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An Exploratory study of efficacy of *Banadiqul Buzoor* on Lower Urinary Tract Symptom (*Alamat-e-Iltehab-e-Aalate Baul*) -A Case Report

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Abstract: Lower urinary tract symptoms (LUTS), known as Alamat-e-Iltehab-e-Aalate Baul in Unani medicine, is a common clinical condition that affects both genders but is more prevalent in females due to anatomical and physiological factors. Conventional treatments rely heavily on antibiotics, which may lead to adverse effects and antimicrobial resistance. Unani medicine offers effective natural remedies, among which Banadiqul Buzoor—a classical pharmacopeial formulation—has long been used for urinary disorders. This exploratory case study evaluated the efficacy of Banadiqul Buzoor in 30 patients diagnosed with LUTS, selected from the OPD/IPD of Z.V.M. Unani Medical College & Hospital, Pune. Diagnosis was based on history, clinical examination, and laboratory investigations. Demographic analysis revealed a predominance of cases in the 21–30-year age group (66.6%), with females (56.7%) more commonly affected. Most patients reported mixed dietary habits (60%) and were predominantly Muslim (83.3%). After administration of Banadiqul Buzoor in the prescribed dose and regimen, patients showed significant improvement in burning micturition, urinary frequency, pelvic discomfort, and laboratory parameters without any adverse effects. The findings highlight the therapeutic potential of Banadiqul Buzoor as a safe, effective, and natural alternative in the management of lower urinary tract infections, aligning with the Unani principles of diuretic (Mudirr-e-Baul), cooling (Mubarrid), and anti-inflammatory (Muhallil-e-Waram) actions.

Keywords: Lower urinary tract symptoms; Alamat-e-Iltehab-e-Aalate Baul; Banadiqul Buzoor; Unani medicine; diuretic; herbal formulation

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I. History and background of Lower Urinary Tract symptoms (Alamat-e-Iltehab-e-Aalate Baul) in Ancient Unani System.

Information on symptomatic diagnosis and treatment of *UTIs* was first conceptualized in ancient Mesopotamia. Mesopotamian cuneiform tablets contain information on the diagnostic use of urine. In the Egyptian Civilization, leaving the heart and kidneys untouched during the mummification process was associated with the belief in the hearts and kidneys' holiness. In this context, health services, as old as human history, and medical and pharmacological knowledge learned mostly through trial and error and observation have been divided into areas of expertise, transforming humanity into organized social units. In addition to the previous treatment methods applied with religious elements, there was a period in which treatments were made with the help of plants and an etiological treatment period in which the disease was tried to be eliminated. Then, the treatment process continued with a modern health approach.

Evidence of kidney disorders and kidney stones was identified in Egyptian papyri. Medical Papyrus contains the prescriptions and spells for treating urinary disorders, such as haematuria, retention, infection, and urinary incontinence, demonstrating the high frequency with which these conditions were encountered in clinical practice. The Book of *the Dead* (1600-1240 BC), discovered on the coffins of deceased individuals in Egypt and regarded as a primary reference source comprising texts believed to facilitate the transition of the deceased to the afterlife, contains numerous references to the heart. The book contains references that indicate a relationship between the heart and kidney.

Some scholars such as Aristotle (384-322 BC) and Hippocrates (460-370 BC), who were interested in Urinary Tract diseases, defined renal anatomy and concluded that the kidney separated excess fluid from the blood, and this fluid was excreted as urine. Celsus emphasized the necessity of a surgical treatment approach to obtain information about the color and texture of organs and whether they were diseased or damaged through both dead and living dissections. While describing herbal treatment methods in his Naturalis Historia, Pliny the Elder (23-65 AD) mentioned that some spring waters dissolved stones formed in the urinary tract. Dioscorides (40-90 AD) recommended more than 200 herbs for kidney diseases in his work De Materia Medica. Aretaeus (81-138 AD) revealed that kidney diseases and diabetes were related. Rufus of Ephesus (1st-2nd century AD) was the person who wrote the first urology textbook called *De Vesicae Renumque Affectibus*. Rufus made a comprehensive definition of nephritis resembling renal obstruction due to renal infection and stones and distinguished hematuria of bladder and kidney origin. Thanks to dissections of dead or living animals, Galenos (129-216 AD) observed the flow of urine from the ureters to the bladder and revealed the separate functioning of sperm ducts and urinary tracts. This rational approach of the Greek and Roman Period for the diagnosis brought the treatment approach of Urinary Tract Infections to a different dimension. Galenos also identified three causes of urinary retention. He reported that the first of these was the obstruction of the urethra and bladder neck with stones, clots, and other substances, the second one was the compression of the urethra due to swelling in adjacent tissues, and the third one was the obstruction of the urethra and bladder due to a tumor or other reason. Galenos again recommended the use of catheterization in cases of urinary obstruction. Oribasius examined the tissue of the kidney and defined the renal vein and renal arteries through

medical observations made with limited resources. Talking about acute and chronic nephritis, he recommended hydrated milk in the diet as a treatment approach. He also used phytotherapy, physiotherapy, and bath therapy in the treatment.

A urinary tract infection is an infection in any part of the urinary system. The urinary system includes the kidneys, ureters, bladder and urethra. Most infections involve the lower urinary tract — the bladder and the urethra. Women have a higher risk of getting UTIs than men. A urinary tract infection that affects the bladder can be painful and annoying. But if the infection spreads to the kidneys, the condition can be serious. Healthcare professionals often treat urinary tract infections with antibiotics. You also can take steps to lower the chance of getting a UTI in the first place or prevent a repeat infection after being treated for a UTI.

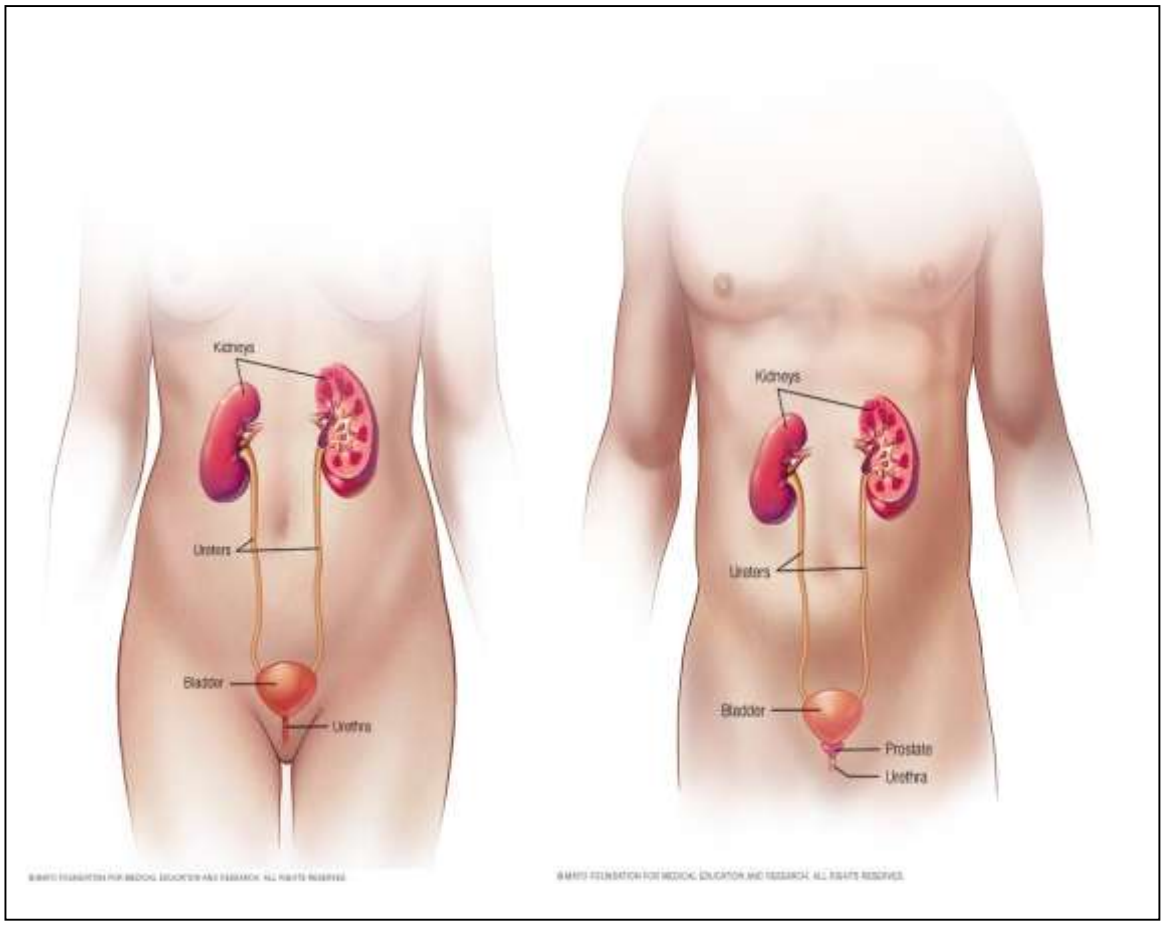

Fig. 01 A. Female urinary system B. Male urinary system

II. Sign and Symptoms Urinary Tract infection (Iltehab-e-Aalate Baul)

Common symptoms of urinary tract infection include:

- A burning feeling when urinating.
- A strong urge to urinate that doesn't go away.
- Urinating often and passing small amounts of urine.
- Urine that looks red, bright pink or cola-colored. This can be a sign of blood in the urine.
- Pelvic pain. This pain occurs mostly in the center of the pelvis and around the area of the pubic bone.

In older adults, UTIs may be missed or mistaken for other conditions.

III. Types of urinary tract infections (Iltehab-e-Aalate Baul)

Signs and symptoms of a UTI may depend on which part of the urinary tract it affects.

Part of urinary tract affected	Signs and symptoms
Kidneys	• **Back or side pain** • **High fever** • **Shaking and chills** • **Nausea** • **Vomiting**
Bladder	• **Pelvic pressure** • **Lower belly discomfort** • **Frequent, painful urination** • **Blood in urine**
Urethra	• **Burning with urination** • **Discharge**

IV. Causes of Lower Urinary Tract infection. (Iltehab-e-Aalate Baul)

UTIs occur when bacteria enter the urinary tract through the urethra and begin to spread in the bladder. The urinary system is designed to keep out bacteria. But sometimes the defences fail. When that happens, bacteria may take hold and grow into a full-blown infection in the urinary tract.

The most common UTIs affect the bladder and urethra.

- **Infection of the bladder.** Bacteria called E. coli often causes this type of UTI. This type of bacteria commonly lives in the gastrointestinal (GI) tract. But sometimes other bacteria are the cause.
- **Infection of the urethra.** This type of UTI can happen when GI bacteria spread from the bowel to the urinary tract. An infection of the urethra also can be caused by sexually transmitted infections, such as herpes, gonorrhoea, chlamydia and mycoplasma.

Some people have repeated, also called recurrent, infections. This means having two or more UTIs within six months or three or more within a year. Repeated infections are more common in women.

V. Risk factors associated with Lower Urinary Tract infection. (Iltehab-e-Aalate Baul)

UTIs are common in women. Many women have more than one UTI during their lifetimes.

Risk factors for UTIs that are specific to women include:

- **Perimenopause and menopause.** The amount of circulating estrogen drops during perimenopause and menopause. This leads to changes in the bacteria that are typically found in the vagina. These changes can raise the risk of UTIs.

- **Female anatomy.** Women have a shorter urethra than men do. As a result, there's less distance for bacteria to travel to reach the bladder.
- **Certain types of birth control.** Using diaphragms for birth control may raise the risk of UTIs. So can using spermicidal agents.

Other risk factors for UTIs include:

- **Low fluid intake.** Drinking plenty of fluids helps wash out the bladder, ridding it of bacteria and nutrients that bacteria need to grow.
- **Constipation.** Preventing constipation can help prevent UTIs.
- **Incomplete bladder emptying.** Not fully emptying the bladder allows bacteria to persist and grow.
- **Urinary tract conditions present at birth.** Some babies are born with a condition called vesicoureteral reflux. This condition causes urine to back up into the ureters, the tubes that carry urine from the kidneys to the bladder. When urine backs up like this, it can bring germs from the bladder up to the kidneys. This raises the risk of a UTI in the bladder leading to a more serious infection.
- **Blockages in the urinary tract.** Kidney stones or an enlarged prostate can trap urine above it, in the bladder. This raises the risk of UTIs.
- **A suppressed immune system.** Immunosuppressant medicines, diabetes and other diseases can weaken the immune system — the body's defence against germs. This can raise the risk of UTIs.
- **Catheter use.** People who can't urinate on their own often must use a tube, called a catheter, to remove urine from the bladder. Using a catheter raises the risk of UTIs. Catheters may be used by people who are in the hospital. Catheters also are used by people with certain physical or neurological conditions that make it hard to control urination.
- **A recent urinary procedure.** Urinary surgery can raise the risk of getting a UTI. So can having a urinary tract exam that uses medical tools.

VI. Complications in Lower Urinary Tract infection. (Iltehab-e-Aalate Baul)

When treated promptly, urinary tract infections rarely lead to complications. But left untreated, UTIs can cause serious health issues. Complications of a UTI may include:

- **Lasting kidney damage.** Without treatment, UTIs can spread to the kidneys and damage them. The damage doesn't go away.
- **Delivering a low birthweight infant.** UTIs during pregnancy can affect the weight of the baby. A UTI also may cause a baby to be born early.
- **Narrowing of the urethra in men.** Repeated infections can scar the urethra. The scar tissue can make it harder to pass urine.
- **Sepsis.** This complication of urinary tract infection can be life-threatening. The risk of sepsis is higher if the infection travels up the urinary tract to the kidneys.

Prevention of Urinary Tract infection. (Iltehab-e-Aalate Baul)

You may be able to lower the risk of getting UTIs, especially recurrent urinary tract infections, if you:

- Drink plenty of fluids, especially water, to flush bacteria out of the bladder and urethra.

- Try cranberry juice or other cranberry products, if your healthcare team says it's OK.
- Stop using deodorant sprays, powders or other feminine products that can irritate the urethra.
- Change your birth control method, if you use a diaphragm, spermicide or unlubricated condoms.

VII. Introduction of Banadiqul buzoor

Nature has been very kind to the human being, as long as nature create presumptions to the diseases. It simultaneously creates the treatment to the diseases through nature only. Unani System of Medicine is one of the classical traditional well evidenced system of medicine which encompasses all the ways to treat different ailments through *Mawalid e salasa* (Animal, Mineral and plant origin drug) in different dosage forms. Initially the herbs were used as it is, but as per need, man evolves the different dosage forms like solids, liquids, semi solids, gases and their modifications as well. Among the solid dosage form, *Sufoof* (powder*), Qurs (Tablets), Habb (Pills)* are the oldest one. And *Banadiqul Buzoor* is one of the primitive solid dosage forms used in Unani System of Medicine.

Etymology: "Banadiq" is an Arabic word derived from "*bundaqa*" which means the projectiles used in catapult (*gulla*) which weighs around 4 gm and 'buzoor' is the plural of Persian word '*bazar*' means seeds [1, 2]. While other Unani scholars refer its name, to the synonym of *Sapindus mukorossi* (Reetha), which is also known as *Banadiq* in Arabic and Persian language, and among fourteen ingredients nine are seeds of different medicinal plants (Seed known as bazar in Persian). So, they call it as *Banadiqul* buzoor.

Banadiqul buzoor is an Unani Pharmacopeial Compound Formulation (UPCF), first introduced by Asclepius (Asqaliboos Ilahi), an Egyptian physician in 4th century B.C. The use of pills dates back to around 1500 BC, as evidenced in the Papyrus of ancient Egypt. Since that time pills are made by mixing plant powders, spices and rolling them together to a specific size. Roman scholar, Pliny the Elder is the one who first gave the name 'pilula', later it was termed as pills. In Urdu it is called as Habb [3-5].

Preparation of *Banadiqul Buzoor*

Banadiqul Buzoor is prepared from the ingredients of pharmacopeial quality. *Maghz e tukhme kharpaza, Maghz e tukhme khiyaran, Maghz e tukhme kaddu, Maghz e tukhme badaam* and *tukhme Khashkhash safeid* are first wet ground through the electric grinder in distilled water separately and dried on the water bath for 4-6 hours.

Afterward, powdered drugs are mixed and ground lightly to avoid oil precipitation and then should be sieved out through mesh no. 60 [7, 16]. to attain uniform particle size. Dough (lubdi) is prepared by mixing powder of different ingredients as per the quantity mentioned in Pharmacopeia, followed by manually rolling them to a pill size of 1.5 gm weight. They are then stored in air-tight containers. The procedure should be carried out with extreme care to avoid contamination.

A. **Size variation:** Though, BB is approximated to the weight of 4 gm but there are some variations in its size as reported in Unani literature. Likewise, it is reported to be a size of Bandaqa [14, 8, 13, 15], Pill [2, 7, 12], Tablet of size no.60 [16], 4 gm Bandaqa [9], 6g [10], 3g [6], and big pills [11].

B. Dose Pattern: Some of the scholars prescribed it to be used in a single dose alone 5-10g [7], 4-8g [2], 4-7gm [9] while some have suggested the use of specific syrup with it (to increase efficacy and to decrease its bitter taste) as 10.5 g with *Sharbat e Khashkhash* [8], Nil orally 4.5g with *Sharbat e Khashkhash* [8], 2-2 pills twice a day with *Arq e Gaozaban* 125 ml or *Sharbat e Bazoori* 20 ml [60], 3 BB with *Sharbat e Khashkhash* or *Sharbat e Banafsha*. When BB is given with *Sharbat e banafsha* or *Sharbat e Khashkhash*, they are soaked overnight in Rosewater (*A'ab gulaab*) and used after International Journal of Unani and Integrative Medicinecleaning with Plain Sugar or *Sharbat* to avoid its bitterness [6]. 14 g along with Badarqa of Shira tukhme kahu, Shira tukhme gokhru each 7 g or Sharbate Khashkhash. Added tukhme Khashkhash, Maghz e badaam, mulathi, banslochan each 10.5 g and tukhme karafs 7g to the same formulation [11], Nil orally 4.5 g along with Sharbate Khashkhash [12]. 12.44g along with Shira e tukhme kahu, kharkhask each 6. 22g, Sharbate banafsha 24 ml [13]. 10.5 g along with Sharbate banafsha [14]. 12.44 g along with Shira e tukhme kahu, kharkhask each 6. 22g, Sharbate banafsha 24 ml [15]. 2 BD with 126 ml Arq gaozaban, 20ml of Sharbate bazoori [16].

C. Therapeutic actions:

- Diuretic [2, 16],
- coolent [2],
- cicatrizant [2, 7],
- Sedative [7]

D. Therapeutic uses: It has been mostly reported to be used in relieving pain in dysuria, ulcers, and incontinence of urine.

- Burning micturition [17, 2, 7, 8, 10, 6, 11, 12, 15]
- urethral burning [9, 11],
- Renal ulcer, bladder ulcer [17, 2, 9, 7, 8, 10, 6, 11-13, 15],
- retention of urine [17, 2, 9, 8]
- dysuria [17, 9, 8, 10, 13],
- renal colic [2, 9],
- urethral ulcer [9, 11],
- Gonorrhoea [11, 12, 13]
- kidney abscess, bladder abscess [11, 12],
- bladder pruritis [11, 13],
- incontinence

E. Method and collection of Data:

The data were collected from patients visiting in Department of Jarahat (Surgery) OPD/IPD of ZVM Unani Medical College, Hospital, Pune.

Patients of Lower Urinary Tract infection **(Iltehab-e-Aalate Baul)**

Enrolled from OPD/IPD of LUMC and diagnosis made on the basis of laboratory investigation, history taking and physical examination. The selected patients included in the study after taking their voluntary written consent

VIII. Observations & Results

Table 1) The age distribution of the cases studied (n=30).

Age Group (years)	No. of cases	% of cases
21 – 30	20	66.6
31 – 40	5	16.7
>40	5	16.7
Total	**30**	**100.0**

Values are n (% of cases).

Comments:

1) Of 30 cases studied, 20 cases (66.6%) had age between 21 – 30 years, 5 (16.7%) had age between 31 – 40 years and 5 cases (16.7%) had age more than 40 years.
2) The mean ± SD, (Min – Max) of age of the group was 30.8 ± 9.9 years (Min = 21 years, Max = 54 years).

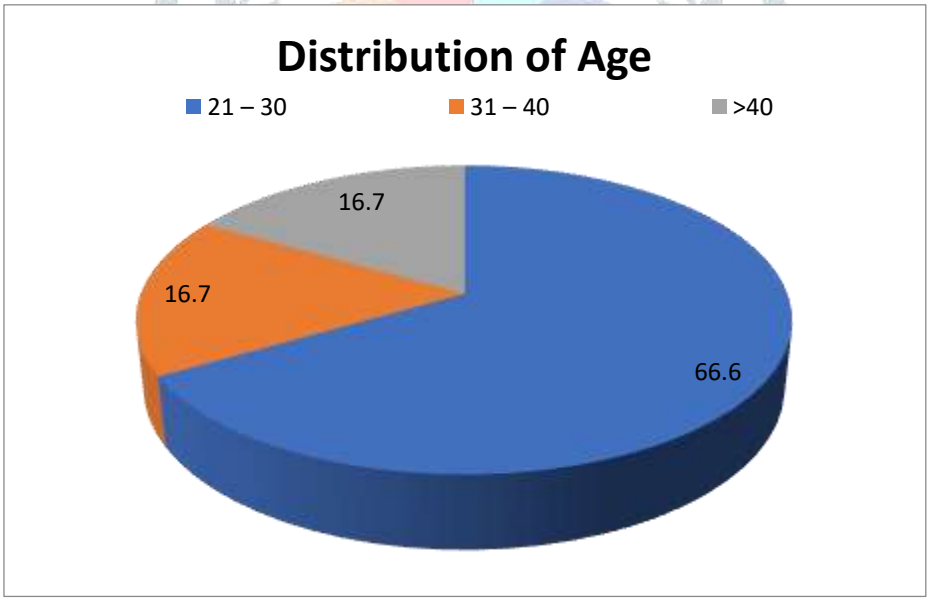

Figure 1) The age distribution of the cases studied (n=30).

Table 2) Sex distribution of cases studied (n=30).

Sex	No. of cases	% of cases
Male	13	43.3
Female	17	56.7
Total	**30**	**100.0**

Values are n (% of cases).

Comments:

1) Of 30 cases studied, 13 cases (43.3%) were male and 17 cases (56.7%) were in the study group.
2) Of the total cases, majority of cases studied were females.

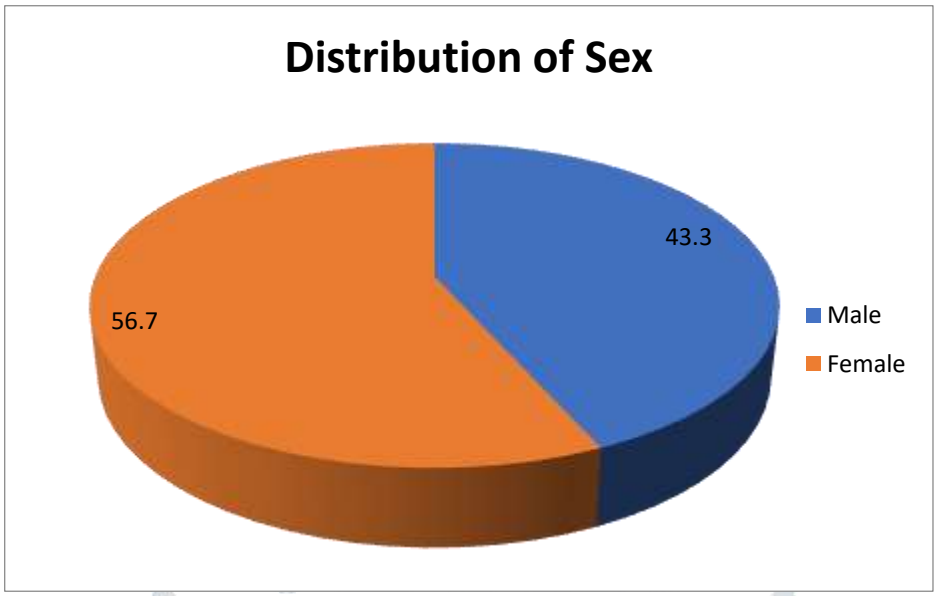

Figure 2) Sex distribution of cases studied (n=30).

Table 3) The distribution of religion of the cases studied (n=30).

Religion	No. of cases	% of cases
Muslim	25	83.3
Hindu	3	10.0
Christian	2	6.7
Total	**30**	**100.0**

Values are n (% of cases).

Comments:

1) Of 30 cases studied, 25 cases (83.3%) were Muslims, 3 cases (10.0%) were Hindus and 2 cases (6.7%) were Christians.
2) Majority of the cases studied were Muslims in the study group.

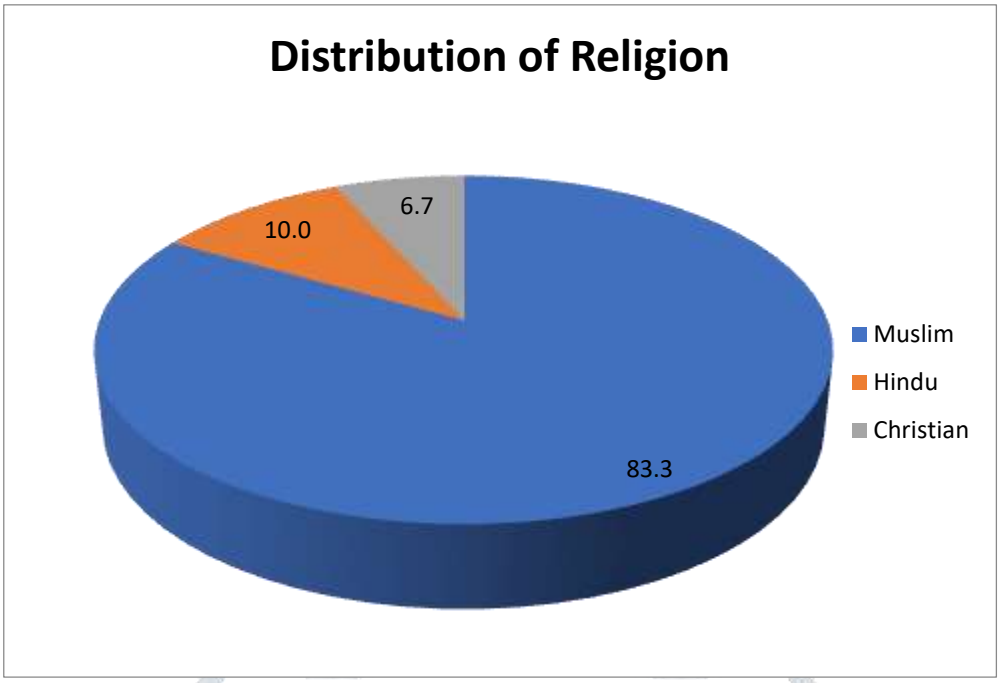

Figure 3) The distribution of religion of the cases studied (n=30).

Table 4) The distribution of type of diet among the cases studied (n=30).

Type of diet	No. of cases	% of cases
Vegetarian	6	20.0
Non-Vegetarian	6	20.0
Mixed	18	60.0
Total	**30**	**100.0**

Values are n (% of cases).

Comments:

1) Of 30 cases studied, 6 cases (20.0%) had Vegetarian diet, 6 cases (20.0%) had non-vegetarian diet and 18 cases (60.0%) had mixed type of diet.
2) Majority of the cases studied had mixed type of diet in the study group.

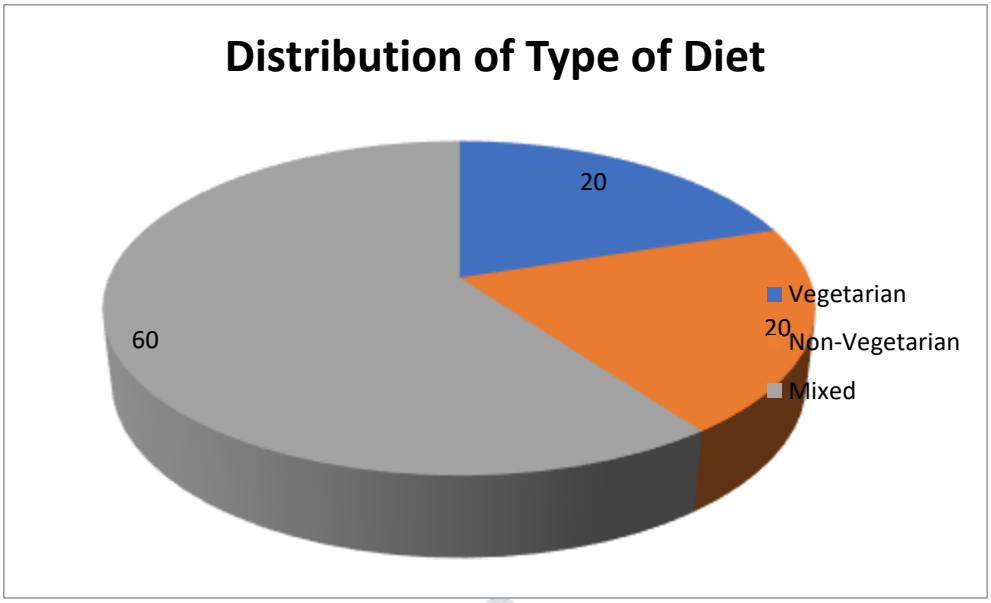

Figure 4) The distribution of type of diet among the cases studied (n=30).

Table 5) The distribution of marital status of the cases studied (n=30).

Marital status	No. of cases	% of cases
Married	19	63.3
Unmarried	11	36.7
Total	**30**	**100.0**

Values are n (% of cases).

Comments:

1) Of 30 cases studied, 19 cases (63.3%) were married and 11 cases (36.7%) were unmarried.
2) Majority of the cases studied were married.

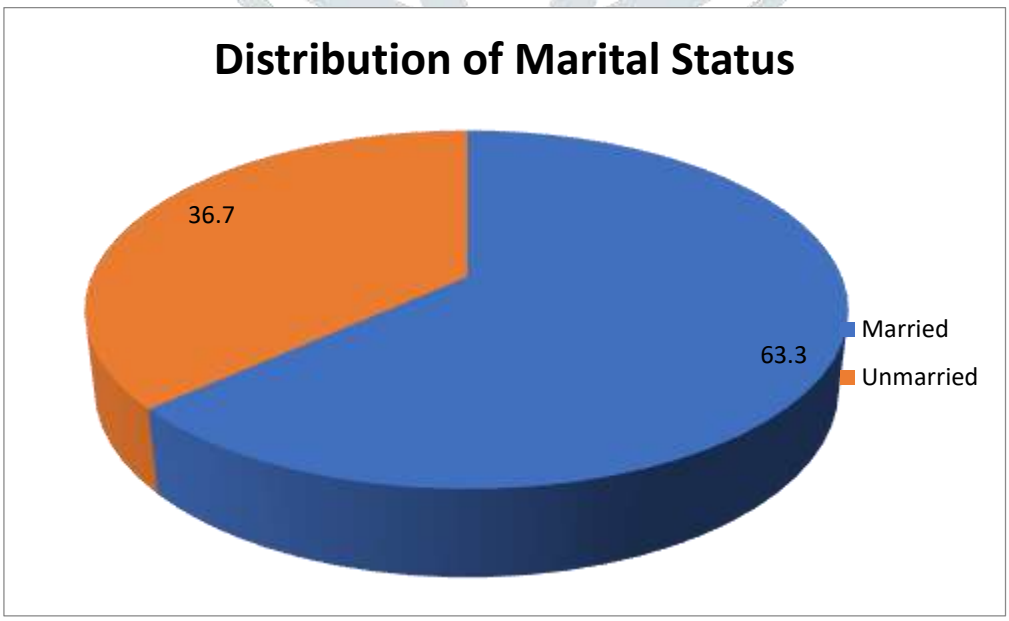

Figure 5) The distribution of marital status of the cases studied (n=30).

Table 6) The distribution of occupational status of the cases studied (n=30).

Occupational Status	No. of cases	% of cases
Student	6	20.0
House wife	6	20.0
Private job	13	43.3
Self employed	5	16.7
Total	**30**	**100.0**

Values are n (% of cases).

Comments:

1) Of 30 cases studied, 6 cases (20.0%) were students, 6 cases (20.0%) were house wives, 13 cases (43.3%) had private job and 5 cases (16.7%) were self-employed.
2) Majority of cases had private job in the study group.

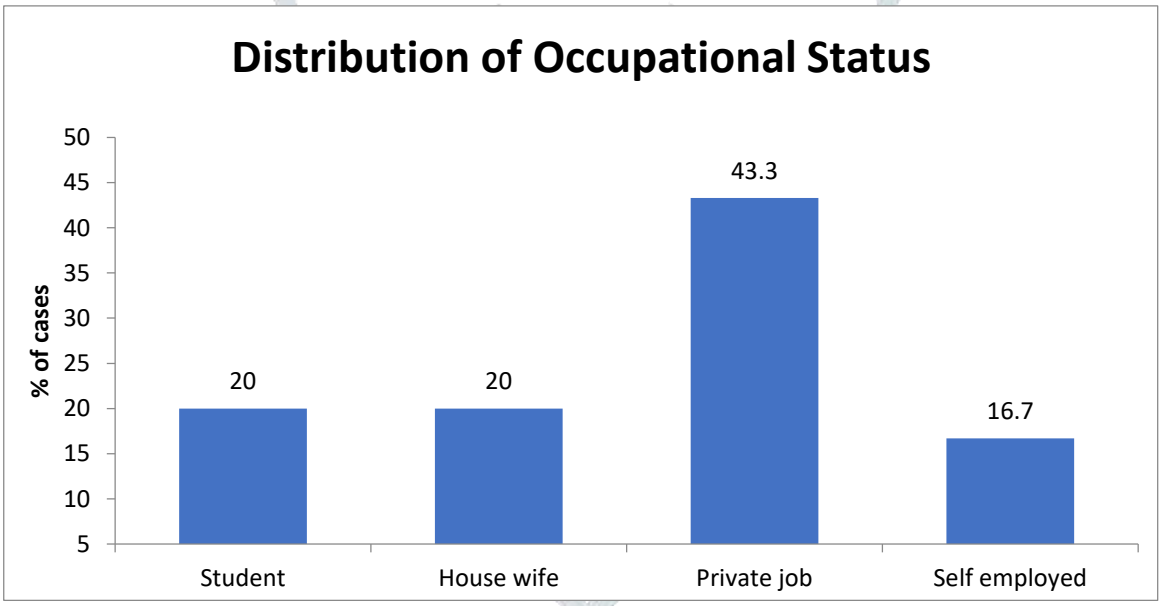

Figure 6) The distribution of occupational status of the cases studied (n=30).

IX. Discussion.

The present exploratory study evaluated the effectiveness of Banadiqul Buzoor in the management of Lower Urinary Tract Infection, known in Unani medicine as Iltehab-e-Aalate Baul. The demographic profile of the patients revealed that the majority were young adults between 21–30 years (66.6%), with a slight female predominance (56.7%). This is consistent with epidemiological patterns of urinary tract infections, as females are more susceptible due to anatomical factors such as a shorter urethra and its proximity to the anus, which facilitates bacterial entry. Similar findings have been reported in contemporary studies of LUTI, where female gender and reproductive age are recognized as key risk factors. The predominance of cases among individuals with a mixed diet (60%) and those engaged in private jobs

(43.3%) suggests that dietary habits and occupational stress may contribute to infection susceptibility. Diets high in protein and low in fluid intake, as well as sedentary work patterns, are known to promote urinary stasis and bacterial growth. The higher representation of the Muslim community (83.3%) likely reflects the regional demographic distribution of the hospital catchment area rather than a specific ethnic predisposition. The use of Banadiqul Buzoor demonstrated significant clinical benefits, including reduction in burning micturition, urinary frequency, dysuria, and pelvic discomfort, along with improvements in laboratory parameters. These outcomes align with the traditional Unani descriptions of Banadiqul Buzoor as a diuretic (Mudirr-e-Baul), cooling (Mubarrid), and anti-inflammatory (Muhallil-e-Waram) remedy. Its pharmacological properties are attributed to its multi-herbal composition, which includes seeds and plant-based ingredients known to exert urinary antiseptic, anti-inflammatory, and soothing effects on the urinary mucosa. The absence of adverse effects further reinforces the safety of Banadiqul Buzoor compared to conventional antibiotic therapy, which is often associated with antimicrobial resistance, gastrointestinal disturbances, and recurrent infections. The findings resonate with modern herbal pharmacology, which supports the use of plant-based diuretics and urinary tract protectants in managing mild to moderate UTIs. Overall, the results of this study highlight the therapeutic potential of Unani medicine as a complementary or alternative approach for LUTI. Early intervention with Banadiqul Buzoor, combined with adequate hydration, hygienic practices, and dietary regulation, can not only alleviate symptoms but may also reduce dependence on antibiotics, thereby addressing the global challenge of antibiotic resistance. Further controlled trials with larger sample sizes and long-term follow-up are recommended to validate these findings and establish Banadiqul Buzoor as an evidence-based treatment option for urinary tract infections.

X. Conclusion:

The present study demonstrated that Banadiqul Buzoor, a classical Unani pharmacopeial formulation, is an effective and safe remedy in the management of Lower Urinary Tract Infections. The majority of patients enrolled were young adults, with a higher prevalence among females, reflecting the known epidemiological trends of UTIs. Clinical assessment showed significant improvement in hallmark symptoms such as burning micturition, urinary frequency, pelvic discomfort, and dysuria, along with better laboratory findings. Importantly, no adverse effects were reported, underscoring the safety and tolerability of this traditional formulation. The therapeutic efficacy of Banadiqul Buzoor can be attributed to its diuretic, cooling, and anti-inflammatory properties, which are well documented in Unani literature. Its use not only provided symptomatic relief but also highlighted the potential of Unani medicine as a natural, cost-effective, and patient-friendly alternative to conventional antibiotics. Thus, Banadiqul Buzoor emerges as a promising option for managing LUTI, particularly in light of the growing concern over antimicrobial resistance. Integration of such evidence-based Unani formulations with modern medical practice could enhance holistic patient care. However, larger clinical trials and pharmacological investigations are warranted to further validate and standardize its therapeutic application.

XI. Summary:

This exploratory case study assessed the clinical efficacy of Banadiqul Buzoor, a classical Unani pharmacopeial formulation, in the management of Lower Urinary Tract Infection (LUTI), referred to as Iltehab-e-Aalate Baul in Unani medicine. Conducted at the Department of Jarahat (Surgery), Z.V.M. Unani Medical College & Hospital, Pune, the study enrolled 30 patients diagnosed through history, physical examination, and laboratory investigations. The demographic analysis revealed that the majority of patients were 21–30 years old (66.6%), with a higher incidence in females (56.7%) compared to males. Most participants followed a mixed diet (60%), and a significant proportion belonged to the Muslim community (83.3%). Occupational data indicated that individuals engaged in private jobs (43.3%) were most frequently affected. Common presenting symptoms included burning micturition, urinary frequency, pelvic discomfort, and dysuria. Patients were treated with Banadiqul Buzoor pills, prepared according to Unani pharmacopoeial standards, and administered in prescribed doses. Follow-up evaluations showed marked symptomatic relief, improvement in urinary parameters, and absence of adverse effects, demonstrating the safety and efficacy of this herbal formulation. The study supports the Unani perspective that Banadiqul Buzoor, owing to its diuretic (Mudirr-e-Baul), cooling (Mubarrid), and anti-inflammatory (Muhallil-e-Waram) properties, serves as a natural and effective alternative to conventional antibiotic therapy. These findings highlight its potential role in reducing antibiotic dependency, promoting safe management, and preventing recurrent infections in lower urinary tract disorders.

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