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Case Report

Successful Treatment of Allergic Contact Dermatitis in Unani Medicine: A Case Report

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ABSTRACT

Allergic contact dermatitis (ACD) develops due to involvement of immunological pathway, being a type IV reaction to exogenous contact antigen. ACD manifest in acute form as erythema, oedema, papulo-vesiculation; in chronic form as itching, lichenified plaques. Plaques may associate with weeping, fissure and erosion. In Unani System of Medicine (USM) Nar-e-Farsi, resembling to features of eczema equivalent and include all variants. In USM various therapies like Moaddilate Dam (Blood purifier), Mohallil (Anti-inflammatory), immunomodulators are effectively used. Here we report a case study of 52 years old male admitted with itching, burning, oedema, oozing, fissuring and erythematous eruption over both legs for 1.5 months precipitated by application of prescribed ointment diagnosed as ACD,was treated with oral& topical Unani drugs.After50 days (35 days in IPD then 15 days in OPD basis)of treatment a significant improvement was observed and depicted here in photograph of the skin lesions.

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INTRODUCTION

Allergic contact dermatitis (ACD) is a common skin disease caused by a T-cell-mediated immune reaction to usually harmless allergens (Ashton, 2014). It is an inflammatory reaction occurring at the site of contact with allergen in sensitized individuals. It is characterized by redness, papules and vesicles, followed by scaling (Habif, 2018; Ashton, 2014). ACD causes dry skin due to involvement of immunological pathway, being a type-iv hypersensitive reaction, that causes eruption in only a few who come in contact with it (Jindal, 2019). Therefore, it is developed only in small proportion of patients exposed to the antigens (Habif, 2018), this differentiates ACD with the other types of eczema. Recent studies found that ACD could be responsible for 50 to 60% of occupational contact dermatitis (OCD) and 20 to 30 % of all occupational diseases. ACD affects approximately 20%of the adult population. In conventional medicine topical & systemic steroids, antibiotics, emollients and oral anti-histaminic are being prescribed (Khanna, 2016).

In Unani System of Medicine (USM), ACD is not described as such, instead *Nar-e-farsi* has been described, is an eruption on skin surface in which initially there is erythema, burning sensation followed by formation of papules along with itching on the affected site. The pathology, clinical presentation and the treatment of disease has equivalence and include all types of eczema. The cause of *Nare Farsi* are excessive production of abnormal *Safra* (yellow bile) or mixed with *Sauda* (black bile) and or *Sauda muhtariqa* (burned back bile) (Sina, 2007; Khan 1906: Qarshi, 2011).

Various therapies are used such as *Moaddilate Dam* (Blood purifier), *Mohallil* (Anti-inflammatory) and immunomodulators to normalize temperamental derangements, resolve inflammation and modulate the excessive allergies against allergens.

The objective of this paper is to provide an overview of the literature of ACD and to present a case study, management through USM.

MATERIALS AND METHODS

Case Report

A 52 years old male patient came to the Skin OPD with complained of skin itching, burning, oedema, oozing and erythematous eruption over both legs for1.5months. According to the patient, it is precipitated by a prescribed ointment with combination of povidone, iodine, ornidazole, applied for 3-4 weeks. Left leg is more affected than right leg. There is history of recurrent eczematous eruption on both legs for 5 years. There is also history of pain in legs during walking, mild to moderate type, non-radiating and localised to the lower leg for 5 years.

History of present illness

The patient was apparently well before 5 years then he gradually developed rashes over both lower legs and bilateral feet. Over a period of time, the patient developed itching and oozing. The itching was localized to the lower leg. He also complained of pain in both legs while walking, moderate type, non-radiating and localised to the lower leg.

History of past illness

There was no medical history of Diabetes, Hypertension and Tuberculosis. No history of any major surgery or trauma.

History of Allergy

There is no history of contact with industrial irritant, poisonous ivory and *Parthenium hysterophorus* grass.

Family History

There was no familial history of eczema and varicosity.

General physical examination

General appearance was fair; Cyanosis and icterus not present and Clubbing absent. Oral mucosa was normal pinkish and no sign of pharyngitis, tonsillitis and stomatitis.

Dermatological findings on examination

Erythematous thick scaly disseminated plaque type of lesions was present over both lower leg (left>Right) and dorsal feet. Oozing and fissuring was present.

Treatment

Patient was given both oral and topical treatment and was under observation for 35 days in our Hospital IPD and 15 days follow-up on OPD basis.

Oral

Decoction of *Joshanda Musaffi* (Table 3)12 gm, prepared freshly in water was given twice on empty stomach in the morning before breakfast and evening at around 5 PM. *Majoon Ushba* (Table 4) was given 7 gm twice a day after food with plain water. *Safoofe Satte Gilo* (Table 5) was given 4 gm twice a day after food with plain water.

Topical

Marham Marham Raal (Table 4) and dusting powder (*Kafoor* and *Sange Jarahat* in equal amount) was applied for local application twice a day with 2 hrs of gap between them. The patient was advised to elevate his leg end to 15^0 during his entire stay in the hospital.

Table 1: Signs and Symptoms Grading Scale (Left Leg).

S N	Sign/ Symptom	Baseline	7th Day	15th Day	35th Day	50th Day
1	Itching	3	3	2	1	1
2	Burning Sensation	2	1	1	0	0
3	Erythema	4	3	2	2	1
4	Pain	3	2	1	0	0
5	Oedema	2	2	1	1	0
6	Sanguine-ous Oozing	3	2	0	0	0
7	Fissuring	2	2	1	0	0

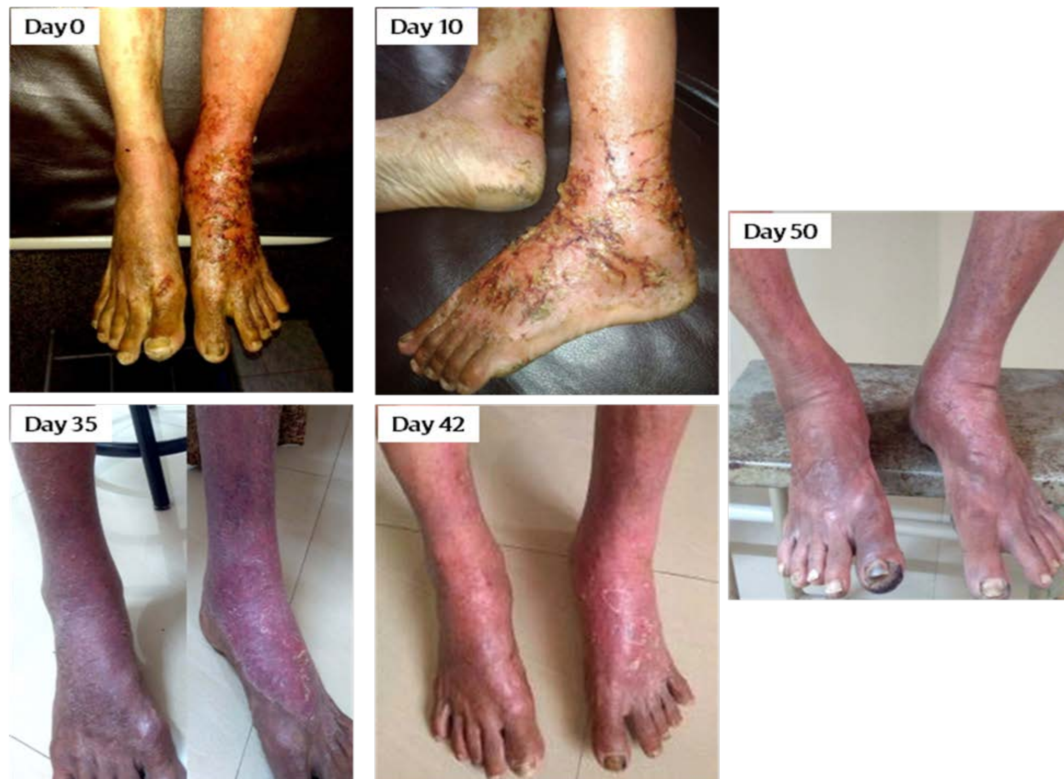
Table 2: Signs and Symptoms Grading Scale (Right Leg).

S N	Sign/Symptom	Baseline	7th Day	15th Day	35th Day	50th Day
1	Itching	3	2	1	1	1
2	Burning Sensation	1	1	0	0	0
3	Erythema	3	2	2	2	1
4	Pain	1	1	0	0	0
5	Oedema	1	1	0	0	0
6	Sanguineous Oozing	1	0	0	0	0
7	Fissuring	1	0	0	0	0

Table 3: Composition of *Joshanda Musaffi* (Anonymous, 2019; Hakeem, 2002; Ghani, YNM; Ibn-i-baitar, 2000)

Drug	Scientific name	Dose (g)
Shahatra	*Fumaria officinalis*	3 gm
Chiraita	*Swertiachirayita*	3 gm
GuleSurkh	*Rosadamascena*	3 gm
Berge Neem	*Azadirachtaindica*	3 gm

Figure: Photograph of lesion Day wise



RESULTS AND DISCUSSION

The patient was carefully observed daily. After 15 days of treatment oozing was completely reduced, Itching, burning, erythema, fissuring and pain were slightly reduced. After 35 days of treatment burning, oedema, fissuring and pain was subsided. Itchingand erythema were also reduced. After 50 days of treatment further improvement was observedand no recurrence and aggravation observed after discharged from IPD. (Table 1 & 2)

From the above result it is obvious that Unani treatment is very effective in the management of ACD. *Joshanda Musaffi* has ingredients like *Shahatra (Fumaria officinalis), Chiraita* (*Swertiachirayita*), *Gule Surkh (Rosa damascena)* and *Berge Neem* (*Azadirachta indica*). They all have *Muaddilate Dam* (Blood purifier)action and extensively used in various skin disorders. *Shahtara* eliminates *Mirrah Safra* and *Sauda Muhtariqa* through diuresis. *Chiraita* acts as blood purifier with *Mulattif* (demulcent), *Mujaffif* (desiccant) and *Qabiz* (astringent) properties. Berge Neem has *DafeTa' ffun* (antiseptic), *Muaddil Dam*, *Musakkin* (analgesic), *Muhallil* (anti-inflammatory) properties. Afteemoon (*Cuscuta reflexa*), Halela (*Terminalia chebula*), Balela (*Terminalia belerica*), Bisfaij (*Polypodium vulgare*) all have Mushile Sauda (black bile specific purgative) properties. Ushba (*Smilax officinalis*) has blood purifying and Mudirebol (diuretic) properties. Satte Gilo (*Tinospora cardifolia*) has an antioxidant and immunomodulatory properties. *Raal*

Table 4: Composition of *Majoon Ushba* (Khan, 1996)

Drug	Scientific name	Ratio (g)
Post halelazard	*Terminalia chebula*	17.5
Post halelakabuli	*Terminalia chebula*	17.5
Post balela	*Terminalia belerica*	17.5
Halelasiyah	*Terminalia chebula*	17.5
Shahtra	*Fumaria officinalis*	17.5
Bisfaij	*Polypodium vulgare*	17.5
Turbud	*Ipomoea turpethum*	17.5
Aftimoon	*Custareflexa*	17.5
Amla	*Emblicaofficinalis*	10.5
Burge Sana	*Cassia angustifolia*	35
Ushba	*Smilax officinalis*	60
Qandsafaid	Sugar	3 time of total drugs

Table 5: Composition of *Safoof Satte Gilo* (Anonymous, 2019)

Drug	Scientific name	Dose(g)
Gilo	*Tinospora cardifolia*	1
Tabasheer (Bamboomanna)	*Bambusabambos*	1
Dana Heele Kalan	*Amomum subulatum*	1
Dana Heele Khurd	*Elettaria cardamomum*	1

Table 6: Composition of *Marham Raal* (Anonymous, 2006)

Drug	Scientific name	Ratio (g)
Raal	Oleo Resin of *Shorearobusta*	10.5
Kafoor	*Cinnamomumcamphora*	10.5
Katha	Extract of *Acacia catechu*	10.5
Kunjad Oil	*Sesamum indicum*	60 ml

(Shore arobusta) has *Mundamile Qurooh* (wound healing), astringent and anti-inflammatory properties. Sange Jarahat (Alabaster) has Mujaffif (desiccant), *Habis-ud Dam* (Haemostatic) properties. *Kafoor (Cinnamomum camphora)* has antiseptic, analgesic, coolant and haemostatic properties. (Khan, 1906; Kabeeruddin, 2007; Hakeem, 2002; Ghani, YNM; Ibn-i-baitar; 2000, Khan, 1996; Anonymous, 2006; Kabiruddin, 2007, Anonymous, 2013)

CONCLUSION

It can be concluded from the result that Unani treatment was found effective and promising result in ACD with least side effects. However further clinical trials with large sample size should be carried out to further evaluate efficacy and safety of drugs.

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CONFLICT OF INTEREST

None Declared.

REFERENCES

Anonymous, Pharmacy Formulations, National Institute of Unani Medicine Bangalore:2019; p. 6.

Anonymous. National Formulary of Unani Medicine. Part1. New Delhi: Central Council for Research in Unani Medicine (CCRUM); 2006:p. 96.

Anonymous. Unani treatment for Nar-e-farsi and Daus Sadaf (Psoriasis). New Delhi: CCRUM,Ministry of Health and Family Welfare, Government of India; September 2013.

Ashton R, Leppard B, Cooper H. Differential diagnosis in dermatology. 4th ed. New York: CRC Press; 2014. p. 242.

Ghani N. Khazain-ul Advia. New Delhi:Idara Kitab-usShifa; YNM. p. 595,894, 1133, 1330

Habif TP, Dinulos JGH, Chapman MS, Zug KA. Skin Disease Diagnosis and Treatment. 4th ed. New York: Elsevier publications; 2018. p. 45-49.

Hakeem HMA. Bustan-ul Mufradat. New Delhi:Idara Kitab-usShifa; 2002. p. 230, 371, 490, 598.

Ibn-i-baitar ZABAM. JamiulMufradat al AdviawalAghzia. Vol. 3& 4. New Delhi:CCRUM. 2000. p. 108, 416.

Jindal S. Review of Dermatology. 3rd ed.New Delhi: Jaypee Brothers; 2019. p.291.

Kabiruddin H. Makhzan-ul Mufradat. New Delhi:Idara Kitab-usShifa; 2007. p. 183,279, 311, 350, 371, 410.

Kabiruddin H. Makhzan-ulMufradat. New Delhi:Idara Kitab-usShifa; 2007. p. 70-1, 110, 121-2, 268, 294, 311, 415.

Khan MA. Akseere Azam.Vol. iv. Lucknow: Matba Nami munshi naval Kishore;1906. p. 379-380.

Khan MA. Qarabadeene Azam (Urdu translation by Azmat Ali). New Delhi: Aijaz Publishing house; 1996. p. 576, 577.

Khanna N. Dermatology and sexually transmitted disease. 5th ed. New Delhi: Elsevier publications; 2016. p. 112-114.

Qarshi HMH. Jamia-ulHikmat. New Delhi: Aijaz Publication House; 2011. p. 990.

SinaI. Al Qanoon Fit Tib (Urdu Translation by Kantoori Sayed Ghulam Hasnain). New Delhi: IdaraKitabushShifa; 2007. p. 169, 170.