

Unveiling the Concept of *Ḥaṣā al-Kulya* (Renal Stones) through the Prism of Unani Medicine: A Narrative Review

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ABSTRACT

Ḥaṣā al-Kulya (renal stones/nephrolithiasis) is a common and recurrent urinary disorder with multifactorial causation. Unani medicine contains extensive classical literature on renal stones; however, the relevant information is dispersed across various classical texts and has not been comprehensively organized. The present review was undertaken to compile, organize, and synthesize the available Unani literature on *Ḥaṣā al-Kulya*, with particular emphasis on its etiopathogenesis, types, clinical manifestations, diagnosis, risk factors, and preventive measures. A narrative literature review was conducted using classical Unani sources and relevant contemporary medical literature. Classical descriptions of eminent Unani physicians, including *Ibn Sīnā*, *Jālīnūs*, *Ibn-e-Abbās Majūsī*, *Zakariyā Rāzī*, and *Ibn-e-Zuhr*, were reviewed and synthesized. The review revealed that renal stone formation, according to Unani

concepts, is mainly associated with the accumulation and retention of *Ghalīz Mādda* (thick morbid matter), excessive *Harārat-e-Gharīziyya* (innate heat), *Sū-e-Mizāj-e-Kulya*, renal weakness, and impaired expulsive power. The process involves concentration, drying, hardening, and eventual solidification of morbid matter. Several Unani concepts show similarities with contemporary understanding of urinary concentration, supersaturation, crystal formation, dietary influences, hydration, and urinary stasis. Overall, the classical Unani literature provides a valuable conceptual framework for understanding the etiopathogenesis of *Ḥaṣā al-Kulya* and may serve as a foundation for further scientific research on its prevention and management.

Keywords: *Ḥaṣā al-Kulya*; Nephrolithiasis; Urolithiasis; Unani Medicine; Etiopathogenesis; Risk Factors; Diagnosis; Prevention.

INTRODUCTION

Nephrolithiasis (*Haṣā al-Kulya*) is one of the most common health problems that affect approximately 15% population worldwide and about 2.3% population of India.¹⁻³ It is a complex disease and globally affecting all age groups.⁴ Peak incidence of Nephrolithiasis occur at 20-40 years of age in both gender and is more common in male (12%) than female (6%).⁵ Approximately 12% of people worldwide will experience Nephrolithiasis at some point in their lives. It affects people of all ages, genders, and races; however, in the 20-49 age range, men are more likely than women to experience it.⁶ In the United States, Kidney stones affect approximately 1 in 11 people.⁷ Kidney stones were more common among obese than normal-weight individuals (11.2% [95% CI, 10.0-12.3] compared with 6.1% [95% CI, 4.8-7.4], respectively; $p < 0.001$).⁷

Nephrolithiasis is a significant health problem in India, with its prevalence estimated at approximately 12% of the population.⁽⁸⁾ Certain regions of India, namely Maharashtra, Gujarat, Punjab, Haryana, Delhi, and Rajasthan, are recognized as the "stone belt" due to the high occurrence of urolithiasis, with the condition frequently affecting several members of the same family throughout their lives.⁽⁹⁾ However, incidence of this is lower in southern part of the country.

In Unani System of Medicine, kidney stones are referred to as *Haṣā al-Kulya*. According to *Ibn Sīnā*, kidney stones are soft, small, and reddish in color, whereas urinary bladder stones are harder, larger, and greyish, blackish, or whitish.¹⁰⁻¹² *Jālīnūs* stated that Kidney stones form when pus from a kidney ulcer thickens and solidifies.^{12,13} while *Majūsī* attributed their formation to *Khilt Ghalīz Lazij* (Thick and sticky fluid) such as *Balgham* (Phlegm), *Ghalīz Khun* (Thick blood), or *Reem* (Pus) and the action of *Harārat-e- Gharziyya* (Innate heat).^{8,14}

Haṣā al-Kulya (Renal stones) have long been an important disease in Unani medicine. Classical Unani literature provides extensive information on these disorders; however, the

available knowledge is scattered across numerous Classical texts, and their etiological and pathogenetic aspects have not been comprehensively explored. To address this gap, the present review was undertaken to systematically compile, organize, and elaborate the Unani concepts of *Haṣā al-Kulya*. A comprehensive understanding of the Unani perspective on Renal diseases and their underlying causes may contribute to improve strategies for their prevention and treatment.¹²

MATERIALS AND METHODS

A narrative literature review was undertaken using classical Unani sources and relevant contemporary medical literature. Contemporary literature was searched through PubMed, the Cochrane Central Register of Controlled Trials (CENTRAL), and the resources available through the Central Library of SUMC. Information concerning the concept, terminology, etiological factors, pathogenesis, types, clinical manifestations, diagnosis, risk factors, prevention, and complications of *Haṣā al-Kulya* was identified, organized, critically reviewed, and synthesized. Classical descriptions from prominent Unani physicians, including *Ibn Sīnā*, *Jālīnūs*, *Ibn-e-Abbās Majūsī*, *Zakariyā Rāzī*, and *Ibn-e-Zuhr*, were examined alongside contemporary concepts and evidence related to nephrolithiasis.

UNANI CONCEPT OF KIDNEY STONES (HAṢĀ AL-KULYA)

In Unani medicine, Kidney stones are viewed through the lens of humoral theory, where an imbalance in bodily humors contributes to their formation.¹⁵ Ancient Unani scholars such as *Buqrat (Hippocrates)*, *Jalinoos (Galen)*, *Razī*, *Ibn sina*, and *Jurjani* have discussed the etiopathogenesis, symptomatology of this disease in detail.

According to *Jalinoos*, Renal stones are formed as a result of Renal ulcer, when its fluid is not expelled out and become solidify in the kidney and becomes a stone.¹⁶

According to **Sahib-e-Kamil**, formation of stone take place in kidney due to *Harārat-e-Gharīzī Nārī* (Excessive heat of the body) and thick morbid matter.

Excessive heat cause dryness in the liquid part of this morbid matter and it become more and more thick, hard and ultimately become a stone.¹⁷

According to **Ibn sina**, two things are essential for Renal stone formation, one is *Ghaleez Maddah* (thick morbid matter) and other is retention of this *Ghalīz Mādda* (morbid matter.) This *Ghalīz Mādda* (Thick morbid matter) is obtained by *Ghalīz Mādda*. E.g. Milk, cheese, dry meat, large fishes, Every type of roasted meat, rice and milk.¹⁸

Azam Khan stated that obesity is associated with a greater tendency for stone formation in the kidneys, whereas in lean and thin individuals, urinary calculi are more commonly formed in the urinary bladder.¹³

According to **Hakeem Ajmal Khan**, excessive consumption of moist and impure foods leads to the accumulation of morbid, earth-dominant fluids in the kidneys and urinary bladder. Prolonged retention of these fluids, under the influence of innate heat, causes the elimination of their subtle components, leaving behind dense earthy matter that gradually forms urinary sand or develops into calculi.¹⁹

According to **Ibn-e-Abbas Majoosi**, concentrated humours and highly viscous fluids accumulate and adhere to the renal calyces. Under the influence of excessive heat, these substances undergo desiccation and gradually solidify into crystals, ultimately leading to the formation of renal calculi.^{20,21}

Ibn-e-Zohr proposed that when the kidneys are unable to effectively eliminate thick and dense humours due to impaired renal strength, these substances accumulate within the renal tissue. Over time, the accumulated material undergoes gradual crystallization and deposition in successive layers, ultimately resulting in the formation of renal calculi.²¹

Zakaria Razi suggested that the disease results from an imbalance of the bodily

humors, which are expelled as a thick, viscous fluid. Upon reaching the kidneys, this material gradually solidifies and crystallizes, eventually giving rise to stone formation.^{21,22}

ETIOPATHOGENESIS:

The kidneys are endowed with five faculties (*Quwā*). Weakness or impairment of any of these faculties, particularly the **Quwwat-e-Mumayyizah** (discriminative faculty), **Quwwat-e-Hāzimah** (digestive faculty), or **Quwwat-e-Māsikah** (retentive faculty), may result in the appearance of blood in the urine. This is attributed to impaired processing and retention of the urinary matter.²³

According to Unani concept, factors such as kidney weakness (*Zof-e-Kulyah*), dense and sticky bodily fluids *Ghalīz Mādda*, imbalanced kidney temperament (*Su-e-Mizaj Kulyah*), inflammation of kidneys (*Warm-e-Kulyah*), ulcers of kidneys (*Qurooh-e-Kulyah*), reduced expulsive power of the kidney (*Zof-e Quwwat-e-Dafey'ah*), and elevated body temperature (*Su-e-Mizaj Har*) are believed to be the potential contributors to kidney stones. Morbid matter is believed to arise from the consumption of *Ghalīz Ghizā* (thick and dense foods).

Stones are formed due to thick secretions and drying heat. **Atibbā** says that stone often form in the cavity of Kidney.²³ **Ibn-e-Abbas Majoosi**, in **Kamil-us-Sana'ah**, explained that the moisture (*ratubat*) present in the already viscous *Ghalīz Mādda* (**morbid matter**) gradually dries up under the influence of excessive heat. With continued drying and accumulation over time, this material becomes increasingly hard and eventually develops into a stone.^{15,21}

According to Modern medicine, the development of kidney stones is a complex, multifactorial process influenced by both intrinsic and extrinsic factors. Intrinsic determinants include age, sex, and genetic predisposition, whereas extrinsic factors comprise geographical location, climate, dietary habits, mineral composition, and fluid intake. Kidney stone formation is primarily associated with physicochemical

alterations in urine, particularly urinary supersaturation. Normal urine contains a balanced mixture of solvents and dissolved solutes; disruption of this equilibrium can promote crystal formation and abnormal crystallization. This process progresses through three phases: undersaturation, in which stone-forming substances remain dissolved; saturation, in which urine reaches the equilibrium point for crystal formation; and supersaturation, in which the concentration of solutes exceeds their solubility, favoring crystal precipitation.^{15,24} The pathophysiology of nephrolithiasis involves a sequence of events including **nucleation, crystal growth, aggregation, and retention** within the urinary tract. Stone development and subsequent enlargement are also influenced by the ability of crystals to attach to the renal tubular epithelium. Such crystal attachment commonly occurs on areas containing calcium phosphate, particularly apatite deposits. In addition, certain anatomical abnormalities can predispose individuals to stone formation by causing urinary stasis. Conditions such as horseshoe kidney, polycystic kidney disease, and ureteropelvic junction obstruction can impair normal urinary drainage, thereby increasing the likelihood of crystal retention and subsequent kidney stone formation.^{15,24}

Risk factors:

1. Metabolic factors:

It includes Type-2 Diabetes Mellitus and Gout. These two factors are highly associated with Nephrolithiasis. History of kidney stones associated with an increased risk of the incidence of type 2 diabetes in men and women. Insulin resistance, which may develop before the clinical onset of diabetes, is thought to play a central role in the bidirectional association between nephrolithiasis and diabetes, along with the urinary abnormalities that develop as a consequence of diabetes. Compared with non-diabetic individuals who form stones, diabetic stone formers tend to have a significantly lower urinary pH and increased urinary oxalate excretion, both of which

contribute to a greater risk of calcium oxalate (CaOx) stone formation. Furthermore, persistently acidic urine is an important risk factor for uric acid stones, which are particularly common among patients with diabetes.²⁵

2. Fluid and beverages:

Higher fluid consumption is widely regarded as the most effective and universally accepted strategy for preventing kidney stone formation. Since epidemiological studies have not demonstrated a significant association between water hardness and the risk of nephrolithiasis, the quantity of water consumed appears to be more important than its mineral composition. Recent data from the National Health and Nutrition Examination Survey (NHANES) 2009–2012, involving 8,195 adults aged ≥ 20 years, further demonstrated an inverse relationship between adequate hydration and nephrolithiasis. Consistent with earlier evidence, individuals consuming more than 2,500 mL of water per day and producing at least 2 L of urine daily had a lower prevalence of kidney stones.²⁵

3. Dietary intake:

Major epidemiological studies investigating dietary factors have reported broadly consistent findings. Current evidence indicates that adequate fluid intake, along with greater consumption of fruits and vegetables, is associated with a reduced risk of kidney stone formation. In contrast, diets rich in salt and meat or other animal proteins are consistently recognized as important risk factors for nephrolithiasis. Animal protein may contribute to stone formation by increasing proton production, which promotes proximal tubular citrate reabsorption, thereby reducing urinary citrate and increasing calcium excretion. It may also increase the risk of uric acid stones by lowering urinary pH and enhancing uric acid excretion. Conversely, very low dietary calcium intake, particularly from dairy sources, may also increase the risk of kidney stone formation.²⁵

4. **High temperature:** According to Sahib-e-kamil, high temperature of the body is responsible for Renal stone formation.
5. A higher serum albumin level is a risk factor for coax (calcium oxalate) stone formation in bladder.
6. History of Hypertension and low urinary pH are highly associated with Urolithiasis.
7. Other factors include obesity, old age, irregular or excessive eating, congestion, and weakness of Quwwat Hādima (Digestive faculty) and Dafi'a (Expulsive faculty).¹²⁻¹⁴

TYPES OF RENAL STONES:

According to Unani System of medicine, there are 5 different types of stones can formed in kidneys.

Type I: This type of stones are rounded or oval in shape, regular or granular and heavy in weight. These are also known as *Hasāt-e-Boliyah* (Uric acid and Urate stones). It accounts approximately for 3–10% of all stone types.¹⁵

Type II: Also known as *Hasāt-e-Layyinah*. This type of stones are soft and generally small in size.²⁶

Type III: This type of stones are very hard, blackish in colour and irregular in shape.

Type IV: This type of stones are also known as *Hāssah-e-Zubāniyah* (Cystine stones), because they become melt when melting by special method. These are white in colour and soft in consistency. It comprises less than 2% of all stone types.^{15,26}

Type V: Also known as *Hāssah-e-Qā'imūliyah* (calcium phosphate). These stones are white and like chalky soil and their surface are smooth (5%).^{15,26}

According to Modern medicine, the chemical composition of kidney stones depends on the abnormalities in urine composition of various chemicals. Stones differ in size, shape, and chemical compositions. Calcium stones are predominant renal stones comprising about 80% of all urinary calculi. The proportion of calcium stones may account for pure calcium oxalate (50%), calcium phosphate (5%), and a mixture of

both (45%).¹⁹ Struvite stones occur to the extent of 10–15% and have also been referred to as infection stones and triple phosphate stones.¹⁹ Uric acid and Urate stones accounts approximately for 3–10% of all stone types.¹⁹ Cystine stones comprise less than 2% of all stone types.¹⁵

Clinical features:

The condition is characterized by a burning micturition, decreased urine output, a feeling of heaviness in the lower back, and intermittent pain that becomes more severe with increased intestinal fullness or heaviness.^{12,13} Sometimes stones and other debris interfere with the kidney's ability to expel urine.

Al-Majusi identified several clinical signs suggestive of kidney stone formation, including pain or discomfort in the lower back, difficulty in passing urine, and the presence of sediment in the urine. These urinary deposits may appear yellow, reddish, or brownish in color and may occasionally resemble pomegranate seeds.

The clinical features depend on size, position and type of stone. Patients with urinary stones generally present with the typical reno-ureteral colic and less frequently with loin pain. The pain is classically abrupt in onset, paroxysmal, and waxing and waning in character. When a stone moves into the ureter, the discomfort often begins with a sudden onset of unilateral flank pain. The intensity of pain can increase rapidly, and there are no alleviating factors. The pain which is often associated with nausea, vomiting, fever or haematuria, may radiate, depending on the location of the stone. If the stone lodges in the upper part of the ureter, pain can radiate to the ipsilateral testicle in men or the ipsilateral labium in women. If the stone is lodged at the right ureteral pelvic junction, symptoms may mimic those of acute cholecystitis. If the stone is lodged in the ureter at the ureterovesical junction, the patient may experience urinary urgency and frequency and in men, the pain may radiate to the tip of the penis. However, some patients can also be asymptomatic.^{15,27}

According to Modern Medicine, Renal stones can cause Colicky Pain in lumbar region. Haematuria gross or microscopic in urine occur in 90% of cases. Dysuria, Burning micturation, Urgency, Frequency of micturation, Strangury, renal angle tenderness, lumbar region tenderness are positive. Systemic symptoms like restlessness, writhing in distress, nausea and vomiting or both, fever and chills or both it is often associated with infection.²⁸

DIAGNOSIS AND INVESTIGATIONS

Before the advent of Modern laboratory investigations and imaging techniques, Unani physicians relied primarily on detailed clinical observation and examination of bodily fluids, particularly urine (*Qarūra*), to diagnose diseases. By carefully assessing the colour, consistency, turbidity, quantity, odour, and sediment of urine, along with the patient's presenting symptoms, Unani physicians were able to identify various urinary disorders, including renal calculi.

For diagnostic evaluation, the patient's overnight urine may be collected in a clean container, protected from dust and other contaminants. The following morning, the urine should be carefully decanted, and the sediment at the bottom of the container examined. The presence of reddish or yellowish sand-like particles in the sediment may be suggestive of Renal calculi.^{12,13}

Initially, the urine (*Qarūra*) appears turbid and concentrated but gradually becomes clear and less dense. A characteristic indication of the movement of a Renal calculus is pain that radiates from the lower back toward the groin. The sudden cessation of this pain is generally considered to indicate that the stone has passed from the kidney into the urinary bladder.^{12,13}

Diagnosis of urinary tract calculi generally begins with a comprehensive medical history, including any previous episodes of stone formation in the patient or family, the duration and progression of symptoms, and the presence of possible signs of sepsis. Physical examination may provide useful information, although its main purpose is

often to rule out non-urological causes of the presenting symptoms. Urine analysis is recommended for all patients suspected of having urinary calculi. In addition to detecting the commonly observed microhematuria, assessment of urinary pH and identification of crystals are important, as these findings can provide clues regarding the composition of the stone. Uric acid stones are generally associated with acidic urine, whereas infection-related calculi are typically associated with alkaline urine.¹⁵

Blood investigations including Complete blood count, estimation of urea, creatinine, electrolytes, renal function (GFR), serum calcium, phosphorus, alkaline phosphatase, uric acid estimations may reveal etiology.¹⁵ Stone composition can be assessed using X-ray-based imaging i.e KUB radiography. Approximately 90% of urinary calculi contain calcium and are therefore radiopaque, whereas around 10% are radiolucent and may not be visualized on plain X-ray; these include stones composed of uric acid, cystine, and xanthine. Intravenous urography (IVU), once considered the traditional gold-standard imaging modality for urolithiasis, has largely been replaced by non-contrast computed tomography (NCCT). NCCT offers superior sensitivity and specificity for detecting ureteric calculi, irrespective of their location, size, or chemical composition.¹⁵

PREVENTIVE MEASURES

Approximately two-thirds of patients who have had one kidney stone are at risk for developing another in the future.

1. Increased fluid intake to maintain hydration status and to reduce urinary concentration. Strive to drink enough fluids to pass 2 liters of urine a day.¹⁵
2. A diet rich in fruits and vegetables can help prevent kidney stones.
3. High dietary sodium ingestion is accompanied by increased urinary calcium excretion and CaOx crystal deposition in the kidney. Therefore, sodium intake should be restricted.¹⁵

4. Maintaining a healthy body weight through a balanced diet and regular physical activity may help lower the risk of kidney stone formation.
5. Foods like cashew nuts, spinach, mushrooms, cauliflower, brinjal etc which contain high oxalate, should be avoided.¹⁵

Complications

According to *Hakeem Ajmal Khan*, Renal pain intensifies when running or riding a camel. There is a frequent need to urinate. and the urine comes mixed with blood or blood comes after urination. Sometimes there is constipation and the patient vomits repeatedly. When large stones are present in both kidneys, the kidneys cannot expel urine and the urine becomes blocked and the patient dies.¹⁹

CONCLUSION

Ḥaṣā al-Kulya (renal stones) is a common and recurrent urinary disorder with multifactorial causation. This review highlights that classical Unani physicians provided detailed descriptions of its etiopathogenesis, clinical manifestations, and diagnostic features. The observations of classical scholars such as *Jalinoos*, *Ibn Sīnā*, *Majūsī*, *Ibn-e-Zohr*, and *Zakaria Razi* demonstrate a systematic understanding of stone formation through the accumulation, concentration, drying, and solidification of morbid matter. Overall, the available Unani literature provides a valuable traditional framework for understanding *Ḥaṣā al-Kulya*. By organizing dispersed classical texts, it provides a framework for the study of *Ḥaṣā al-Kulya*. Such integration of traditional concepts with present-day approaches may enhance diagnosis, improve therapeutic planning, and open new ways for research in the holistic management of the disease.

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