



Migraine [Shaiqa], Historical Background, Etiology, Triggering Factors, A Comparative Review Of Unani And Modern Literature.

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Abstract: Migraine, referred to as Shaiqa in the Unani system of medicine, is a chronic, episodic headache disorder that predominantly affects one side of the head and has been documented since ancient times. Classical Unani scholars described Shaiqa within the framework of humoral imbalance and deranged temperament (mizāj), emphasizing the influence of dietary habits, emotional states, lifestyle factors, and environmental exposures. In contrast, modern medicine characterizes migraine as a complex neurovascular disorder involving genetic predisposition, altered cortical excitability, trigeminovascular activation, and neurogenic inflammation. This narrative review explores the historical development of migraine concepts in Unani and modern medical literature and critically examines etiological factors and triggering mechanisms described in both systems. Classical Unani texts identify prolonged fasting, excessive exertion, menstrual irregularities, emotional stress, sleep deprivation, gastrointestinal disturbances, sensory overload, and specific dietary factors as major precipitants of Shaiqa. Contemporary biomedical research reports remarkably similar triggers, including psychological stress, hormonal fluctuations, irregular sleep patterns, dietary components, sensory stimuli, and environmental changes. Despite differences in theoretical explanations, both traditions demonstrate striking convergence in clinical observations and preventive strategies. Integrating Unani and modern perspectives may therefore provide a more comprehensive understanding of migraine and support the development of patient-centered, integrative management approaches.

Keywords; Migraine, Shaiqa, Sudae Nisfi, Adhasisi (Hemicrania), Sudae Ghasyani (Sick Headache), Akhlat -e- Arbaa, Humours, Mizaj

I. INTRODUCTION

Migraine is a form of primary headache. The term "hemi-crania" is a Greek word, with its Latin meaning "hemicranium", which got translated to "mergin" in old English and later to "migraine" in French.¹

Migraine is a primary headache disorder characterized by recurrent episodes of headache associated with neurological and systemic symptoms. It is an inherited, episodic condition of the brain in which headache represents only one component of a broader neurobiological disturbance. Although the precise mechanisms underlying migraine are not completely understood, the pain is believed to arise from activation of sensory nerve pathways supplying the intracranial blood vessels and meninges, leading to complex neurovascular interactions.²

Migraine affects a substantial proportion of the global population, with higher prevalence reported in Western countries compared to Asia and Africa. The disorder commonly begins during adolescence or early adulthood and often persists throughout the most productive years of life². Epidemiological studies consistently demonstrate a higher prevalence among females than males, suggesting a significant role of hormonal influences. Globally, migraine is recognized as a leading cause of disability due to its recurrent nature and its considerable impact on quality of life.⁵

Clinically, migraine presents as recurrent headache attacks lasting between 4 and 72 hours,¹ typically unilateral, pulsating in nature, and of moderate to severe intensity.⁵ The pain is often aggravated by routine physical activity and is commonly accompanied by nausea, vomiting, photophobia, or phonophobia. Owing to these associated features, migraine is frequently referred to as a "sick headache."⁴

UNANI PERSPECTIVE ON SHAQIQA [MIGRAINE]

Shaqiqa is a well known disease in the Unani System of Medicine, which is also referred as Sudae Nisfi, Adhasisi (Hemicrania), or Sudae Ghasyani (Sick Headache). The term "shaqiqa" literally means "a part" or "a portion," reflecting the fact that this headache is often localized to one side or a specific portion of the head, which is why it is also called shaqiqa or sudae nisfi (Hemicrania). This is a distinct form of headache that occurs in sudden episodes, typically affecting either the right or left longitudinal half of the head, frequently accompanied by symptoms like nausea, vomiting, flashing lights, and visual auras. Occasionally, the headache can affect the entire head, but its intensity is usually milder on one side. It may also begin at sunrise, progressively intensify, and persist until sunset. The onset of shaqiqa can occur in childhood with recurrent / cyclical vomiting, while the classic migraine form tends to appear during adolescence and continue intermittently until around the sixth decade of life. This condition is more prevalent in women (20%) compared to men (6%).⁶

CLASSIFICATION OF SHAQIQA [MIGRAINE] ON BASIS OF AKHLAAT -E ARBAA [HUMORS] AND MIZAJ [TEMPERAMENT] RESPECTIVELY

Based on the concept of *Akhlāt-e-Arbaʿa* (the four humours), *Shaqiqa* is classified into four types: Damvi (originating from blood), Safravi (resulting from bile), Balghami (arising from phlegm), and Saudavi (caused by black bile). Additionally, on the basis of *Kaifiyat* (qualitative temperament), shaqiqa is broadly grouped into two forms: Shaqiqa Ḥār, associated with blood or bile, and Shaqeeqa Bārid, linked to phlegm or black bile.⁶

REVIEW LITERATURE

Historical Background.

Migraine is among the earliest recorded medical disorders known to humanity. Ancient civilizations believed that headaches were manifestations of malevolent spirits. Evidence of such beliefs and the remedies designed to relieve head pain has been found in records dating back almost 7000 years.⁷ Mesopotamian physicians considered headache not merely a symptom but a distinct disease caused by an evil spirit called Tiu. Its diagnosis was not essential due to acceptance of supernatural phenomenon and treatment was dependent upon appeasing or releasing the evil spirit.¹

An Egyptian papyrus dated to 2500 BCE explains a treatment in which a clay figure of a sacred crocodile was bound to the patient's head with a bandage, accompanied by prayers. It remains unclear whether this method alleviated headaches due to a placebo effect or because the tight bandage physically compressed swollen scalp arteries linked to the external carotid system. If this treatment was ineffective, the next step involved creating an opening in the skull using a trephine to release the presumed malicious spirit.¹

In Unani classical literature, migraine—referred to as Shaqiqa—is also recognized as an ancient condition. Nearly all major Unani scholars have discussed it extensively.

Hippocrates (460–370 BC) is credited with one of the earliest recorded descriptions of migraine, which was first mentioned as a recurring condition in Mesopotamian poetry around 3000 B.C. He described intense pain affecting one side of the head, accompanied by visual disturbances. According to his observations, the individual would see a bright light, typically in a portion of the right eye, followed shortly by severe pain starting at the right temple and then spreading across the head and neck. Vomiting, when it occurred, could alleviate the pain and lessen its intensity. These detailed accounts accurately captured key characteristics of migraine, including the visual aura, its one-sided nature, and relief provided by vomiting.⁸

Galen (131–201 AD) introduced the term hemicrania, meaning “half of the head,” which later evolved linguistically into the English word migraine.¹ He noted that the pain typically affected the weaker part of the head, often reaching toward its center, and could be continuous or episodic.²¹

Rabban Tabri (780–850 AD) explained that the term Shaqiqa refers to pain occurring in one half (shaq) of the head. He attributed the condition to small quantities of harmful substances lodged in the cranial arteries and classified migraine into Shaqiqa Haar (hot type) and Shaqiqa Barid (cold type). He also cited Ibn Sayyar's observation that migraine may occasionally involve the entire head.^{17,19}

Razes (Zakariya Razi, 850–923 AD), in Kitab al-Hawi, discussed the pathogenesis, causes, clinical features, and treatment of Shaqiqa. He attributed its origin to coldness, thick morbid humors, or excessive bodily evacuation such as heavy menstrual or puerperal bleeding. He also observed that certain headaches could cause transient facial paralysis.²²

Ali Ibn Abbas Majoosi (930–994 AD) in Kamil al-Sana described migraine in detail, linking it to the accumulation of dense fluids, vapors from the stomach, or feverish conditions such as humma muharriqa and humma ghib.¹⁵

Ibn Sina (Avicenna, 980–1037 AD) explained Shaqiqa as pain involving half of the skull, originating either in the meninges or the temporal muscles. Pain arising from the meninges was perceived deeply, often behind the eye, while muscular pain became intolerable even to touch. He cited hot and cold humors, flatus, and vapors as causative factors and recommended venesection of the wareed Jabeehi and the use of enemas as treatment.¹⁴

Ibn Zuhr (1092–1162 AD) believed that hot flatus, congestion, or vapors arising from morbid stomach contents could trigger Shaqiqa.²⁰

Hubal Baghdadi (1121–1213 AD) classified Shaqiqa as a form of Suda-e-Maddi and recommended Habbe Qoqaya for its treatment.¹⁸

Hakim Azam Khan (1813–1902 AD) in Al-Akseer emphasized the role of vapors, morbid humors, and flatus accumulating on one side of the head. He warned that untreated migraine could lead to complications such as cataract or visual impairment.¹⁹

Hakim Ajmal Khan (1927 AD) described migraine pain as initially mild but progressively severe, accompanied by photophobia, nausea, and pulsating discomfort. He noted the patient's preference for darkness.¹⁶

In Western medicine, Thomas Willis (1664) expanded Hippocratic and Galenic ideas by proposing that migraine resulted from dilation of intracranial blood vessels—the earliest vascular theory of migraine. This theory gained credibility when compression of the superficial temporal artery was observed to reduce headache intensity.⁹

By the late 19th century, the vascular theory was challenged by the emerging view that migraine stemmed primarily from neurological dysfunction. **Moebius (1898)** stated that “parenchyma is the master, circulation the servant,” suggesting that both neural and vascular mechanisms contribute to migraine attacks.⁹

PRECIPITATING FACTORS / TRIGGERING FACTORS:-

- 1: Prolonged exposure to bright light
- 2: Physical stress
- 3: Emotional stress
- 4 :lack of exercise
- 5: lack of sleep
- 6 : prolonged fasting
- 7: use of Oral contraceptives pills
- 8: 4 cs of Migraine (cheese, chocolate, caffeine, citrus fruits)^{10,11,12}

ETIOLOGY AND PATHOGENESIS

The exact cause of migraine remains largely unclear, although a familial pattern is frequently observed, indicating an underlying genetic susceptibility. The marked predominance in females, along with the tendency for some women to experience attacks at specific phases of the menstrual cycle, points toward a significant hormonal influence. The role of oral contraceptives is not fully established; however, evidence suggests that they may worsen migraine in many individuals and slightly increase the risk of stroke in patients who experience migraine with aura. In certain cases, specific dietary factors—such as cheese, chocolate, or red wine—act as identifiable triggers. When psychological stress contributes to migraine, attacks often develop after the stressful period has passed, which explains why some individuals experience headaches during weekends or at the onset of vacations.

The aura seen in classical migraine is thought to reflect a wave of cortical electrical activation followed by suppression of neuronal activity. Although the precise mechanism remains uncertain, this phenomenon is likely related to transient disturbances in cortical modulation pathways originating from the brainstem, particularly those involving serotonergic projections. The occurrence of migraine-like symptoms in rare inherited disorders linked to calcium channel gene mutations further supports the idea that aura may result from episodic dysfunction of neuronal ion channels. The headache phase itself is believed to arise from dilation of extracranial blood vessels and, similar to post-epileptic headache, may represent a non-specific consequence of disrupted neuronal activity.¹¹

ETIOLOGY OF SHAQIQ[A MIGRAINE] IN UNANI

Weakness of one side of head [Galen]²¹

Active bad vapors [buray bukharat] that raise towards head due to abundance of bad secretions or their intense heat or cold nature^{14,24}

Blood disorder, Weakness, Fatigue, Starvation ,Indigestion, Insomnia, Bright light , Excessive sexual intercourse, Kidney diseases ,Eye diseases.^{23,25}

CILNICAL PATTERNS

Migraine attacks vary from intermittent headaches indistinguishable from tension headaches to discrete episodes that mimic thromboembolic cerebral ischaemia. Distinction between variants is somewhat artificial.

Migraine can be separated into phases:

well-being before an attack (occasional) prodromal symptoms

* the main attack - headache, nausea, vomiting

* sleep and feeling drained afterwards.¹³

Migraine with aura (classical migraine)

Prodromal symptoms are usually visual and related to depression of visual cortical function or retinal function. Unilateral patchy scotomata (retina), hemianopic symptoms (cortex), teichopsia (flashes) and fortification spectra jagged lines like battlements) are common. Transient aphasia sometimes occurs, with tingling, numbness, vague weakness of one side and nausea. The prodrome persists for a few minutes to about an hour. Headache then follows. This is occasionally hemicranial (i.e. splitting the head) but often begins locally and becomes generalized. Nausea increases and vomiting follows. The patient is irritable and prefers the dark. Superficial scalp arteries are engorged and pulsating. After several hours the migraine settles, sometimes with a diuresis. Deep sleep often ensues.¹³

Migraine without aura (common migraine)

This is the usual variety. Prodromal visual symptoms are vague. There is a similar headache often accompanied by nausea and malaise.¹³

Clinical Features Unani

Symptoms Before the onset of a migraine attack,[Alamat Munzirah].

patients often experience warning symptoms such as blurred or reduced vision, dizziness, and the appearance of flashing lights or sparks in front of the eyes.

As the migraine progresses, the headache starts gradually and increases in intensity over time. Eventually, the pain becomes severe and throbbing, giving the sensation that the head is bursting. Physical activities such as walking or movement worsen the pain. The headache usually affects one side of the head, although in some cases the entire head may be involved, with greater intensity on one side.

On examination, tenderness or a palpable lump may be felt over the forehead and eyebrows, which may also be visibly prominent. Patients often become incapacitated by physical exertion and develop marked sensitivity to light (photophobia) and sound (phonophobia). Visual disturbances such as flashing lights, ringing in the ears (tinnitus), pallor of the face and body, and a weak, irregular pulse may also be present. Associated symptoms commonly include nausea and vomiting. The pain may extend from one side of the head to the neck and can last from a few minutes to several hours. In severe cases, it may persist for two to three days. The attack usually ends with deep sleep, after which the patient feels relief. The headache may recur after several days or weeks.^{21,25}

Simplified diagnostic criteria for Migraine

Repeated attacks of headaches lasting 4-72 hrs that have following features:

- A. Normal physical examination
- B. No other reasonable cause for the headache
- C. Atleast two of: Unilateral pain; Throbbing pain; Aggravation of pain by movement
- D. Atleast one of : Nausea or vomiting; Photophobia and phonophobia .^{10,12}

Principles of treatment

1. Address and correct the underlying cause of the disease.
2. Administer *Musakkināt-e-Ālam* (analgesic agents) to alleviate pain.
3. Eliminate the predominant and pathological humours from the body and brain.
4. Perform *Fasd* (venesection) of the cephalic or saphenous vein when *Khilt-e-Dam* (blood) is the dominant humour.
5. In cases of headache without accumulation of morbid matter, instead of *Tanqiyah* (evacuation), bring about a moderate correction of *Mizāj* (temperament).
6. Following *Tanqiyah* of morbid humours, undertake *Ta 'dīl-o-Taqwiyat-e-Dimāgh* (regulation and strengthening of brain function).
7. Implement preventive measures and prescribe drugs to inhibit *Sa 'ūd-e-Bukharāt* (upward movement of vapors) toward the head.

8. Apply *Lāziq Advia* (local adhesive medications) to reduce excessive pulsation of the superficial temporal artery.
9. Place the patient in a quiet, darkened environment and perform gentle head massage (*Dalk*) using *Roghan-e-Gul* (cool rose oil, optionally with ice), or administer *Nutūl* with hot or cold herbal decoctions depending on the nature of the morbid humour.
10. Identify and eliminate predisposing as well as triggering factors.
11. Relieve constipation, if present, as part of comprehensive management.⁶

Comparative analysis of Migraine in unani and modern medicine

Parameter	Unani Perspective (Shaqeeqa)	Modern Medical Perspective (Migraine)	Comparative Interpretation
Conceptual Basis	Based on humoral theory and imbalance of <i>mizaj</i> (temperament)	Based on neurovascular and neurobiological mechanisms	Different theoretical models but similar clinical recognition
Historical Understanding	Described since Greco-Arab period by classical Unani scholars	Scientifically characterized in the 19th–20th century	Ancient empirical observations align with modern findings
Etiology	Derangement of humors, accumulation of morbid matter, lifestyle errors	Genetic predisposition, cortical hyperexcitability, neurotransmitter imbalance	Both recognize internal predisposition with external modifiers
Pathogenesis	Altered humoral flow affecting cranial vessels and nerves	Activation of trigeminovascular system and neurogenic inflammation	Vascular and neural involvement acknowledged in both systems
Nature of Pain	Recurrent, unilateral, severe headache	Recurrent, unilateral or bilateral, pulsating headache	Strong similarity in symptom description
Triggering Factors	Fasting, excessive exertion, sleep deprivation, emotional stress, sensory stimuli, dietary factors	Stress, hormonal changes, sleep disturbance, sensory and dietary triggers	High degree of overlap in precipitating factors
Role of Lifestyle	Central role in causation and disease progression	Important role in prevention and trigger avoidance	Lifestyle modification emphasized in both
Approach to Patient	Holistic and individualized	Evidence-based and mechanism-oriented	Complementary strengths in patient care

Limitations of this review This is a focused narrative synthesis — not a systematic review. Unani literature is heterogeneous in language, classical vs modern sources, and trial quality; many Unani reports are observational or small trials, limiting meta-analytic inference.

Conclusion

Migraine and Shaqiqa, as described in modern medicine and the Unani system respectively, exhibit substantial similarity in clinical presentation, triggering factors, and preventive priorities, despite being grounded in different theoretical paradigms. Modern medicine explains migraine through neurovascular and neurobiological mechanisms, whereas Unani medicine interprets the condition in terms of humoral imbalance and altered temperament. Nevertheless, both traditions emphasize the central role of lifestyle factors, emotional balance, dietary regulation, and sensory moderation in disease onset and prevention. An integrative, patient-centered approach that combines evidence-based modern therapies with validated Unani regimens and preventive strategies may enhance overall migraine management. Future research should focus on systematically evaluating Unani interventions using rigorous scientific methodologies to strengthen their evidence base and facilitate their safe incorporation into integrative headache care.

References;

1. Rapoport A, Edmeads J. Migraine: The evolution of our knowledge. *Archives of Neurology*. 2000;57(8):1221–1223.
2. Khairmode DV, Kapare PR, Jadhav KL, Khade RH, Keskar CH, Ghongade KD, Kamble R, Mali AS. Migraine is not just a headache. *Pharma Science Monitor*. 2018;9(1):28–34
3. Kajal M, Malik M, Kumari R. Correlation of stress with migraine: A review. *International Journal of Current Research*. Year;Volume(Issue):Page numbers.
4. Prameela B, Subhashini S, Anusha V, Tony DE, Rao NR. Migraine – a malady: A short review. *Scholars Academic Journal of Pharmacy*. 2014;3(3):285–289.
5. Shah B, Pandey DR. Migraine. *European Journal of Biomedical and Pharmaceutical Sciences*. 2017;4(4):226–230.
6. Akhtar MS, Rajesh, Kibria T, Camri MA, Anas M. Shaqeeqa (migraine): Concept and management in Unani medicine. *International Journal of Creative Research Thoughts (IJCRT)*. 2020;8(11):Page numbers.
7. Hirschinger R. Caring for head pain and sleep apnea: Muscle and nerve pain of the head and neck. Dr. Rich Hirschinger – Orofacial Pain and Sleep Apnea Clinic [Internet]. n.d. Available from: <https://www.hirschinger.com>
8. Pearce JMS. Historical aspects of migraine. *Journal of Neurology, Neurosurgery, and Psychiatry*. 1986;49:1097–1103.
9. Villalón CM, Centurión D, Valdivia LF, Vázquez PD, Saxena PR. Migraine pathophysiology, pharmacology, treatment and future trends. *Current Vascular Pharmacology*. 2003;1:71–84.
10. Fauci AS, Braunwald E, Kasper DL, Hauser SL, Longo DL, Jameson JL, Loscalzo J. *Harrison's Principles of Internal Medicine*. 17th ed. Vol. 1. New York: McGraw-Hill; . p. 96–98.
11. Colledge NR, Walker BR, Ralston SH. *Davidson's Principles and Practice of Medicine*. 20th ed. New York: Elsevier; p. 1162–1163.
12. Golwalla AF, Golwalla SA. *Golwalla's Medicine*. 24th ed. . p. 395–397.
13. Kumar P, Clark M. *Kumar & Clark's Clinical Medicine*. 7th ed. p. 1136–1137
14. Ibn Sina, *Al Qanoon fil Tib* vol.3 part 1 Pg no. 530, Idara Kitabus Shifa, New Delhi.
15. 2.Ali Ibn Abbas Majoosi (Gulam Hussain sb.Kantoori) *Kamil us sana* vol.2 Pg no. 302 Idara kitabus Shifa, CCRUM Pg no. 545, New Delhi.
16. Masihul Mulk Hakeem Ajmal Khan, *Haziq* Pg no. 24,25,26, Idara Kitabus Shifa, New Delhi.
17. Abul Hasan Ahmad Bin Mohd. *Tabri, Moalijat Buqratia* Pg no. 284
18. Abul Hasan Ali bin Ahmad Bagdadi, *Kitabul Mukhtar fil Tib*, vol .3 Pg no.19,CCRU New Delhi.
19. Kabiruddin, *Al Akseer*, pg no. 144,145,146,147,148,149,150 Aijaz publication new Delhi
20. . Ibn Zuhri, A. M. (n.d.). *Kitāb al-Taysīr fī al-Mudāwāt wa al-Tadbīr* p 77,78. CCRUM; New Delhi
21. Allama Najeebuddin Samarqandi, *Sharah Asbab* pg no. 39,40,41 Idara kitabus shifa,New Delhi.
22. . Zakaria Razi, *Hissa 1 Urdu Tarjuma, Kitabul Hawi* Pg no. 192, CCRUM New Delhi

23. 14.Hkm Doctor Gulam Jilani, Makhjanul Hikmat Pg no. 714 Idarakitabus shifa, New Delhi
24. .Zakariya Razi, Kitab Al Fakhir pg no. Jild awwal 62,63 CCRUM New Delhi
25. .Hakeem Mohd Kabiruddin, Kitab al Tashkhees pg no. 112.113,114

