

Qulā' (Stomatitis): A Comparative Review of Unani and Modern Medical Perspectives on Etiopathogenesis, Classification, and Management

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ABSTRACT: Qulā' (stomatitis) is a common oral ulcerative disorder recognized in both Unani and modern systems of medicine, characterized by painful, superficial ulcerative lesions of the oral mucosa that interfere with eating, drinking, and speaking. In classical Unani literature, Qulā' is described under the concept of Tafarruq-i-Ittisāl, arising from the ascent of hot vapours (Bukharāt-e-Hārrah) from the stomach that lead to the formation of blisters (Naffāṭāt), which subsequently rupture to form ulcers. Eminent Unani physicians such as Ibn Sina, Najib al-Din Samarqandi, and Hakim Akbar Arzani classified these lesions according to the predominating humour, namely Damwi (sanguineous/red), Abyaz or Ratoobati (phlegmatic/white), Aswad (atrabilious/black), and Safrawi (bilious). In modern medicine, the corresponding and most prevalent presentation is recurrent aphthous stomatitis (RAS), reported in up to 30% of the general population, and classified as minor, major, and herpetiform types. Modern etiopathogenesis is considered multifactorial, involving genetic, immunological, microbial, nutritional, hormonal, psychological, and mechanical factors, whereas Unani causation (Asbāb) emphasizes humoral imbalance, indigestion, excessive heat in the blood, and irritant dietary habits. Management in modern medicine ranges from topical antiseptics, corticosteroids, and analgesics to systemic immunomodulatory agents in severe cases, while Unani management is based on Tanqiya-i-Mawād (evacuation of morbid humours), Ta'dīl-i-Mizāj (normalization of temperament), and the use of single and compound formulations along with dietary regulation (Ghidhā wa Parhez). This review compares both systems to highlight areas of conceptual convergence and to underline the potential of an integrative approach in the diagnosis and management of Qulā'/stomatitis.

IndexTerms - Qulā', Stomatitis, Recurrent Aphthous Stomatitis (RAS), Unani Medicine, Tafarruq-i-Ittisāl, Naffāṭāt, Akhlāt Arba'a, Integrative Medicine

INTRODUCTION

Qulā' is a common oral ulcerative disorder described in classical Unani literature under the concept of Tafarruq-i-Ittisāl, which denotes a loss of continuity of the oral mucosal surface. The condition is characterized by multiple superficial ulcerative lesions involving the mucous membrane of the mouth and tongue. According to classical Unani literature, Qulā' is believed to develop due to the ascent of hot vapours from the stomach to the oral cavity, resulting in the formation of Naffāṭāt (blisters), which subsequently rupture to form ulcers. Clinically, the Qula presents with redness or whitening of the oral mucosa, inflammation, and small blisters or papules that cause pain and discomfort during eating, drinking, and speaking ^{1,2}

The Arabic term Qulā' refers to superficial blisters affecting the oral mucous membrane. When these lesions become deep-seated and persistent, they are described as Qurūḥ-i-Khabītha Dahan. Some classical authors have considered Qulā' synonymous with Aphthae; however, according to Hāziq, chronic aphthous stomatitis associated with foul breath and oral ulceration is termed Akalat-ul-Fam (gangrenous stomatitis)¹. Furthermore, Hakim Akbar Arzani, in Tibb-e-Akbar, stated that oral pustules and sores (Busūr al-Fam) occur due to the predominance of blood mixed with a small quantity of Safrā' (yellow bile), producing severe pain and difficulty in chewing. Classical Unani physicians further classified these lesions according to the predominating humour and their colour as white (phlegmatic), yellow (bilious), red (sanguineous), and black (atrabilious), with the black variety regarded as the most severe.⁵

In Unani medicine, Qulā' is defined as Qurūḥ (ulcers) affecting the mucous membrane of the mouth (Muh) and tongue (Zubān). It is described under the concept of Tafarruq-i-Ittisāl, indicating a loss of continuity of the oral mucosal surface. Initially, superficial blisters (Naffāṭāt) develop, which rupture to form ulcers and may progress to Qurūḥ-i-Khabītha Dahan if deep-seated and

persistent.³ In modern medicine, the inflammatory disorder of the oral mucous membrane is called stomatitis. The most prevalent ulcer is recurrent aphthous ulcer (RAS), Aphthous ulcers are superficial and painful; they occur any part of the mouth.⁶

HISTORICAL BACKGROUND^{1,12}

The concept of Qulā' (stomatitis) has been described in classical Unani literature by eminent physicians. Ibn Sina (982–1087 CE), in his renowned treatise *Al-Qanun fi al-Tibb*, described Qulā' as Qurūḥ (ulcers) affecting the mucous membrane of the mouth (Muh) and tongue (Zabān) due to Fasād (derangement) of the Akhlāt Arba'a (four humours). He explained that the ascent of hot vapours (Bukharāt-e-Hārrah) from the stomach leads to the formation of Naftāt (vesicles), which subsequently rupture to form Qulā'. He further stated that when these ulcers become deep-seated and persistent, they are termed Qurūḥ-i-Khabītha.

Subsequently, Najib al-Din Samarqandi (c. 1222), in *Sharh-e-Asbab*, further elaborated the concept of Qulā', describing it as a Zakhām (wound) or Qurūḥ (ulcer) involving the superficial layer of the oral mucosa. He noted that the lesions may spread throughout the buccal cavity and, in severe cases, extend to the oesophagus. The condition is associated with pain, burning sensation, excessive salivation, halitosis, and a coated tongue.¹²

Epidemiology^{6,24}

Recurrent aphthous stomatitis (RAS) is one of the most common ulcerative conditions affecting the oral mucosa, with a reported prevalence of up to 30% in the general population.^{6,24}

The disease usually begins during childhood and occurs more frequently in females, particularly before menstruation. It is also reported more commonly in non-smokers. The frequency and number of recurrent episodes generally decline before the age of 40 years. A positive family history is often present, suggesting a familial tendency, although affected individuals usually do not exhibit any evidence of an underlying systemic disease.⁶

ETIOPATHOGENESIS²⁵

Modern Perspective

The exact etiopathogenesis of recurrent aphthous stomatitis (RAS) remains incompletely understood. Current evidence suggests that the condition is multifactorial, resulting from the interaction of genetic, immunological, environmental, nutritional, microbial, hormonal, psychological, and systemic factors.

Genetic predisposition: Genetic susceptibility plays an important role in RAS, with approximately 40% of affected individuals reporting a positive family history. Patients with hereditary predisposition tend to develop lesions at a younger age and often experience more severe and recurrent episodes.

Microbial factors: Although several microorganisms, including streptococci, herpes simplex virus (HSV), adenoviruses, varicella-zoster virus, and cytomegalovirus, have been investigated, there is no conclusive evidence supporting a direct infectious cause of RAS. Antiviral agents such as acyclovir have generally failed to prevent recurrences, suggesting that viral infections are unlikely to be the primary etiological factor. In some individuals, however, HSV reactivation may act as an immunological trigger rather than a direct cause of ulceration.

Nutritional deficiencies: Deficiencies of hematinic factors, particularly vitamin B12, folic acid, and iron, have been associated with RAS. These deficiencies occur more frequently in patients with recurrent ulcers than in healthy individuals, although findings vary among studies due to differences in dietary habits, genetic backgrounds, and study populations.

Psychological stress: Emotional stress and anxiety are recognized as important precipitating factors for RAS. Many patients report ulcer onset during periods of increased psychological stress. Stress may influence immune function directly or indirectly by promoting parafunctional habits such as cheek or lip biting, thereby increasing the risk of mucosal trauma.

Food hypersensitivity: Certain dietary components, including chocolate, coffee, nuts, strawberries, tomatoes, cheese, and gluten-containing foods, have been implicated as potential triggers in susceptible individuals. However, the relationship between food allergy and RAS remains inconsistent and appears to vary among patients.

Mechanical trauma: Local trauma to the oral mucosa, such as injury from sharp teeth, dental procedures, local anesthetic injections, or aggressive tooth brushing, may precipitate ulcer formation in susceptible individuals. Reduced salivary protection may further increase mucosal vulnerability by decreasing lubrication and impairing the barrier against mechanical injury and antigenic exposure.

Tobacco smoking: Epidemiological studies have consistently reported a lower prevalence and severity of RAS among smokers compared with nonsmokers. Some individuals develop ulcers after smoking cessation, while nicotine replacement therapy has been reported to reduce ulcer frequency in selected cases. The protective effect is thought to be related to nicotine-induced changes in oral mucosal keratinization and immune responses.

Immunopathogenesis: Immune dysregulation is considered central to the pathogenesis of RAS. Patients demonstrate alterations in cell-mediated immunity, including increased T-helper lymphocyte activity, reduced T-suppressor cell function, elevated antibody-dependent cellular cytotoxicity, and increased serum immunoglobulin levels. Histopathological studies consistently reveal infiltration of activated T lymphocytes around ulcerative lesions, supporting the concept that RAS represents an abnormal cell-mediated immune response in genetically susceptible individuals. Despite extensive research, the precise immunological mechanisms remain incompletely defined.

Hormonal influences: Hormonal fluctuations appear to contribute to ulcer development in a subset of women. Lesions may recur during the menstrual cycle, particularly around menstruation or the luteal phase, while remission during pregnancy and recurrence after childbirth have also been reported. Evidence linking RAS with menopause remains inconclusive.

Drug-induced ulcers: Several medications, including nonsteroidal anti-inflammatory drugs (NSAIDs) and β -blockers, have been associated with aphthous-like oral ulceration. These lesions typically resolve following discontinuation of the offending medication.

Systemic diseases: RAS-like ulcers may occur as manifestations of systemic disorders such as Behçet's disease, celiac disease, Crohn's disease, ulcerative colitis, and HIV infection. Oral ulceration may precede the gastrointestinal manifestations of celiac and Crohn's disease, making recurrent oral ulcers an important clinical indicator warranting further systemic evaluation when accompanied by suggestive symptoms

Unani Perspective^{1,15}

According to Ibn-e-Sina's book *Alqanoon-fit-tib*, Qulā' is the Qurūh (ulcer) of the outermost layer of the mouth that disturbs any Akhlāt Arba'a. In *Moalijat-e-Buqratiya Qulā'*, Abdul Hassan Ahemad bin Mohmmad Tabri defines Qulā' as mouth wounds that lead to the development of tiny ulcers in the mouth and tongue. These ulcers are caused by the hiddat of Şafrā' in blood.

CAUSES (ASBAB) ACCORDING TO UNANI^{1,2,3,4,5,7}

- Occurs commonly in nursing infants, especially during the teething period.
- More frequent in infants fed cow's milk, goat's milk, or commercially available milk instead of breast milk.
- Indigestion (Bad Hazmi) is considered a major cause.
- Disorders of the stomach and digestive tract.
- May also occur in adults suffering from Naqras (gout).
- Inflammation of the mouth, throat, or nose.
- Associated with scarlet fever and malaria.
- Excessive intake of salty, sour, hot, spicy, and irritating foods.
- Use of tobacco, cigarettes, betel nut, red chilli, and mercury.
- Constipation.
- Decayed tooth causing local irritation.
- Spread of inflammation from the nose or throat to the oral cavity.
- Impurities of the blood.
- Excess of Milhi (saline) or Saudawi (melancholic) humors.
- Excessive heat (Hararat) in the blood.
- May occur in patients with gonorrhoea, syphilis, tuberculosis, or other chronic illnesses.
- May result from the internal use of mercurial preparations in the treatment of gonorrhoea or syphilis.
- In otherwise healthy individuals, an excess of blood (Dam) or heat (Hararat) is also considered a causative factor.

PREDISPOSING FACTOR^{8,9,10}

- Hot and spicy food.
- In children during eruption of teeth.
- Constipation.
- Use of corrosive (mercury, lead)
- Tobacco
- Cigarette (smoking)
- In some disease syphilis and gonorrhoea in which inner temperament of blood increase mostly in the late stages.
- The last stage of that disease that leads to general weakness e.g. TB.
- It is found in different type of fever e.g. malaria, measles etc.
- It is commonly found in humid season i.e. rainy season.
- In elderly person having gout.

CLASSIFICATION OF RECURRENT APHTHOUS STOMATITIS

Modern Perspective¹³

Minor RAS: Minor RAS is the most prevalent form and typically occurs in patients who are 5 to 19 years old. Outbreaks are characterized by a few, superficial, round ulcerations that are <10mm and accompanied by a gray pseudo membrane and erythematous halo. Minor aphthae are usually confined to the lips, tongue, and buccal mucosa.

Major RAS: Major RAS has a wider distribution (commonly extending to the gingiva and pharyngeal mucosa), is larger in size (>10mm), and has a longer duration of outbreak. Minor aphthae typically resolve within 14 days of presentation, whereas major aphthae may persist for over six weeks. Further, major aphthae pose a significant scarring risk as well.

Herpetiform RAS: Herpetiform RAS presents with dozens of small, deep ulcers that often coalesce and therefore present as large ulcers with an irregular contour. Outbreaks are nonscarring and typically resolve within one month. Regardless of the subtype, RAS lesions can impair one's ability to effectively speak, swallow, and maintain dental hygiene¹³

Unani Perspective^{5,12,15}

1. **Qulla-e-Damwi** (Red ulcers) — It is formed due to imbalance in humour Damwi. Its signs are red & hot ulcers and the surface of the ulcerated region is raised, reddish, foul-smelling; painful ulcers are formed in the palate and tongue. It occurs in fever and intake of hot, spicy food. Other Atibbas said it occurs due to intake of hot foods which causes dryness, thickness in blood — humoral imbalance.

2. **Qulla-e-Abyaz** (Qulla-e-Ratobati) — It is formed due to salted Balghami Ratoobat. Its signs are ulcers that are white and less painful. Mucous membrane of mouth becomes oedematous and swollen. It mostly occurs in small children (infants and toddlers) due to indigestion of milk. In this type slight pain is present, anorexia — loss of appetite is seen.

3. **Qulla-e-Aswad** (Black ulcers) — This type of Qulla is formed with acute combustion of black bile. Its symptoms are black tongue, more painful ulcer irritation, dryness & burning sensation are seen. In children it causes serious infection.

CLINICAL FEATURES OF RECURRENT APHTHOUS STOMATITIS

Modern Perspective¹³

- Recurrent, painful oral ulcer.
- Round or oval ulcers with a yellowish-white base and red halo.
- Commonly involve the labial/buccal mucosa, tongue, floor of the mouth, and soft palate.
- Pain increases during eating, drinking, and speaking.
- A burning or tingling sensation may occur before ulcer formation.
- Minor ulcers heal without scarring; major ulcers may heal with scarring.
- Lesions recur with symptom-free intervals

Unani Perspective^{3,4,5,7}

- Inflammation and pain of the oral cavity are the main presenting features.
- Eating, drinking, chewing, swallowing, and speaking become painful and difficult.
- Excessive salivation or drooling is commonly observed.
- Foul-smelling breath (halitosis) may be present.
- Mild fever may occur, often accompanied by restlessness and irritability.
- Loss of appetite and increased thirst are common symptoms.
- The tongue appears coated, red, and mildly swollen.
- The oral mucosa, including the gums, inner lips, cheeks, and tongue, becomes red and inflamed.
- Small vesicles, blisters, or ulcers develop on the oral mucosa, particularly on the lips, tongue, corners of the mouth, and beneath the tongue.
- In severe cases, the lesions may spread to the throat, esophagus, and stomach, causing greater difficulty in swallowing, speaking, and breathing.
- Vomiting and diarrhea may occur, especially in children.
- In debilitated children, the ulcers may enlarge and occasionally lead to tissue necrosis.

CLINICAL FEATURES OF DIFFERENT TYPES OF QULĀ'-I-DAHAN^{5,12,15}

Damwi

- Extreme pain.
- A burning feeling.
- Bad odour (halitosis).
- Having trouble masticating.
- Dysphagia.

Balghami

- Little discomfort with mild pain.
- Too much salivation.
- Loss of oral mucosa thickness.
- Blisters that are white in colour.

Sawdāwi

- This type of patient has an extremely uncommon complaint.
- Extreme discomfort, due to unbearable pain.
- Dry mouth.
- Halitosis.
- Upon examination, the oral mucosa shows a black ulcer.

Safrawi

- An intense scorching feeling of pain.
- Burning sensation that is extremely intense.
- Dysphonia.
- Dyspepsia.
- Dysphagia.

DIFFERENTIAL DIAGNOSIS OF RECURRENT APHTHOUS STOMATITIS (RAS)¹³

- Idiopathic: Recurrent aphthous stomatitis (RAS).
- Drug-induced disorders: Fixed drug eruption, linear IgA bullous dermatosis, drug-induced bullous pemphigoid, drug-induced pemphigus, Stevens–Johnson syndrome, and toxic epidermal necrolysis.

- Autoimmune and inflammatory diseases: Behçet disease, Crohn disease (orofacial granulomatosis), celiac disease, systemic lupus erythematosus, oral lichen planus, granulomatosis with polyangiitis, and linear IgA disease.
- Traumatic lesions: Ulceration caused by dental appliances, mechanical trauma, or necrotizing sialometaplasia.
- Hematological disorders: Iron deficiency anemia, neutropenia, and hypereosinophilic syndrome.
- Periodic fever syndromes: Cyclic neutropenia, PFAPA syndrome, Sweet syndrome, familial Mediterranean fever, and hyperimmunoglobulinemia D syndrome (HIDS).
- Vesiculobullous disorders: Pemphigus vulgaris, linear IgA disease, and erythema multiforme.
- Nutritional deficiencies: Deficiencies of iron, folate, zinc, and vitamins B1, B2, B6, and B12.
- Viral infections: Cocksackievirus A, herpes simplex virus, varicella-zoster virus, cytomegalovirus, Epstein–Barr virus, and human immunodeficiency virus (HIV).
- Bacterial infections: Tuberculosis and syphilis.
- Fungal infections: Coccidioidomycosis, cryptococcosis, and blastomycosis.
- Inherited disorders: Epidermolysis bullosa and chronic granulomatous disease.
- Other conditions: MAGIC syndrome, hormonal factors (including menstruation-associated ulcers), smoking, and oral malignancies¹³

MANAGEMENT^{6,24}

Modern Perspective — Topical Treatment (First-line)

- First-line treatment for most patients; aims to relieve pain, reduce inflammation, and promote healing.
- Chlorhexidine (0.2%) mouthwash/gel – antiseptic, reduces secondary infection.
- Triclosan – antiseptic, anti-inflammatory, and analgesic effects.
- Amlexanox (5%) – effective when used early; reduces pain, erythema, ulcer size, and healing time.
- Topical antibiotics (doxycycline, tetracycline, minocycline) – reduce pain and recurrence by inhibiting inflammatory enzymes.
- Topical corticosteroids (Triamcinolone, Fluocinolone, Clobetasol, Dexamethasone) – most effective local treatment; reduce pain, inflammation, and accelerate healing.
- Other options: Diclofenac + hyaluronic acid, hyaluronic acid gel, lidocaine/benzocaine, Nd:YAG laser, and natural agents such as quercetin, licorice, myrtle, and Damask rose.

Systemic Treatment (Second-line)

- Reserved for severe, extensive, or refractory RAS.
- Prednisone/Prednisolone – first-choice systemic therapy.
- Montelukast – effective alternative with fewer adverse effects.
- Colchicine – reduces recurrence but has more side effects.
- Pentoxifylline – second-line or adjunctive therapy.
- Thalidomide – highly effective in severe RAS but limited by serious adverse effects.
- Levamisole – decreases frequency, duration, and size of ulcers.
- Zinc sulfate, Clofazimine, and Potassium penicillin G have also shown beneficial effects in selected patients.

Unani Perspective — Ilaj and Usul-e-Ilaj (Principles of Treatment)¹⁴

- Treatment should begin with identifying and eliminating the underlying cause.
- If Mawād-i-Fāsida (morbid/vitiated humours) are responsible, Tanqiya-i-Mawād (evacuation of morbid matter) should be performed.
- In cases of Sū'i-i-Mizāj Sāda (simple derangement of temperament), treatment should focus on Ta'dīl-i-Mizāj (normalization of temperament).
- Cooling therapies are recommended for Sū'i-i-Mizāj Hārr (hot temperament), whereas warming therapies are indicated for Sū'i-i-Mizāj Bārid (cold temperament).

Mufrad Advia (Single Drugs) ¹⁴

- Aqirqarha (Anacyclus pyrethrum)
- Aqaqiya (Acacia arabica)
- Gil-e-Armani (Armenian bole)
- Gul-e-Surkh (Rosa damascena)
- Haldi (Curcuma longa)
- Kafoor (Cinnamomum camphora)
- Shubb-e-Yamani (Alum)
- Qaranfal (Syzygium aromaticum)
- Kabab Chini (Piper cubeba)
- Neem (Azadirachta indica)
- Zanjabeel (Zingiber officinale)
- Barg-e-Sudab (Ruta graveolens)

Murakkab Advia (Compound Formulations) ¹⁴

- Zaroor-e-Kath
- Zaroor-e-Qula
- Kushta-e-Khabs-ul-Hadeed
- Jawarish-e-Jalinoos
- Habb-e-Kabid Naushadri
- Jawarish-e-Mastagi
- Jawarish-e-Kamuni

GHIDHĀ WA PARHEZ (DIET AND DIETARY RESTRICTIONS) ^{4,7,12}

Recommended Diet

- Patients should be advised to consume a cooling, light, easily digestible, and nutritious diet.
- Milk, sago (Sagoodana), barley water (Āsh-e-Jow), and soft flatbread (Phulka) are recommended.
- Cooling vegetables such as spinach, purslane (Khurfa), apple gourd (Tinda), and bottle gourd (Kaddu) are considered beneficial.
- Well-cooked moong dal and arhar (pigeon pea) dal may also be included in the diet.

Dietary Restrictions

- Patients should avoid spicy, salty, sour, oily, and flatulence-producing foods, as these may aggravate the condition.

PREVENTION ²³

- Maintain good oral hygiene.
- Brush twice a day after meals.
- Eat fresh fruits and vegetables.
- Avoid too hot meals and beverages.
- Avoid smoking & tobacco chewing.
- Avoid salty, spicy, and citrus-based foods.

DISCUSSION

A comparative analysis of Qulā' as described in classical Unani texts and stomatitis/RAS as understood in modern medicine reveals notable conceptual parallels alongside distinct differences in framework and terminology. Both systems recognize the condition as a common, recurrent, and multifactorial ulcerative disorder of the oral mucosa that significantly impairs mastication, deglutition, and speech, and both acknowledge that the disorder tends to begin at a young age with a strong tendency toward familial/hereditary

predisposition — reflected in the modern concept of genetic susceptibility and in the classical emphasis on inherited humoral temperament.

Where the two systems diverge most clearly is in their explanatory models. Modern medicine attributes RAS to an interplay of immunological dysregulation, genetic susceptibility, nutritional deficiency, hormonal fluctuation, psychological stress, and mechanical trauma, without invoking a single unifying causative humour. Unani medicine, in contrast, situates the disease within the framework of Akhlāt Arba'a, viewing Qulā' as a manifestation of Fasād-i-Akhlāt or Sū'i-i-Mizāj, with the specific colour and behaviour of the ulcer (Damwi, Balghami, Sawdāwi, Safrawi) indicating the dominant morbid humour. Interestingly, several individual causative factors described in Unani texts — indigestion, excessive intake of hot/spicy/salty food, tobacco use, constipation, dental irritation, and systemic illnesses such as tuberculosis, syphilis, and gonorrhoea — find reasonable correspondence with modern observations on mechanical trauma, food hypersensitivity, tobacco's paradoxically protective mucosal effect, and RAS-like ulcers associated with systemic disease.

The classification systems also show a degree of overlap in severity grading rather than mechanism: the Unani division into Damwi (painful, red, hot), Balghami/Abyaz (mild, white, oedematous), Sawdāwi/Aswad (severe, black, necrotic-prone), and Safrawi (intensely burning) broadly mirrors the modern grading of minor, major, and herpetiform RAS in terms of pain severity, appearance, and prognosis — for instance, the severity and scarring tendency attributed to the "black" Sawdāwi type in Unani literature parallels the larger size, longer duration, and greater scarring risk described for major RAS in modern texts.

In management, both systems favour a first-line local/topical approach: modern medicine relies on antiseptic mouthwashes, topical corticosteroids, and analgesic gels, while Unani medicine employs single drugs (Mufrad Advia) such as Gul-e-Surkh, Kafoor, and Shabb-e-Yamani, along with compound formulations (Murakkab Advia) like Zaroor-e-Qula and Jawarish-e-Mastagi, many of which possess demonstrable anti-inflammatory, astringent, or antimicrobial properties. Both systems further converge strongly on dietary management — the Unani recommendation of a cooling, light, easily digestible diet with avoidance of spicy, salty, sour, and oily foods is consistent with modern dietary advice for RAS patients. Systemic Unani treatment through Tanqiya-i-Mawād (evacuation of morbid humours) may be viewed as conceptually analogous to modern systemic immunomodulatory therapy (corticosteroids, colchicine, thalidomide) reserved for severe or refractory disease, in that both aim to correct an underlying systemic derangement rather than merely treat the local lesion.

Taken together, this comparison suggests that while the theoretical basis of Qulā' in Unani medicine and RAS in modern medicine differ substantially, the clinical observations, grading of severity, and first-line topical/dietary management strategies show meaningful convergence. This overlap strengthens the rationale for an integrative approach, wherein Unani single and compound formulations — many of which are already reported to be clinically effective in open-label trials — may serve as safe, low-cost adjuncts or alternatives to conventional topical therapy, particularly for recurrent, mild-to-moderate presentations where long-term corticosteroid use is undesirable.

CONCLUSION

Qulā' (stomatitis) remains a common and clinically significant oral mucosal disorder in both Unani and modern medicine, with a shared recognition of its recurrent nature, multifactorial causation, and considerable impact on quality of life. While modern medicine offers a well-defined immunological and clinical classification along with evidence-based topical and systemic therapies, Unani medicine provides a complementary humoral framework with time-tested single and compound formulations and dietary regimens that address both the local lesion and the underlying temperamental derangement. Given the overlapping clinical features and management principles identified in this review, an integrative approach combining the diagnostic precision of modern medicine with the holistic, humour-based therapeutic and dietary strategies of Unani medicine may offer a safer and more comprehensive option for the management of recurrent Qulā'/stomatitis. Further well-designed clinical trials and pharmacological studies are warranted to scientifically validate classical Unani formulations and to establish standardized integrative treatment protocols for this widely prevalent condition.

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