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Breast Cancer: A Comprehensive Review of Modern Oncological Advances and Unani Perspectives

Dr. Sumayya Fatima[1], Dr. Bhatti Afira Khanam[2]

[1] P.G Scholar, P.G Department of Qabalah wa Amraz e Niswan, Govt Nizamia Tibbi College, Hyderabad, India
Corresponding Author Email: *sumayyamehamood[at]gmail.com*

[2] P.G Scholar, P.G Department of Qabalah wa Amraz e Niswan, Govt Nizamia Tibbi College, Hyderabad, India

Abstract: ***Breast cancer is the most prevalent malignancy among women worldwide, contributing significantly to morbidity and mortality. Its etiology is multifactorial, involving genetic, hormonal, environmental, and lifestyle factors. Modern oncology has made substantial advances in molecular pathophysiology, diagnostic techniques, and therapeutic modalities, including surgery, chemotherapy, radiotherapy, and targeted therapy. Despite these developments, challenges persist in early detection, treatment efficacy, and prevention of recurrence. The Unani system conceptualizes breast cancer as Sartan-e-Saddi, emphasizing the balance of humors (Akhlaṭ), temperament (Mizaj), and lifestyle modifications. Classical Unani scholars described its etiology, clinical features, and management through humoral correction, herbal therapy, dietary regulation, and surgical intervention. This review integrates modern oncological advances with Unani perspectives to provide a holistic understanding of breast cancer. It highlights complementary approaches in prevention and treatment and underscores the potential of integrative care in improving patient outcomes.***

Keywords: Breast cancer, *Sartan-e-Saddi*, Modern oncology, Unani system of medicine, Integrative therapy

1. Introduction

Breast cancer comprises a heterogeneous group of malignancies originating in breast tissue, characterized by uncontrolled proliferation of abnormal cells that evade immune surveillance and apoptotic mechanisms. These malignant cells can disseminate from the primary site to distant organs through the bloodstream or lymphatic system [1]. Modern oncology has made substantial progress in understanding the molecular pathogenesis, improving diagnostic modalities such as imaging and histopathology, and advancing therapeutic options including surgery, systemic therapies, targeted agents, and immunotherapy. Despite these advances, challenges remain in early detection, effective personalized treatment, and long- term survivorship care [2]. Unani medicine, a traditional system rooted in humoral theory, conceptualizes cancer including breast cancer (*Sartan-e-Saddi*) in terms of imbalances in temperament (*Mizaj*) and morbid humors (*Akhlaṭ*). Classical Unani scholars provided detailed descriptions of disease progression, clinical presentation, and principles of treatment based on humoral correction and holistic care [3].

Understanding modern oncological advances alongside traditional Unani perspectives may enrich the overall conceptualization and management of breast cancer. This review aims to integrate contemporary scientific knowledge with Unani insights to provide a comprehensive and multidimensional understanding of the disease.

2. Modern Oncology Concepts

2.1 Epidemiology [4], [5]

Breast cancer is the second most common cancer globally, with 2.3 million new cases and 665,684 deaths reported by GLOBOCAN 2022. Its incidence is rising in developing countries, while mortality is declining in high-income nations due to better screening and treatment. In India, it accounts for about 192,020 cases (14% of female cancers) and 98,337 deaths, with higher incidence in urban areas and peak occurrence between 40–60 years. According to the American Cancer Society, breast cancer incidence varies by race/ethnicity: non-Hispanic White (128.1/100,000), African American (124.3/100,000), Hispanic/Latina (91.0/100,000), American Indian/Alaska Native (91.9/100,000), and Asian American/Pacific Islander (88.3/100,000).

2.2 Risk Factors of Breast Cancer [6]-[8], [14], [15]

Breast cancer risk factors are broadly classified into **non-modifiable** and **modifiable**.

2.2.1 Non-Modifiable Factors

a) **Female Sex:** Female sex is a major risk factor due to hormonal influence, particularly estrogen and progesterone. Hormonal imbalance increases susceptibility. Male breast cancer is rare (<1%) but associated with age, BRCA mutations, estrogen excess, Klinefelter syndrome, and radiation.
b) **Older Age:** Risk increases with age; most cases occur >50 years. Carcinogenesis is linked to cumulative cellular damage. Younger women more often develop aggressive subtypes (e.g., triple-negative), while older women show luminal A subtype.
c) **Family History:** First-degree relatives increase risk, especially at younger ages. Risk rises with number of affected relatives and is influenced by genetic and environmental factors. Associated also with ovarian cancer history (BRCA mutations).

d) **Genetic Mutations:** High-risk genes include BRCA1 and BRCA2. Others: TP53, PTEN, CDH1, STK11. Moderate-risk genes include ATM, CHEK2, PALB2. These mutations increase susceptibility to breast and ovarian cancers.
e) **Race/Ethnicity:** Incidence is higher in white women, while mortality is higher in black women, indicating disparities in outcomes.
f) **Reproductive History:** Prolonged estrogen exposure increases risk. Early pregnancy and multiparity are protective. Early menarche increases risk, while early menopause reduces it. Breastfeeding lowers risk.
g) **Breast Tissue Density:** Higher breast density is associated with increased risk in both premenopausal and postmenopausal women.
h) **Personal History of Breast Disease:** Previous breast cancer or benign proliferative conditions (e.g., atypical hyperplasia) significantly increases risk.
i) **Previous Radiation Exposure:** Radiation therapy, especially before age 30, increases risk. Risk varies with dose, technique, and genetic predisposition.

2.2.2 Modifiable Factors

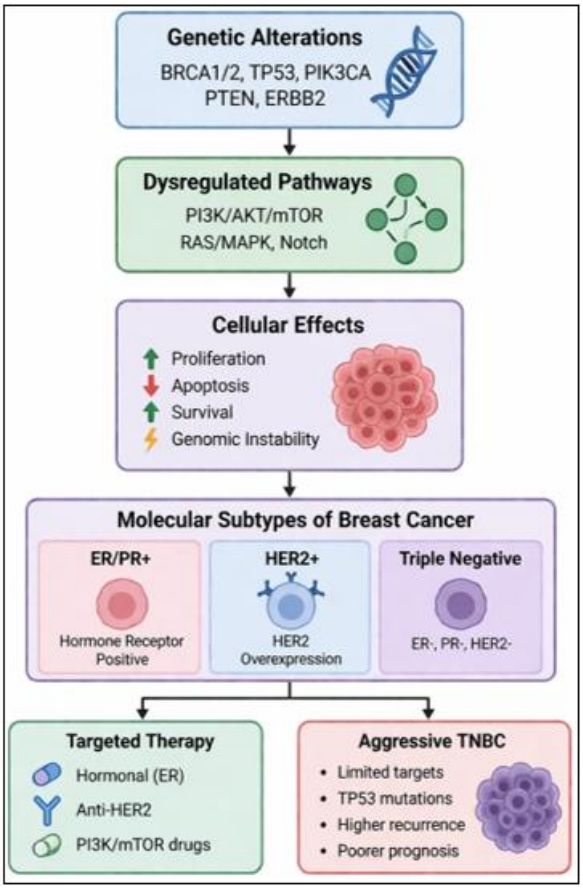
a) Drug Exposure: Hormonal replacement therapy (long-term use) increases risk. Diethylstilbestrol [DES] exposure and certain drugs (antidepressants, antibiotics) show possible associations, though evidence is inconsistent.
b) **Physical Activity:** Regular physical activity reduces risk, possibly via hormonal regulation and immune modulation.
c) **Body Mass Index (BMI):** Obesity, especially postmenopausal, increases risk and worsens prognosis due to hormonal and inflammatory effects.
d) **Alcohol Intake:** Alcohol increases estrogen levels and breast cancer risk, particularly hormone-positive types.
e) **Smoking:** Active and passive smoking increase risk through carcinogenic effects on breast tissue DNA.
f) **Vitamin Deficiency:** Vitamin D may have protective effects, though evidence for other vitamins remains inconclusive.
g) **Artificial Light Exposure:** Exposure to light at night may disrupt melatonin and increase risk, though evidence is still evolving.
h) **Diet:** Processed foods and saturated fats increase risk. Diets rich in fruits, vegetables, fiber, and phytoestrogens are protective.
i) **Chemical Exposure:** Chronic exposure to chemicals (e.g., DDT, PCBs, PAHs) increases risk via endocrine and epigenetic disruption.
j) **Other Drugs:** Some medications (antihypertensives, NSAIDs, statins) have uncertain associations with breast cancer risk.

2.3 Molecular Pathogenesis [9]-[11]

Breast cancer is a heterogeneous malignancy characterized by molecular alterations influencing tumor behavior, prognosis, and therapy. It is classified based on ER, PR, and HER2 status, guiding treatment strategies. ER/PR-positive tumors are driven by estrogen signaling and respond to endocrine therapy (e.g., tamoxifen, aromatase inhibitors). HER2-positive cancers show ERBB2 amplification, leading to aggressive growth but responsiveness to trastuzumab.

Key mutations include BRCA1/2, impairing DNA repair and increasing hereditary risk. Other mutations (TP53, PIK3CA, PTEN) contribute to abnormal proliferation. The PI3K/AKT/mTOR pathway promotes growth and survival, while RAS/MAPK and Notch pathways contribute to proliferation and resistance.

Triple-negative breast cancer (TNBC) lacks ER, PR, and HER2, showing aggressive behavior and frequent TP53 mutations with limited targeted options. Targeted therapies include PI3K inhibitors (alpelisib) and mTOR inhibitors (everolimus), with evolving immunotherapy and antibody-drug conjugates.



2.4 Classification [8]

Table: Breast Carcinoma classification

Type	Definition / Origin	Incidence / Prevalence	Key Clinical Features	Risk
Ductal Carcinoma In Situ (DCIS)	Non-invasive lesion confined to breast ducts	~20% of new breast cancers	Often asymptomatic; detected by mammography (clustered microcalcifications)	Early recognition prevents progression to invasive disease
Lobular Carcinoma In Situ (LCIS)	Non-invasive lesion from lobules & terminal ducts	Found with invasive carcinoma in ~5% of cases	Often bilateral, multifocal; usually asymptomatic	~20% risk of invasive breast cancer over 20–25 years
Paget Disease of the Breast	Intraepithelial adenocarcinoma of nipple-areola complex	1–3% of new breast cancers	Scaly, eczematous, ulcerated nipple lesion	97% have underlying DCIS or invasive carcinoma
Invasive Ductal Carcinoma (IDC)	Malignant epithelial cells infiltrating breast tissue	70–80% of invasive cancers	Firm, grey-white mass; nonuniform cells histologically	Most common invasive subtype
Invasive Lobular Carcinoma (ILC)	Malignant cells from lobules, infiltrate stroma in single-file pattern	10–15% of invasive cancers	Multicentric, often bilateral; uniform small round cells	Second most common invasive subtype
Inflammatory Breast Cancer (IBC)	Aggressive carcinoma with dermal lymphatic invasion	1–5% of breast cancers	Rapid enlargement, warm breast, erythema, peau d'orange	Often stage III/IV at diagnosis; highly aggressive

2.5 Clinical Features of Breast Cancer [12], [14], [15]

2.5.1 Symptoms

The most common presenting symptom is a breast lump, observed in approximately 70% of patients, and is usually painless. Nearly 90% of breast masses are first detected by the patient herself.

Other symptoms include breast pain, nipple discharge, nipple erosion, retraction, enlargement, or itching, along with changes in breast size such as enlargement or shrinking. In some cases, patients may present with axillary swelling, swelling of the arm, or bone pain due to metastatic involvement. Systemic symptoms such as weight loss may also be present in advanced disease.

2.5.2 Signs

Clinical examination may reveal a palpable breast mass, often firm in consistency. Other findings include redness, generalized hardness of the breast, and changes in size and contour. Axillary lymph node enlargement may also be present.

2.6 Diagnosis

2.6.1 Essentials of Diagnosis [12]

Early Findings:
- Single, non-tender, firm to hard breast mass with ill-defined margins
- Mammographic abnormalities, sometimes in the absence of a palpable mass

Intermediate (Locally Advanced) Findings:
- Skin or nipple retraction
- Axillary lymphadenopathy
- Breast enlargement, redness, and edema
- Brawny induration and *peau d'orange* appearance
- Pain and fixation of the mass to the skin or chest wall

Late Findings:
- Ulceration of the breast
- Supraclavicular lymphadenopathy
- Edema of the arm
- Evidence of distant metastases involving bone, lungs, liver, brain, or other organs

2.6.2 Diagnostic Modalities [9], [10], [13]
- Early and accurate diagnosis of breast cancer relies on a combination of clinical evaluation, imaging techniques, and histopathological confirmation.
- Mammography is the primary screening tool and is highly effective in detecting early lesions, particularly microcalcifications, even before a palpable mass develops.
- Ultrasonography (USG) is useful as an adjunct to mammography, especially in women with dense breast tissue, and helps differentiate solid from cystic lesions.
- Magnetic Resonance Imaging (MRI) provides high sensitivity in detecting multifocal, multicentric, and bilateral disease, and is particularly useful in high-risk patients.
- Definitive diagnosis is established by tissue sampling techniques, including fine-needle aspiration cytology (FNAC), core needle biopsy, or excisional biopsy, which allow histopathological examination and receptor status assessment (ER, PR, HER2).

2.7 Screening [39], [40]

American College of Obstetricians and Gynecologists - ACOG 2017 (updated 2024)

According to ACOG, screening mammography is recommended to begin at 40 years in average-risk individuals. Screening should be performed every 1–2 years with shared decision-making and continued at least until 75 years, with individualization thereafter.

United States Preventive Services Task Force (USPSTF, 2024)

The USPSTF Grade- B recommends biennial screening mammography for women aged 40 to 74 years.

2.8 TNM Classification [16], [17]

The TNM system classifies breast cancer by tumor size (T), regional lymph node involvement (N), and distant metastasis (M) to determine disease extent and guide management **(U.S. National Cancer Institute, 2025)**.

T (Tumor):
- TX: Tumor cannot be assessed
- T0: No evidence of primary tumor
- Tis: Carcinoma in situ (pre- invasive)
- T1: ≤ 2 cm
- T2: > 2–5 cm
- T3: > 5 cm
- T4: Invasion of chest wall or skin, including inflammatory carcinoma

N (Nodes):
- NX: Regional nodes cannot be assessed
- N0: No nodal metastasis
- N1–N3: Increasing nodal involvement, from limited axillary nodes to extensive regional nodes

M (Metastasis):
- M0: No distant metastasis
- M1: Distant spread (bones, lungs, liver, brain)

This staging defines anatomical extent and is the basis for clinical and pathological stage grouping in breast cancer management.

2.9 Treatment and Advances in Breast Cancer [6], [9], [10], [18]-[20]

Management of breast cancer is based on a multidisciplinary approach, including systemic therapy, radiotherapy, surgery, tailored according to tumor stage, molecular subtype, and patient factors.

2.9.1 Targeted Therapy
Targeted therapy has revolutionized breast cancer treatment.
- **HER2-targeted agents** such as trastuzumab and pertuzumab significantly improve survival in HER2-positive tumors.
- **CDK4/6 inhibitors** (e.g., palbociclib) are used in advanced hormone receptor–positive cancers.
- **PI3K inhibitors** (e.g., alpelisib) are used in selected cases with specific mutations.

These therapies specifically target molecular pathways involved in tumor growth.

2.9.2 Hormonal Therapy
Hormonal (endocrine) therapy is indicated in hormone receptor–positive breast cancers.
- **Tamoxifen** is used in premenopausal women.
- **Aromatase inhibitors** (letrozole, anastrozole) are preferred in postmenopausal women.

These therapies act by blocking estrogen effects or reducing estrogen production, thereby inhibiting tumor growth.

2.9.3 Chemotherapy
Chemotherapy plays a crucial role in both early-stage and advanced breast cancer, particularly in high-risk and aggressive subtypes. Commonly used agents include anthracyclines and taxanes, which help reduce tumor burden and improve survival outcomes.

It may be administered as:
- **Neoadjuvant therapy** (before surgery) to shrink tumors.
- **Adjuvant therapy** (after surgery) to reduce recurrence risk.

2.9.4 Surgical Management
Surgery remains the cornerstone of treatment for early-stage breast cancer. The main surgical options include breast-conserving surgery (lumpectomy) and mastectomy, depending on tumor size, location, and patient preference.

Sentinel lymph node biopsy is commonly performed to assess regional lymph node involvement, while **axillary lymph node dissection** is reserved for patients with confirmed nodal metastasis.

2.9.5 Radiotherapy
Radiotherapy is commonly used after breast-conserving surgery to eliminate residual tumor cells and reduce local recurrence. It is also indicated in selected post-mastectomy cases, particularly in patients with large tumors or lymph node involvement.

2.9.6 Recent Advances
Recent advances in breast cancer management include:
- **Immunotherapy** (e.g., pembrolizumab), especially in triple-negative breast cancer.
- **Antibody–drug conjugates** (e.g., trastuzumab emtansine).
- **Personalized medicine** based on genetic and molecular profiling.

These developments have improved survival rates and opened new avenues for targeted and individualized treatment strategies

3.1 Unani Conceptual Perspective on Breast Cancer (*Sartan-e-Saddi)*

Terminology and Historical Background
Sartan is an Arabic term meaning *crab*, used in Unani literature to denote cancer. Scholars compared cancer to a crab, as the disease firmly adheres to affected tissues, making it difficult to remove. The earliest recorded description of cancer comes from ancient Egypt, around 3000 BC, documenting eight cases of breast tumors or ulcers treated by cauterization with a fire drill, representing one of the first surgical interventions for the disease [21].

Anatomy and Physiology of the Breast
The breast is composed of soft, glandular tissue containing a complex network of channels. These channels carry blood toward the glandular tissue, where it is transformed into milk. Situated over the chest, the breasts receive warmth from the major vessels of the heart, which branch within the breasts to maintain the required warmth for proper function. Proper circulation and warmth are crucial for normal physiology, and their disruption may contribute to pathological conditions such as *Sartan* [22], [32].

Nature and Pathophysiology of *Sartan*
Sartan is a severe and debilitating disease (*muhallik marz*) characterized by hard swelling (*sakht waram*) with deep roots, associated with roughness, tension, heat, and irritation (*khashunat, tanav, hiddat wa hararat*). It may begin as a small nodule but can gradually enlarge, often spreading to axillary soft tissue and surrounding glands. Pain and warmth on

palpation (*malmas*) are typical, though some cases show minimal pain. Early-stage recognition (*ibtedayi marhala*) can stabilize the disease, but enlargement or suppuration (peep) leads to severity and complicates treatment [23], [24].

Etiology and Contributing Factors

Sartan-e-Saddi may arise from *saudawi mada* or result from improper management of *saudawi waram*. Key contributing factors include:

The presence of *khilt e saudawi*, Inherent susceptibility of breast tissue, and Excessive use of hot medications (*garam muhallilat*) [25].

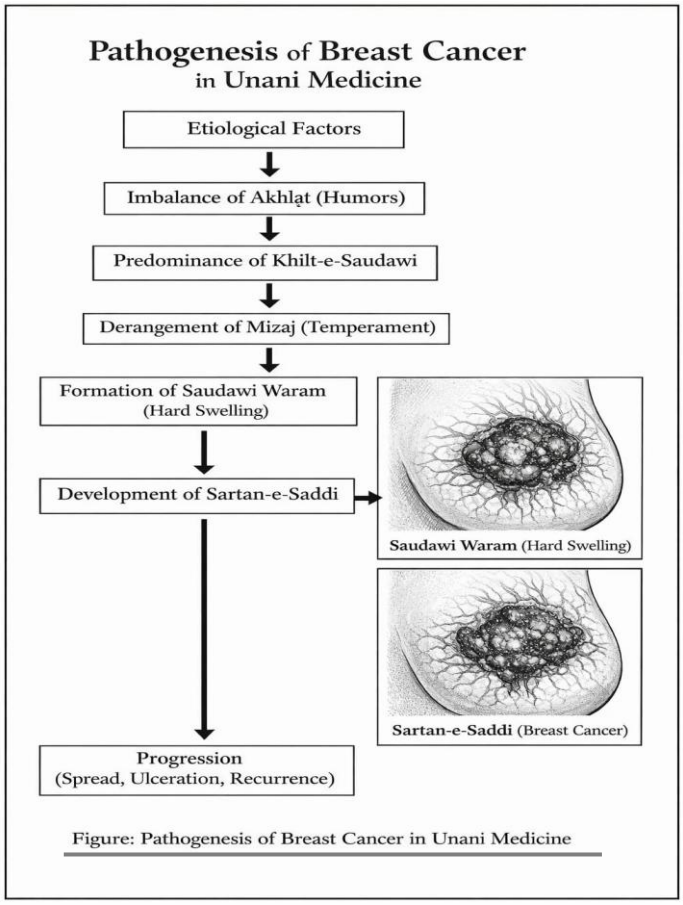


Figure: Pathogenesis of Breast Cancer in Unani Medicine

Clinical Features and Scholarly Perspectives

The disease manifests with early causative factors (*Asbab-e-marz*), presence of *Mada-e-marz*, firm nodular masses, hard uneven skin with reddish-black hue (*siyahi mayil surkh*), stagnation of blood in surrounding vessels, external enlargement, firmness, and persistent burning or pricking sensations [25].

Classical scholars provided insights into treatment: ***Buqrat*** recommended *mushil-e-sauda* and protective measures for ulcerated tumors (*munfajar*); ***Muhammad bin Zakariya al-Razi*** added oil in management; ***Jalinoos*** noted internal (*baatni*) *sartan* is difficult to cure; ***Younus*** highlighted its prevalence in women due to soft bodies and susceptibility to abnormal humors (*fuzlat*). Early physicians (***mutaqaddimeen***) reported recurrence in the other breast, which ***Ibn Sina*** explained as latent mada manifesting post-removal of the first breast [26]-[27], [34].

Progression, Prognosis, and Therapeutic Considerations

Waram sulb may progress to *Sartan*, which often resists conventional treatment. The disease is extremely severe, and complete recovery is rare. Treatment focuses on preventing progression, halting ulceration (*mutaqarrah*), and managing complications to protect other organs [28], [33].

3.2 *Usul-e-Ilaj* (Principles of Treatment) [29]-[31]

The management of *Sartan-e-Saddi* in Unani medicine is based on the following principles:

1) *Tadil-i-Mizaj*: Restore the balance of temperament using cooling remedies and avoiding hot, aggravating foods and medications.
2) *Tanqiya-i-Akhlaṭ*: Eliminate morbid humors through *fasd* and purgation, targeting accumulated *Khilt-e-Saudawi* and *Mawad-e-Mutawatir*.
3) *Izala-i-sudda*: Remove local blockages and reduce swelling by applying herbal pastes and promoting drainage of pus if present.
4) *Taqwiyat-i-A'da Ra'isa*: Strengthen vital organs and maintain systemic health with light, nourishing foods and drinks.
5) *Tadbeer-e-Amali*: Surgically excise tumors when necessary, ensuring proper wound care with Unani healing pastes to prevent recurrence.

6) *Hifz-e-Aza wa Sehat*: Prevent disease progression and complications by controlling pain, avoiding rupture, and following dietary and lifestyle interventions.

3.3 Unani Management of Sartan-e-Saddi [23]-[25], [29]-[31],[35]-[38]

Unani treatment aims to restore the balance of *Mizaj* (temperament), *Akhlaṭ* (humors), and *Tadbir* (lifestyle), targeting the root causes of disease. The treatment of *Sartan-e-Saddi* involves a combination of humoral correction, topical applications, dietary regulation and surgical intervention.

Humoral Correction and Systemic Therapy

a) Early management involves removal of morbid humors. Give *Naqoo Shahitra* as a *mundij* and perform cleansing with *Matbookh Aftimoon* or *Matbookh Sana*
b) Administer daily *Luab-e-Behdana*, *Sheera Unnab*, *Arq Murakkab Musaffi Khoon*, and *Sharbat Nilofer* to cleanse the system.
c) Perform *Fasd Basaleeq* or *Haft Indam* to eliminate *Khilt-e-Saudawi*.

Topical and Herbal Applications

a) For breast tumors and nodules: Crush fresh leaves of *Shaftalu* or *Sudab* and apply the paste to the affected area.
b) For warm breast swelling: Grind *Bakhli* and *Hulba*, mix with *Khatmi*, *Tukhm Katan*, and *Joshanda-e-Karnab*, add *Zafran*, and apply to the breasts. If excessive warmth is present, include *Aab-e-Mako*.
c) For firm breasts (*Salabat pastan*): Boil *Mom Safed*, *Cholai*, *Aarad Jao*, *Charbi-e-Batq*, *Charbi-e-Murgh*, *Barasinge ki Charbi*, *Aarad Hulba*, *Roghan-e-Khairi*, *Aarad Baqli*, *Gul-e-Babuna*, and apply the mixture externally.
d) For pus-filled swellings (*Peep*):
   - Grind *Anjeer* in *ghee*, mix with *Arq Chukandar* or *Methi*, and apply.
   - Crush *Alsi* and *Til*, mix with *Anjeer ka Sheer*, and apply as a paste.
e) For hard or firm breasts: Mix finely ground *Baqle ka aata*, *Babuna*, *Nakhuna*, *Khushk Banafsha*, and *Maveez Munaqqa* with a small amount of *Bakri ki Charbi* melted in *Roghan Sosan*. Alternatively, boil *Karam Kalla* alone and mix with *ghee* before application.
f) Prepare a topical paste by grinding *Aab Kasni Sabz*, *Aab Mako Sabz*, *Aab Kahu Sabz*, *Aab Kashneez Sabz*, *Gil-e-Armani*, *Roghan-e-Gul*, *Sandal Safed*, and *Kafoor*; apply externally to relieve burning and pain.

Dietary recommendations

- Dietary recommendations include *Aash Jao* as the best option or *Halwan ka Gosht* prepared with cooling vegetables such as *Kaddu*, *Khurfa*, or *Paalak*.
- Provide cool and moist foods (*Sard aur Tar*) such as *Kashkab*, *Roghan-e-Badam*, *Baiza-e-Murgh Neem Birya*, *Moong*, *Paalak*, and *Kaddu* while avoiding all hot and blood-aggravating foods.

Surgical Intervention (*Tareeqa Dastkari*)

- The patient is placed supine and anesthetized with chloroform. An assistant stretches the affected breast (*Maof-e-Pastan*) to tense the tissue.
- The surgeon makes a careful incision near the lower edge of the breast on the skin over *Uzla Sadariya Kabeera* (Pectoralis Major) and separates diseased tissue from the healthy breast.
- Severed vessels are ligated to control bleeding, and remaining diseased tissue is meticulously removed.
- Wound edges are approximated with sutures or plaster, and a healing paste made from *Kundur*, *Sibr*, *Anzaroot*, and *Dammul Aqwain* is applied. A small rubber tube ensures drainage of any remaining pus (peep). The wound is then covered with sterile cotton and properly bandaged.

Figure: *Sartan-e-saddi tareeqa e dastkari*

Prevention of Progression

- If pain arises in the breast, perform *Fasd*, followed by application of *Sandal* and *Aqaqiya* to prevent progression toward *Sartan*.
- If swelling with pain and redness (*Salabat Gududi*) occurs, apply *leeches* and repeat bloodletting as needed.

Avoidance of Aggravating Factors

- Repeated purgation (*Matbooq Aftimoon*) helps eliminate accumulated morbid matter (*Mawad*).
- Avoid foods and medicines producing *Maulidat-e-Sauda*, such as *Masoor ki Dal*, *Qanbeet*, meat of wild animals, beef, and *Sharab-e-Aswad*, which generate impure blood.
- Refrain from all hot foods and medications that darken blood or worsen the condition.

Evidence-Based Support for Unani Medicines [41]-[48]

Recent studies have demonstrated the potential anticancer, antioxidant, and anti-inflammatory effects of several Unani drugs used in the management of *Sartan-e-Saddi.*

- Withania somnifera (*Asgandh*)
- Curcuma longa (*Haldi*)
- Nigella sativa (*Kalonji*)
- Trigonella foenum-graecum (*Hulba*)
- Glycyrrhiza glabra (*Mulethi*)

These agents have been shown to inhibit tumor cell proliferation, induce apoptosis, and modulate key molecular pathways involved in carcinogenesis. Additionally, certain Unani formulations have exhibited cytotoxic effects against breast cancer cell lines in experimental studies.

Integration of Modern Oncology and Unani Perspectives

Breast cancer can be understood through both modern and unani frameworks. Modern oncology describes it in terms of molecular mechanisms, including genetic mutations, hormonal receptor status, tumor microenvironment, and pathways driving proliferation and metastasis [9]. Unani medicine interprets breast cancer as *Sartan-e-Saddi*, resulting from humoral imbalance (*Khilt-e-Saudawi*), deranged temperament (*Mizaj*), and systemic obstruction (*Sudda*) [3]. Both systems recognize the progressive nature of the disease, local tissue invasion, and the importance of early intervention.

Therapeutically, modern interventions include surgery, chemotherapy, radiotherapy, hormonal therapy, and targeted agents, whereas Unani treatments focus on temperament correction, humoral cleansing, removal of blockages, herbal and topical therapies, and regimental measures. Conceptually, integrating these approaches could provide a holistic model: modern medicine ensures rapid tumor control, while Unani therapy may support systemic health, symptom management, and long-term maintenance.

3. Discussion

The integration of Modern and Unani perspectives suggests potential benefits in patient-centered care. Modern therapies aim to eradicate the tumor and improve survival, while Unani interventions may contribute to quality-of-life improvement, symptom relief, and systemic balance. Clinically, Unani approaches could serve as adjunctive therapies, particularly for supportive care, management of treatment-related side effects, and prevention of recurrence.

Currently, a limitation is the lack of robust scientific validation for many unani formulations. Standardization, dosing guidelines, and safety evaluations are essential before they can be widely integrated. Future research should focus on clinical trials combining unani therapies with standard oncology care, studies correlating humoral imbalances with molecular biomarkers, and interdisciplinary collaboration to develop evidence-based integrative protocols.

4. Conclusion

Breast cancer remains a major global health challenge, with rising incidence and complex pathophysiology. Modern oncology has made remarkable progress in early detection, molecular understanding, and targeted therapies, significantly improving survival and outcomes. Unani medicine offers a complementary perspective, emphasizing the importance of humoral balance, systemic health, and individualized care in disease prevention and management. Understanding *Sartan-e-Saddi* provides historical insights into disease progression, early intervention, and holistic patient support.

An integrative approach combining evidence-based modern oncology with validated Unani interventions may enhance overall patient care, improve quality of life, and support long-term maintenance. Future research focusing on the scientific evaluation of Unani formulations and regimens alongside modern therapies could open new avenues for comprehensive, patient-centered breast cancer management.

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