious humour decoction of Halela Zard 6gm, Sana Maki 6gm, Shahatra 6gm, and Afsanteen 6gm BD can be used.
- For the purpose of evacuation of morbid phlegm humour capsule of (Sibr, Turbud, Gariqoon, Shahm-e-Hanzal) is advised.
- For the purpose of evacuation of morbid black bile humour Joshanda Aftimoon is advised.

2. Musaffiyat-e-Dam (Blood purifier) and Mana-e-Ufoonat-e-Jild (Anti-infective)

- **Single drugs (Mufradat):**
A lot of single drugs like Shahtra (Fumaria indica Pugsley), Chiraita (Swertia chirayita Roxb.) Sarphoka (Tephrosia purpurea Linn.), Gul-e-mundi (Sphaeranthus indicus Linn.), and Unnab (Ziziphus jujuba Mill.) etc are used.
- **Compound drugs (Murakkabat):**
There are some compound drugs like Qurs Musaffi Khoon, Majoon Ushba, Sharbat Musaffi Murakkab, Sharbat Unnab, Sharbat Nilofer, Arq-e-Shahatra, Arq-e-Mundi etc. are mostly used in the treatment of Jarab (scabies).

3. Musakkinat-e-Jild (Sedative to the skin) and Mana-e-Ufoonat-e-Jild (Anti-infective) as local application

- Apply Roghan-e-Gul, Vineagar and Arq-e-Gulab each in equal quantity locally on effected sites.
- Apply Marham Safeda Kafoori for sedation.
- Apply Sandal, Murdarsang, Kafoor, leaves of henna, Shaham-e-Hanzal after mixing in Vineagar or Roghan locally.
- Apply Roghan-e-Gandum locally.
- Apply after mixing the powder of sulphur, Murdarsang, Tootia Sabz in the Roghan-e-Zard locally.
- It is advised to take bath with Neem water mixed with sulphur.

11. PREVENTION ^[4]

11.1 MODERN PERSPECTIVE

The following measures help reduce the risk of **reinfestation and transmission** of scabies:

- Treat all household members and close contacts simultaneously, as asymptomatic mite carriers are common within families.
- After treatment, wear clean clothing to minimize the risk of reinfestation.
- Wash all clothing, towels, pillowcases, and bed linen used during the previous week in hot water, followed by high-heat drying.
- Non-washable items should be dry-cleaned, ironed, tumble-dried without washing, or sealed in a plastic bag and kept in a warm place for two weeks.
- Vacuum floors, carpets, upholstered furniture, play areas, and car interiors thoroughly to remove mites from the environment.
- Fumigation of living spaces is not recommended.
- Pets do not require treatment, as they do not harbor the human scabies mite

11.2 UNANI PERSPECTIVE ^[14]

- Avoiding close contact with infected individuals is essential, as Jarab is a communicable disease transmitted through direct contact.
- Maintaining personal hygiene and cleanliness helps reduce the risk of infestation by limiting conditions that favor disease spread.

- Correction of humoral imbalance (*Islah-e-Akhlat*) is considered important for preventing recurrence of the disease.
- Avoiding factors that disturb humoral equilibrium is recommended to reduce susceptibility to Jarab.

12. INTEGRATIVE PERSPECTIVE

Viewed together, the modern and Unani descriptions of scabies are not contradictory but largely complementary, each contributing a different layer of understanding to the same clinical entity. The precise diagnostic and pharmacological framework of modern medicine, combined with the humoral, hygienic, and preventive principles of Unani medicine, offers scope for a more integrative approach to management. The Unani principles of Tanqiya-e-Badan and Tasfiya-e-Dam, together with topical soothing and anti-infective applications, may hold potential as adjuncts to standard scabicial therapy, particularly in addressing the secondary eczematization, pruritus, and skin irritation that commonly accompany scabies and its treatment.

Because scabies has been designated a Neglected Tropical Disease by the World Health Organization, with a disproportionate burden in resource-limited and overcrowded communities, the hygiene-centred and preventive orientation shared by both systems is of direct public health relevance. An integrative strategy that combines prompt diagnosis and scabicial treatment with reinforcement of personal hygiene, simultaneous treatment of household contacts, correction of humoral imbalance, and environmental decontamination, principles articulated in both the modern and Unani perspectives on prevention, may help reduce the persistent transmission and reinfestation that continue to challenge scabies control programmes.

For such integration to be clinically meaningful, however, the classical Unani formulations and procedures described in this review would need to be evaluated through standardised preparation and rigorous clinical study, so that their safety and efficacy as adjuncts to modern scabicial treatment can be established on the same evidentiary footing as existing therapies.

IV. RESULTS AND DISCUSSION

Scabies (Jarab) has been described in both modern and Unani medicine, although each system explains its pathogenesis through a different conceptual framework. Modern medicine identifies *Sarcoptes scabiei* as the causative agent, whereas Unani medicine attributes the disease to *Fasad-e-Dam* and *Akhlat-e-Faseda*. Interestingly, classical Unani physicians such as Mohammad bin Tabri and Akbar Arzani described organism-like causes of Jarab centuries before the microscopic identification of the mite, highlighting the remarkable observational skills of early scholars.

The historical evolution of the Unani concept of Jarab demonstrates a progressive refinement of knowledge, with successive physicians expanding its understanding of etiology, clinical presentation, environmental influences, and management. Despite their differing theoretical foundations, both systems recognize similar epidemiological factors, including overcrowding, poor hygiene, close physical contact, and environmental conditions, as important contributors to disease transmission. Likewise, both identify intense pruritus as the cardinal clinical feature and describe distinct clinical forms of the disease.

Although the therapeutic approaches differ, their objectives are complementary. Modern management primarily relies on standardized scabicial agents with established clinical efficacy, whereas Unani medicine adopts a holistic approach through correction of humoral imbalance, blood purification, regimental therapies, and topical herbal formulations. Preventive measures in both systems emphasize personal hygiene and avoidance of close contact with infected individuals, while Unani medicine additionally focuses on maintaining humoral balance to reduce the risk of recurrence. Overall, this review demonstrates that modern and Unani medicine provide complementary perspectives on scabies (Jarab). While modern medicine offers evidence-based diagnosis and treatment, the holistic principles of Unani medicine may provide valuable supportive strategies for disease prevention and management. However, further pharmacological investigations and well-designed clinical studies are required to validate classical Unani therapies and establish their role in evidence-based integrative management of scabies.

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