

Efficacy and safety of Unani Formulation in loss of Appetite

ABSTRACT

Aims and objectives: Loss of appetite (LOA) impacts individual well-being and quality of life. It can contribute to weight loss and nutritional deficiencies, and associated poor healthcare outcomes, including increased mortality. This study presents the efficacy and safety of Unani pharmacopeia formulation *Habb-e-Tursh Mushtahi* in loss of appetite (Anorexia)

Study Design: Open-labelled, single arm, clinical trial.

Materials and Methods: The study was conducted on 100 patients having the complaint of loss of appetite; Patients of either sex in the age group of 18 to 65 years and decreased appetite with SNAC ≤ 14 were included in the study. The treatment was given for two weeks and safety assessment was done before and after end of treatment. P-value 0.05 was considered significant.

Results: Females were almost double than men who were suffered with the disease. The considered parameters show a good response $p < 0.05$ after the intervention of Unani pharmacopeia formulation in both genders. In case of safety parameters, no significance $p > 0.05$ has been seen for pathological and biochemical investigations.

Conclusion: The management for the loss of appetite can be easily treated with the unani drug which is effective for the rapid relief without any adverse effect.

Key word: Herbal management, nutritional frailty, anorexia, energy intake

INTRODUCTION:

“Our existence depends on the ability to obtain food for immediate metabolic needs and to store excess energy in the form of fat to meet metabolic demands during fasting. Eating behaviour is stimulated by hunger, craving and hedonic sensations and controlled by homeostatic processes. Appetite is the desire to eat food, sometimes due to hunger. Appealing foods can stimulate appetite even when hunger is absent. Appetite exists in all higher life-forms, and serves to regulate adequate energy intake to maintain metabolic needs. It is regulated by close interplay between the digestive tract, adipose tissue and the brain” [1, 2].

“Loss of appetite is described in Unani system of medicine as *Du'fal-Ishtihā*, *Qilla al-Shahwa* in which desire for food i.e. appetite decreases. It is caused by excessive cold morbid temperament, accumulation of bilious humour/salty humour/viscous phlegm/putrid humour, decrease catabolism and hepatic debility. It is characterized by decrease desire of food. There may be burnt belching, nausea, vomiting, abdominal distension etc associated to it” [3, 4]. “Avicenna and his followers believed that the causes of *Du'fal-Ishtihā* (anorexia) and *Qilla al-Shahwa* (dysorexia) are the same. Avicenna and other sages believed that in time of hunger, pancreas secretes *sawda* (black bile) on the cardia and it causes a burning sensation and subsequently, hunger. Disturbing each of these processes by internal or external disturbers leads to anorexia or dysorexia. *Shāh Arzānī M.* in *Mizan-al-Tib* remarked 7 causes for anorexia, :Simple warm or wet dys temperament in cardia” [5, 6]. “Accumulation of morbid humours in the stomach. Fullness of the body organs from crude phlegm which may lead to reduction of the organs' food demand., Thickening of the skin and blockages of the pores which may lead to reduction of sweating and accumulation of morbid matters., Liver failure and mesenteric vessel blockage., Blockage of aperture between pancreas and cardia. Scholars of Traditional Persian Medicine believed that there is an aperture between cardia of stomach and *Tihāl* (the spleen and pancreas)” [7,8]. “There is no real aperture between the spleen and stomach; however, exocrine pancreatic hormones affect GI tract and contribute to

digestion. It is close to function of *sawdā*, secreted by *Tihāl*, which stimulates cardia of stomach as an orexigenic agent. In this regard, it seems that functions of *Tihāl*, in **Traditional Persian Medicine**, are divided into two parts: purification of blood which is conducted by the spleen and secretion of *sawdā* which is performed by the pancreas. Impairing the sensitivity of cardia to pouring of *the sawdā* from the pancreas on the cardia”[9,10]. “According to traditional views, habits (lifestyle), mental conditions such as depression and grief, spiritual diseases (neuro – psychological) and gastrointestinal worms are the other causes of reducing appetite” [11, 12]. “According to the findings of the modern medicine, hunger sense is associated with several physiological effects, such as rhythmic stomach contractions which give the person a search for enough food”[13]. “Appetite is a desire to eat and it helps in choosing a good quality food” [14, 15]. “If the demand for food is successful, it will be satiated; in addition to environmental and cultural factors, the physiological factors affecting specific centres in the brain are effective in controlling appetite”. [13]

Study rationale: “Decreased appetite plays an important role in the development of under nutrition and is therefore a significant clinical problem. Global eating disorder prevalence increased from 3.4% to 7.8% between 2000 and **2018**” [27]. The prevalence of mild to severe anorexia in India has been reported to be as high as 93% in patients with severe illness. The risk of anorexia was found to be 1.5 times higher in patients with a past history of any disease. Anorexia can affect people of every gender identity, race, and socioeconomic status. There are a variety of factors that can contribute to the onset of anorexia that can put some populations and people at a higher risk for developing the eating **disorder**. Early management of decreased appetite may prevent or delay under nutrition with a series of components.

Traditional and complementary medicine has always been considered for the selection of new treatments. There are several medicinal herbs in traditional medicine, the benefits and effects of which have not yet been investigated on scientific parameters. Considering that traditional medicine is one of the richest medical treasure in the world and it has deep roots in the vast civilization and considering the diversity and distribution of herbal medicines in India, we began to study appetite stimulant herbal drugs. We hope to introduce a new method for effective and low-cost control of appetite.

The use of appetite stimulating medications appears to be better treatment option for alleviating anorexia that may help patients enhance their appetite and gain weight, thereby improving their quality of life. The classical pharmacopeia formulations are in use since long but **these needs** to be validated on scientific parameters for its safety and efficacy. **Habb-e-TurshMushtahi** is one such important Unani pharmacopoeia formulation prescribed frequently by Unani physicians to relieve anorexia and decreased appetite.

Methodology: An open labelled clinical study was conducted at RRIUM Srinagar after getting the **ethical approval** dated 10-1-2015. Patients of either sex in the age group of 18 to 65 years and decreased appetite with SNAC ≤ 14 were included in the study. **Patients** having anorexia nervosa, underlying disorder, known case of hepatic, renal and cardiac ailment were excluded from study. The patients were clinically assessed at every 7th day for 2 weeks

Drug intervention: Habb-e-TurshMushtahi is a solid preparation (pill) taken from the **National formulary of Unani medicine**, made with the ingredients in the formulation

Formulation composition:

1. Zanjabeel [*Zingiber officinale* Rosc.]
2. Satt-e-Leemu QS [citrus lemon]
3. Namak-e-Siyah [Black Salt]
4. Namak sang [rock salt]
5. Qaranfal [clove]
6. Filfildaraaz [piper longum. L.]
7. Kibreetmaghsool [sulphur]

8 Heel khurd[Elettariacardamomum]

Dose:Two pills(5gms) before meals two times a day

Mode of Administration:The drug is taken orally with water before meals

Assessment of efficacy and safety

The results were assessed on the basis of variables considered in the appetite for which the SNAQ was applied. The patients were asked to complete the Simplified Nutritional Appetite questionnaire (SNAQ) (clinical tool for assessment of appetite). The validation study of questionnaire indicated that due to its short nature and reliability, the SNAQ is recommended for clinical use, It is a four item single domain questionnaire. Responses were scored by using a five point (A TO E), verbally labelled likert scale. The total SNAQ score is the sum of scores on the four items, with lower score indicating deterioration in appetite. The SNAQ score may range from four (worst) to twenty (best). A SNAQ Score ≤ 14 may identify persons with anorexia at significant risk of weight loss within six months. The safety of the drug was assessed by recording adverse events (if any) and relevant pathological and biochemical investigations were carried out at baseline and after 14 days of treatment and the results obtained were compared.

Statistical Analysis: The coded data were filled in excel sheet in each follow up of the patients. At the end of the sample of 100 cases, the analysis of the data has been done with the SPSS v29. The categorical data is presented in the frequencies and percentage. A critical area of distribution were two sided and p value < 0.05 were considered as significant. Paired t-test was used to calculate p-value for continuous data and contiguous chi-square test were used for categorical data.

Results:

Table 1: presents the characteristics of the subjects

Parameter	Classification	Male	Female, n,
		number, (%)	number, (%)
Temperament	Damvi	10 (28.6)	6(9.2)
	Balghami	17(48.6)	35(53.8)
	Safrawi	6(17.1)	19(29.2)
	Sawdawi	2(5.7)	5(7.7)
BMI	Under weight	8(22.9)	13(20.0)
	Normal	23(65.7)	48(73.8)
	Over weight	4(11.4)	4(6.2)
Age group	< 28	18(51.4)	35(53.8)
	29 - 38	7(20.)	13(20.0)
	39 - 48	3(8.6)	8(12.3)
	49 - 58	6(17.1)	9(13.8)
	>58	1(2.9)	0.0(0.0)
Nutrition status	Good	9(25.7)	3(4.6)
	Average	25(71.4)	58(89.2)
	Poor	1(2.9)	4(6.2)
Built	Average	23(65.7)	37(56.9)
	Short	4(11.4)	6(9.2)
	Tall	4(11.4)	4(6.2)
	Fatty	1(2.9)	1(1.5)

Muscular	1(2.9)	1(1.5)
Thin	2(5.7)	16(24.6)

In this study 100 cases were recruited out of which 35 were male and 65 female. As per the inclusion criteria of the study 18 years of age at minimum and 60 years maximum cases were considered in the present study. The mean age for the males was reported 35.83 with 11.64 SD and in females 29.1 with 10.8 SD. Both male and female group were classified in considered parameters to know the involvement in disordered eating behaviour and dieting behaviour to lose weight. In table 1 the number and percentage of the cases in each group is present. **Balghami**(Phlegmatic) cases in both groups were more 48.6% in males and 53.8% in females as far as temperament is concerned followed by **safrawi**(Biliious)where **female patients are more than males** (29.2 %). Also 28.6% male cases were Damvi(Sanguineous). Maximum numbers of patients were of normal weight 65.7% males and 73.8 females followed by underweight which were 22.9% males and 20% females. It has been seen that less than 28 years of age were more prone with the disease **51.4% males and 53.8%** females and as age increases less number of cases have been reported. The phenotype of the studied cases where it has been reported the general appearance of the good number of cases in both males 45.7% and females 60% were disturbed at base line due to sleep disturbance. 20% males and 10 % females were not feeling well at base line and after intervention of the **Unani** regime, the drug shows the significant results at 1st follow-up and complete cure of maximum number of cases. In 5.7% males and 10.8% females, the drug did not show any benefit. In this study the cases who are taken average **nutrition** were more prone (male 71.4% and female 89.2 %)to the disease than the persons who take adequate nutrition .

Table 2: presents general status of known subjects

General information	Indicators	Male	Female	Total	p – value
		number, (%)	number, (%)		
Duration	1-month	17(32)	36(68)	53	0.296
	2 month	11(31)	24(69)	35	
	3-month	5(63)	3(37)	8	
	4-month	2(50)	2(50)	4	
Past History of any disease	Yes	5(38)	8(62)	13	0.503
	No	30(34)	57(66)	87	
Marital Status	Married	26(49)	27(51)	53	0.002
	Unmarried	9(19)	38(81)	47	
Diet:	Non Veg	2(33.5)	4(66.5)	6	0.650
	Mixed	33(35)	61(65)	94	
Smoking	Smoker	10(91)	1(9)	11	0.001
	Non smoker	25(28)	64(72)	89	
Past Medication	Allopathic	33(35)	62(65)	95	0.576
	Herbal	2(40)(3(60)	5	

As per the literature the reasons of the symptom anorexia have been reported the most prevalent condition triggering malnutrition, drastic weight loss and serious health issues. In our study the chronicity of the patients has not been seen. The maximum number of cases as

far as duration is concerned were upto **one**-month, 32% males and 68% females followed by **two** months 31% males and 69 females. In socio-economic category middle class has more number of cases 31% males and 69% females followed by lower class. There was no statistical significance in both the categories. Female cases 51 % married and 81% unmarried are suffering more with anorexia than male cases and is very significant $p = 0.002$. Since the study has been conducted in Kashmir valley where majority of the population are habitual to take mixed diet and the same has been reported i.e 94% population are taking mixed diet. A good number of patients reported to have past medication particularly allopathic.

Table3: shows the results of main parameters that were statistically significant.

	Male- n=35						Female- n=65							
	Mean		Std. Deviation	95%CI of the difference		Statistic	p value	Mean		Std. Deviation	95%CI of the difference		Statistic	p value
				Lower	Upper			Lower	Upper					
BMI	*BT	21.19	4.21	-2.42	0.17	-1.766	0.036	*BT	20.99	3.91	-2.01	0.02	1.963	0.024
	**AT	22.31	2.14					**AT	21.98	3.20				
SN AQ	*BT	4.97	0.57	-7.44	-4.74	-9.165	0.01	*BT	5.49	1.34	-5.65	-4.10	12.542	0.01
	**AT	11.06	3.81					**AT	10.37	3.12				

*BT = before intervention of **Unani** regime

AT = after intervention of **Unani regime

Table 4 :Pathological assessment

Pathological assessment		Mean	Std. Deviation	Lower		Upper	p-value
				Lower	Upper		
Hb (gm/dL)	Before intervention	11.269	1.3101	-0.1414	0.2808	0.655	0.514
	After intervention	11.199	1.3163				
TLC (/mm ³)	Before intervention	6825.25	1568.916	-195.902	500.952	0.869	0.387
	After intervention	6672.73	1398.090				
N	Before intervention	60.79	6.060	-0.384	2.606	1.475	0.143
	After intervention	59.68	5.566				

L	Before intervention	36.33	6.172	-2.733	0.386	-1.493	0.139
	After intervention	37.50	5.757				
E	Before intervention	1.45	0.788	-0.145	0.247	0.517	0.607
	After intervention	1.40	0.743				
M	Before intervention	1.30	0.933	-0.262	0.262	0.000	1.000
	After intervention	1.30	0.976				
B	Before intervention	0.01	0.101	-0.045	0.025	-0.575	0.566
	After intervention	0.02	0.142				
1st Hr	Before intervention	15.50	15.632	-2.037	3.690	0.573	0.568
	After intervention	14.67	13.097				
2nd Hr	Before intervention	26.60	19.810	-2.649	4.466	0.507	0.614
	After intervention	25.69	17.539				

Table 5 :Biochemical investigations

Biochemical investigations	Sample collection	Mean	Std. Deviation	95% CI of the mean difference		t	p
				Lower	Upper		
S. Bilirubin (mg/dL) Total	Before intervention	0.708	0.1859	0.0639	0.0149	-1.234	0.220
	After intervention	0.733	0.1685				
SGOT (U/L)	Before intervention	26.085	9.2831	1.5418	2.0907	0.300	0.765
	After intervention	25.810	6.9553				
SGPT (U/L)	Before intervention	25.357	11.5123	1.4079	3.4181	0.827	0.410
	After intervention	24.352	7.6615				
S. Alkaline Phosphatase (U/L)	Before intervention	72.112	19.4412	5.9091	3.9254	-0.400	0.690
	After intervention	73.104	20.9138				
S. Creatinine	Before	0.776	0.1390	0.0505	0.0134	-1.154	0.251

(mg/dL)	intervention						
	After intervention	0.795	0.1236				
Blood Urea (mg/dL)	Before intervention	23.003	9.1264	2.0405	1.7956	-0.127	0.899
	After intervention	23.126	5.5758				
Uric Acid (mg/dL)	Before intervention	4.676	1.1054	0.2447	0.2051	-0.175	0.862
	After intervention	4.696	1.0226				

Necessity, acceptability, feasibility, safety, fidelity, efficacy, effectiveness and cost-effectiveness are the prime focus of Unani regime. To ensure the safety of the cases that has been included in the study, we carry out the possible biochemical and pathological laboratory test of all the subjects included in the study (Table 4, 5). All the parameters shown in above tables are in normal range before and after of the drug intervention.

Discussion: Loss of appetite (LOA) impacts individual well-being and quality of life. Lack of appetite (LOA) and loss of well-being is a major concern for patients and their families. In this study 100 patients coming with the complaint of loss of appetite were enrolled in study. Female outnumbered the male with a ratio of 1 : 1.9 which correlates with maximum studies showing, loss of appetite is more common in females than males [16]. “The socioeconomic data of this research correlates with the national literature demonstrating the female preponderance. Gender differences in many appetite-related areas have been previously highlighted, which may give insight about reasons for the higher satiating effect in women than in men. According to these previous studies, these gender differences may be partly due to physiological regulation of appetite through sex hormones. More specifically, female sex hormones, mainly oestrogens, influence central and peripheral signals from some hormones implicated in feedback controls of eating, including ghrelin, cholecystokinin, insulin, and leptin and may mediate the estrogenic inhibition of eating during the consumption of a meal as highlighted in previous human studies” [17, 19]. In addition, it was observed that women have increased neuronal activation in response to food cues and have a greater attention, cognitive processing, and inhibitory response to food cues than men” [11]. “These differences in brain activation in response to food stimuli may then consequently produce gender specific appetite response”. [11]

In this study less than 28 years age group was more affected by loss of appetite with 53.8% females and 51% males. It showed that teens were more affected by the loss of appetite. Loss of appetite in teens isn't uncommon. A teenager undergoes several physical, psychological, and social changes during adolescence that can cause a teenager to lose interest in food. Adolescence brings about several changes in a teen's body, mind, and social life, any one of which could lead to a loss of appetite. Teens can experience stress due to a variety of factors, including but not limited to peer pressure, the strain to keep up academically and athletically, learning impairments, and issues at school, the death or loss of a loved one, parental divorce, or an unfavourable home environment. Teens may experience a loss of appetite due to chronic health illnesses like Crohn's disease, irritable bowel syndrome, asthma, or hormonal conditions like Addison's disease. Some teens may have a loss of appetite due to chronic health conditions such as food allergies, stomach difficulties, food intolerances, or sensitivities. “The demographic profile of patients enrolled in another study demonstrated a significantly higher rate of anorexia presence in young adults below the age of 30 yrs (59%), being more common in students, when compared to the patient above 30 yrs of age (41%)

also correlates with our study” [17]. Although many other studies does not correlate with our study in which loss of appetite is mostly seen in elders and males, in our study there is a limitation of age group up to 60 years which can add to its non correlation with these studies [20]. The duration of disease in our study was usually less than 1 month(53%) which excludes the chronicity of the disease.

In our study as far as temperament is concerned, Balghami cases in both groups were more, 48.6% in males and 53.8% in females followed by safarvi where female patients are more than males (29.2 %). Also 28.6% male cases were Damvi which again coincides with the study [19] and as per the literature loss of appetite occurs with the accumulation of viscid phlegm which inhibits the action of black bile which is necessary for triggering appetite, resulting in decreased appetite, other causes as discussed in the literature are that due to accumulation of balghami, the stomach becomes busy in expelling this phlegm and its intention to get food is diverted leading to loss of appetite [22, 23]. Since the study has been conducted in Kashmir valley where majority of the population are habitual to take mixed diet and the same has been reported i.e 94% population are taking mixed diet. A good number of patients reported to have past medication particularly allopathic medication like antibiotics, opioids, fluoxetine etc which are responsible for loss of appetite.

In the present study the general appearance of the studied cases both males 45.7% and females 60% were disturbed at base line due to appetite disturbance and after the intervention of the Unani regime, the patient's looks were healthy. The studied cases shows the significant results at 1st follow-up in maximum number of cases and only 15% cases the drug did not show any benefit.

Anyone can manifest anorexia as a loss of appetite or a loss of interest in food, regardless of their sex, age, and weight. This can present as not feeling hungry or lacking the desire to eat [24]. A brief period of anorexia usually accompanies almost all sudden (acute) illnesses. Disorders that affect the part of the brain where appetite is regulated can cause anorexia as well. Underlying causes are treated to the extent possible. We introduce Unani drug which shows a significant results to increase a person's desire to eat, helps appetite and a flexible meal schedule for symptom relief anorexia.

“There are various appetite assessment tools for measuring appetite for example Mini-Nutritional Assessment (MNA), Malnutrition Universal Screening Tool (MUST), Nutritional Risk Screening 2002 (NRS-2002), and Geriatric Nutritional Risk Index (GNRI). While these tools are comprehensive and have been validated in various settings, there remains a need to strike a balance between efficacy and efficiency, especially for resource-intensive tools that require trained assessors or laboratory measurements. The Simplified Nutritional Appetite Questionnaire (SNAQ) is self-administered questionnaires adapted from the Appetite, Hunger and Sensory Perception questionnaire (AHSP), an appetite assessment tool validated among community-dwelling adults in the Netherlands” [4]. “The shorter four-item SNAQ comprising items to have good reliability, sensitivity and specificity to predict malnutrition in both specialized and non-specialized older adult populations” [23].

The results from this study showed that significantly more patients with less than two months complaint were free of all symptoms after only one week their appetite increases and developed taste of food $P < 0.01$ and the patients who were chronic also got benefited at during the intervention $P < 0.05$. Since the present study was guide lined to assess the SNAQ score which was our primary concern to see any significance by intervening the Unani regime and any change in BMI after the completion of the duration of the treatment. The result shows significance in both the variables $p < 0.05$ (Table 3). “We found an amazing improvement in these items that assess appetite, satiety, taste of food and number of meals per day respectively. The SNAQ was developed as a self-assessment screening tool that is quick and easy to administer without the need for trained assessors or laboratory

measurements”[26].“The drug shows equal response in both males and females. . It is worth mentioning that at baseline, the average SNAQ score, as well as the BMI scores were within the class of normal range and after the intervention, they changed to the rank of high normal range. The study demonstrated 1.22 increases in mean score in BMI of the studied cases on an increase of 137 kcal daily energy consumption for 3 weeks duration. The long term use of tested formulation may also contribute to weight gain in patient with anorexia and improved quality of life. A significant increase in SNAQ score was observed in at the end of the study, which was highly notable at post treatment follow up when compared to the baseline score. The result of the present study revealed a modest relationship between the body weight, BMI and SNAQ score. The intervention also helps a good posture of the studied cases and hence developed a healthy confidence level. These results confirm the appetite inducing effect of the tested formulation, which may result in increased energy consumption and weight gain in patients with anorexia. The duration of treatment plays a vital role in the efficacy of herbal therapy. Therapy for at least 2 weeks with appetite-stimulating Unani medications such as megestrol, dronabinol, and mirtazapine has shown benefits in patients with anorexia previously” [28] (is observation is consistent with findings in this study where the treatment duration was for two weeks. “Considering that there is no fixed duration established during which an appetite-stimulating medication may show efficacy, it is expected that treatment with such medications for at least two weeks or more may be likely to depict benefits in patients with anorexia” [3]. In the outpatient setting, the outcomes could be variable considering diverse factors such as patients’ due diligence in taking medications and timing of taking medications, which may in turn affect the weight and appetite of the patient. However, in our study, patients with anorexia were at least 80% compliant with the prescribed appetite-stimulating medication dose and frequency as assessed from patient diaries and self-reported use at follow-up visits, thereby making our findings relevant to an out-patient setting. No significance have been reported for safety parameters before and after the Unani intervention $p > 0.05$. There were no adverse effect of the therapy the reference range of common biochemical and pathological tests remain within range during the intervention and post treatment.

“World Health Organization (WHO) has defined herbal medicines as finished labelled medicinal product that contain an active ingredient, aerial, or underground parts of the plant or other plant material or combinations. According to a report of WHO, about 80% of the world population is reported to rely on traditional medicine for their primary health care needs. Herbal products have become an important and indispensable part of public healthcare around the world” [28].“Various surveys on traditional and alternative medicine have highlighted their widespread use” [27]. However, in order to further widen their forum of acceptance, clinical trials of these herbal products should be encouraged. *Habb-e-Tursh Mushtahi* is a Unani preparation made with the ingredients *Zanjabeel* [*Zingiber officinale* Rosc.], *Satt-e-Leemu QS* [citrus lemon], *Namak-e-Siyah* [Black Salt], *Namak sang* [rock salt], *Qaranfal* [clove], *Filfildaraaz* [piper longum. L], *Kibreetmaghsool* [sulphur] and *Heel khurd* [Elettariacardamomum]

All the ingredients have *duf-al-mida* (Gastric debility), *Mushtahi* (Appetizer) functions. Ginger (*Zingiber officinale Roscoe*) is a common and widely used spice. It is rich in various chemical constituents, including phenolic compounds, terpenes, polysaccharides, lipids, organic acids, and raw fibers. Ginger is one of the incredible herbs that is mostly used as an appetite stimulant. Ginger juice works amazingly well for improving poor appetite.

Kalanamak consists primarily of common salt and trace impurities of sodium sulphate, sodium bisulfate, sodium bisulfite, sodium sulfide, iron sulfide and sulphide. its slight savory and a highly distinctive smell has appetite stimulating effect. As per Unani system of medicine, the drug *-Qaranfal or LaungTila* (Clove) is frequently recommended for ,

Weakness of the Stomach (*Zof-e-Meda*), Hepatitis or Weakness of Liver (*Zof-e-Kabid*). Since ages, Unani physicians used *Filfildaraz*(Piperlongum L.) or long pepper, for enormous therapeutic benefits. Its beneficial actions are digestive, stomachic, (carminative)and appetizer. Literature survey revealed countless important phytoconstituents namely alkaloids such as piperine, volatile oil, esters and resins. These all drugs improve liver function which boost our digestion process and thus makes feel hungry.

Conclusion:

In conclusion the present Unani drug was found effective for loss of appetite. The symptom relief was seen within the seven days of treatment and in chronic cases i.e more than a month shows a major relief after twenty one days. There were no adverse effect reported, hence are safe and effective in both males and females. The presented Unani formulation may be treated as generalised management for the treatment for loss of appetite with zero safety cover.

Research funding:

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Ethical Approval:

As per international standard or university standards written ethical approval from RRIUM Srinagar has been collected and preserved by the author(s).

Consent

As per international standards or university standards, patient(s) written consent has been collected and preserved by the author(s).

Competing interest:

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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