Review

Medicinal benefits of *Nigella sativa* in bronchial asthma: A literature review

Abdulrahman Koshak, Emad Koshak, Michael Heinrich

*Research Cluster Biodiversity and Medicines, UCL School of Pharmacy, University College London, London, UK*

*Department of Natural Products & Alternative Medicine, Faculty of Pharmacy, King Abdulaziz University, Jeddah, Saudi Arabia*

*Allergy and Clinical Immunology Division, Department of Internal Medicine, Faculty of Medicine, King Abdulaziz University, Jeddah, Saudi Arabia*

**Abstract**

*Nigella sativa* L. (NS) seeds, known as black seed, is a spice and a traditional herbal medicine used in various diseases including bronchial asthma. This review aimed to assess the studies supporting the medicinal use of NS in asthma and to highlight future research priorities. Various medical databases were searched for the effects of NS and its active secondary metabolites in asthma inflammation and outcomes. There were fourteen preclinical studies describing multiple effects of NS in animal or cellular models of asthma including bronchodilation, anti-histaminic, anti-inflammatory, anti-leukotrienes and immunomodulatory effects. Furthermore, seven clinical studies showed improvements in different asthma outcomes including symptoms, pulmonary function and laboratory parameters. However, often these studies are small and used ill-defined preparations. In conclusion, NS could be therapeutically beneficial in alleviating airway inflammation and the control of asthma symptoms, but the evidence remains scanty and is often based on poorly characterised preparations. Accordingly, well-designed large clinical studies using chemically well characterised NS preparation are required.

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**Keywords:**

*Nigella sativa*  
Black seed  
Asthma  
Traditional medicine  
Clinical studies

**Abbreviations:**

NS, *Nigella sativa* L.; GINA, Global Initiative for Asthma; IL, Interleukin; ACT, Asthma Control Test; FEV1, forced expiratory volume in one second; Th1, Type 1 T helper (Th1) cells; Th2, Type 2 T helper (Th2) cells; RDBCT, Randomised Double-Blinded Clinical Trial; FeNO, fractional exhaled nitric oxide; IgE, Immunoglobulin E.

*Corresponding author at: Research Cluster Biodiversity and Medicines, UCL School of Pharmacy, London WC1A 1AX, UK.  
E-mail address: m.heinrich@ucl.ac.uk (M. Heinrich).  
Peer review under responsibility of King Saud University.


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1. Introduction

The seeds of the medicinal plant Nigella sativa L. (NS) are commonly used as a spice known as black seed. It also has traditional medical applications and is considered to be a characteristic traditional herbal medicine for diverse diseases in Unani, Arabic, Prophetic and Indian traditional medicines (Ahmad et al., 2013). Popular ancient physicians such as Hippocrates (460–370 BCE), Dioscorides (40–90 CE), Galen (130–210 CE), and Avicenna (980–1037 CE) reported various traditional therapeutic uses of NS (Botnick et al., 2012).

In the context of bronchial asthma and its symptoms, the Muslim scholar Imam Ibn Qayyim Al-Jawziyya (1292–1350 CE), author of the Prophetic Medicine, reported that NS aid in gasping and hard breathing (Abdullah, 2003). Avicenna has also reported its benefit for shortness of breath (ثقل النفس) and for stopping phlegm (متعت فلو) (Avicenna, 1593). Nowadays, NS is still a traditional remedy for many illnesses such as cough and asthma in Arabia (Lebling and Pepperdine, 2006).

The chemical composition of NS has been studied in considerable detail. Mainly, it contains fixed oil (24.76–40.35%), volatile oil (0.5–1.6%), alkaloids, saponins, and other compounds in trace amounts (Ahmad et al., 2013; Botnick et al., 2012; Liu et al., 2011). The activity of NS appeared to be mainly attributed to thymoquinone (Ahmad et al., 2013). Thymoquinone was first isolated from NS oil by El–Dakhakhny (1963).

The Global Initiative for Asthma defined asthma as “a heterogenous disease, usually characterised by chronic airway inflammation. It is identified by the history of respiratory symptoms such as wheeze, shortness of breath, chest tightness and cough that vary over time and in intensity, together with variable expiratory air-flow limitation” (Global Initiative for Asthma, 2017). The Global Asthma Report 2014 considered asthma as an epidemic disease probably affecting about 334 million people worldwide and becoming a global health priority (Global Asthma Network, 2014). In Saudi Arabia (with a population of 28 million), the prevalence of asthma is increasing and affects more than 2 million Saudi (Al-Moamary, 2012).

Asthma is initiated by multiple interactions between inflammatory cells and mediators. After an exposure to a triggering factor, inflammatory mediators are released from mast, macrophages, T-cells and epithelial cells. This cause attraction of other inflammatory cells mainly eosinophil into the pulmonary tissues. These causes lung injury, mucus hypersecretion and smooth muscle hyperactivity. Furthermore, at least 27 cytokines and 18 chemokines play a role in asthma pathophysiology (Koda-Kimble, 2009).

The anti-histaminic effect was shown in four studies used (-hederin (Abd El Aziz et al., 2011; Chakravarty, 1993; Saadat et al., 2015; Saleh et al., 2012). NS oil, thymoquinone or (-hederin demonstrated a bronchodilatory or relaxant effect in six studies (Abd El Aziz et al., 2011; Chakravarty, 1993; Saadat et al., 2015; Saleh et al., 2012). Pathological improvements were detected by thymoquinone or NS oil in five studies (Arabzadeh et al., 2016; Boskabady and Sheiravi, 2002; El Gazzar et al., 2006; Kalemci et al., 2013; Shahzad et al., 2009). The summary of findings of these studies are shown in Table 1.

Generally, the key goals for asthma management are to reach a good control of symptoms and minimize future risk of exacerbations, airflow limitation and treatment adverse effects. Assessment of asthma control level can be done using several tools (Bateman et al., 2008). The Asthma Control Test (ACT) is a global validated numerical tool for the assessment of asthma control which is also commonly used by health care providers in Saudi Arabia (Al-Moamary, 2012). Future risk can be assessed by pulmonary function testing, particularly the forced expiratory volume in one second (FEV1) (Bateman et al., 2008).

From a global clinical perspective, achieving asthma control is considered to be suboptimal regardless of the availability of conventional treatments (Demoly et al., 2012; Price et al., 2014). Poor adherence to asthma medications is one of the factors leading to suboptimal asthma control (Haughney et al., 2008; Horne et al., 2007). Common medication-related reasons for non-adherence include difficulties with inhaler techniques, the complex course of therapy, adverse events, and cost of medications (Bateman et al., 2008; Dima et al., 2015). In Saudi Arabia, a survey of adult asthmatics found that asthma attacks were highly associated with patients on current asthma medications (Moradi-Lakeh et al., 2015). The Global Asthma Physician and Patient Survey reported that 76% of patients and 81% of physicians consider that new treatment options are required (GAPP, 2005). The introduction of novel treatment strategies (such as “add-on” treatments) is a key step for better asthma control (Lommatsch and Stoll, 2016).

Asthma patients tend to use herbal medicines as one of the common therapies of complementary and alternative medicine (Slader et al., 2006). However, these therapies often have insufficient evidence for their effectiveness in asthma. In Saudi Arabia, a questionnaire type study was done by Al Moamary (2008) in 200 asthmatic patients. He found that NS is one of the most commonly non-standard therapies used by 10% of the patients.

In this review, we aimed at exploring and assessing the relevant pre-clinical and clinical studies supporting the use of NS in patients with asthma, and evaluating the current evidence to highlight future research priorities.

2. Methods

A literature search for scientific studies published in electronic databases (PubMed, Science Direct, Scopus, and Google Scholar) was done using the terms Nigella sativa, Black seed, Thymoquinone and (their pharmacological effects) on asthma. Studies were searched for electronically between the years 1990 and 2017. Retrieved studies were assessed and the data was categorised into preclinical and clinical studies.

3. Results

At least nineteen preclinical studies and seven clinical studies reported the effects of NS in asthma. Details of the retrieved studies are summarised in the following.

3.1. Preclinical studies of Nigella sativa in cellular and animal models of asthma

NS and its active compounds thymoquinone, nigellone and (-hederin have been investigated in eighteen whole or cellular animal models and one human cellular model related to asthma. NS oil, thymoquinone or (-hederin showed anti-inflammatory and immunomodulatory effects in seven studies (Abbas et al., 2005; Baiera et al., 2012; El Gazzar et al., 2006; Mansour and Tornhamre, 2004; Saadat et al., 2015; Saleh et al., 2012; Shahzad et al., 2009). NS extracts, thymoquinone or (-hederin demonstrated a bronchodilatory or relaxant effect in six studies (Abd El Aziz et al., 2011; Al-Majed et al., 2001; Boskabady et al., 2008; Gilani et al., 2001; Keyhanmanesh et al., 2013; Saadat et al., 2015). The anti-histaminic effect was shown in four studies used NS oil/aqueous extract, nigellone or (-hederin (Abd El Aziz et al., 2011; Chakravarty, 1993; Saadat et al., 2015; Saleh et al., 2012). Pathological improvements were detected by thymoquinone or NS oil in five studies (Arabzadeh et al., 2016; Boskabady and Sheiravi, 2002; El Gazzar et al., 2006; Kalemci et al., 2013; Shahzad et al., 2009). The summary of findings of these studies are shown in Table 1.

Generally, these studies used animal models sensitised with ovalbumin or isolated Guinea pig trachea. Some studies used cellular models such as human granulocytes or animal mast cells. However, these studies had limitations such as the variability of NS...
### Table 1

Effects of NS in pre-clinical studies of asthma.

<table>
<thead>
<tr>
<th>Studies</th>
<th>Study material</th>
<th>Minimal active dose</th>
<th>Model</th>
<th>Negative control</th>
<th>Positive control</th>
<th>Effects</th>
<th>Serum immunoglobulins</th>
<th>Inflammatory mediators</th>
<th>Inflammatory cells, BALF</th>
<th>Inflammatory cells, lung</th>
<th>Histamine release</th>
<th>Block H1 receptors</th>
<th>Relaxation of SM</th>
<th>Other</th>
<th>Notes &amp; limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chukwupere et al. (2001)</td>
<td>Nigella</td>
<td>11 μg/ml</td>
<td>Mixed</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
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<td></td>
<td></td>
<td>+</td>
<td></td>
<td></td>
<td></td>
<td>No control group (without Thymoquinone)</td>
</tr>
<tr>
<td>Giani et al. (2001)</td>
<td>NS (70% aqueous- methanol extract)</td>
<td>0.1–3.0 μg/ml</td>
<td>Guinea pig trachea</td>
<td>N/A</td>
<td>N/A</td>
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<td>+</td>
<td></td>
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<td></td>
<td>No control group (without Thymoquinone)</td>
</tr>
<tr>
<td>Al-Majeed et al. (2001)</td>
<td>Thymoquinone</td>
<td>50 μM</td>
<td>Guinea pig trachea</td>
<td>N/A</td>
<td>N/A</td>
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<td></td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
<td>No control group (without Thymoquinone)</td>
</tr>
<tr>
<td>Boklabady and Shevrier (2002)</td>
<td>Aqueous extracts of NS</td>
<td>0.3 ml</td>
<td>Guinea pig trachea</td>
<td>Saline</td>
<td>Chlorpheniramine</td>
<td></td>
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<td>+</td>
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</tr>
<tr>
<td>Mansour and Touniame (2004)</td>
<td>Thymoquinone</td>
<td>3 and 10 μM</td>
<td>Human granulocytes</td>
<td>Unretrained human granulocytes</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
<td></td>
<td></td>
<td></td>
<td>No positive control</td>
</tr>
<tr>
<td>Abbas et al. (2005)</td>
<td>NS fixed oil</td>
<td>5 ml/kg/day injected (ip) for 17 days</td>
<td>Conalbumin sensitised (CD1) albino mice</td>
<td>Unretrained mice</td>
<td>Dexamethasone</td>
<td>↓ lgG</td>
<td>↓ serum IL-2 &amp; IL-12</td>
<td>+</td>
<td></td>
<td></td>
<td>+</td>
<td></td>
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</tr>
<tr>
<td>Roykoomit et al. (2005)</td>
<td>NS fixed oil</td>
<td>0.3 ml/day for 1 month</td>
<td>OVA sensitised BALB/c mice</td>
<td>Saline</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
<td></td>
<td></td>
<td></td>
<td>No positive control</td>
</tr>
<tr>
<td>El-Gazzar et al. (2006)</td>
<td>Thymoquinone + 10% DMSO</td>
<td>3 mg/kg TQ in 10% DMSO injected (ip) for 5 days</td>
<td>OVA sensitised BALB/c mice and lung cells</td>
<td>Saline + 10% DMSO</td>
<td>OVA + 10% DMSO</td>
<td>↓ OVA IgG &amp; IgG2</td>
<td>IL-4, IL-5, IL-13</td>
<td>+</td>
<td>eosiophils</td>
<td>eosiophils</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>cotrol</td>
<td>No positive control</td>
</tr>
<tr>
<td>Boklabady et al. (2008)</td>
<td>Methanol and dichloromethane extracts of NS</td>
<td>0.8% of methanol extract-1.2% of dichloromethane extract</td>
<td>Guinea pig trachea</td>
<td>Saline</td>
<td>Thophyline</td>
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<td></td>
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<td>+</td>
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<tr>
<td>Shahid et al. (2009)</td>
<td>NS fixed oil</td>
<td>4 ml/kg/day injected (ip) for 7 days</td>
<td>OVA sensitised E3 rats</td>
<td>Saline</td>
<td></td>
<td>↓ Total IgG</td>
<td>↓ mRNA expression of IL-4, IL-5, IL-6 and TGF-β from lung cells</td>
<td>+</td>
<td>eosiophils</td>
<td>eosiophils</td>
<td>+</td>
<td>No positive control</td>
<td></td>
<td></td>
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<tr>
<td>Abd El Aziz et al. (2011)</td>
<td>Thymoquinone</td>
<td>3 mg/kg injected (ip) for 5 days in guinea pig</td>
<td>8 mg/kg injected (ip) for 21 days in rats</td>
<td>OVA sensitised guinea pig trachea Mast cells of egg-allbumin sensitised rats</td>
<td>Saline</td>
<td></td>
<td>↑ OVA IgG1</td>
<td>↓ Nitric oxide in BALF</td>
<td>eosiophils</td>
<td>eosiophils</td>
<td>+</td>
<td>No positive control</td>
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<td></td>
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</tr>
<tr>
<td>Rabah et al. (2012)</td>
<td>Oral NS oil 4 ml/ kg/day for 31 days</td>
<td>OVA sensitised BALB/c mice</td>
<td>Saline</td>
<td>N/A</td>
<td>↓ Total IgE</td>
<td>↓ OVA IgG1</td>
<td>↓ IL-13 cytokines in BALF</td>
<td>↑ Bronchial and alveolar epithelial hyperplasia, goblet cells and collagen fibres</td>
<td>+</td>
<td></td>
<td>+</td>
<td>No positive control</td>
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</tr>
<tr>
<td>Salib et al. (2012)</td>
<td>Oral NS oil 2.5 ml/ kg/day for 5 weeks</td>
<td>OVA sensitised guinea pig isolated rat peritoneal mast cells</td>
<td>Saline</td>
<td>N/A</td>
<td>↓ PGE2 in lung tissue</td>
<td>↓ Leukocyte, Basophils, Macrophages, Eosinophils &amp; Lymphocytes</td>
<td>↓ Bronchial and alveolar epithelial hyperplasia</td>
<td>+</td>
<td></td>
<td></td>
<td>+</td>
<td>No positive control</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Keyhanmanesh et al. (2013)</td>
<td>Fractions of 20% methanolic extract of NS</td>
<td>(50, 100, 150, 200 mg/L)</td>
<td>Guinea pig trachea</td>
<td>Saline</td>
<td>Thophyline</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>+</td>
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<tr>
<td>Katranci et al. (2013)</td>
<td>Thymoquinone</td>
<td>3 mg/kg/day injected (ip) for 5 days</td>
<td>OVA sensitised BALB/c mice</td>
<td>Dexamethasone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
<td></td>
<td></td>
<td></td>
<td>No positive control</td>
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</tr>
<tr>
<td>Keyhanmanesh et al. (2014)</td>
<td>Thymoquinone</td>
<td>0.3 mg/kg ip.</td>
<td>OVA-oromised guinea pig</td>
<td>Saline</td>
<td>Thophyline</td>
<td></td>
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<td></td>
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<td></td>
<td>+</td>
<td></td>
<td></td>
<td></td>
<td>No positive control</td>
</tr>
<tr>
<td>Saddat et al. (2015)</td>
<td>α-hederin</td>
<td>0.3 mg/kg ip.</td>
<td>OVA-oromised guinea pig</td>
<td>Saline</td>
<td>Thophyline</td>
<td></td>
<td></td>
<td></td>
<td>Total WBC and eosinophils</td>
<td>Total eosinophils</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
<td>No positive control</td>
</tr>
</tbody>
</table>

(continued on next page)
preparations used between most them, and absence of control group in some studies (Table 1).

3.2. Clinical studies of Nigella sativa in patients with asthma

Seven clinical studies showed a potential efficacy of NS on asthma outcomes and biomarkers. Three Randomised Double-Blinded Placebo-Controlled Clinical Trials (RDBPCT) and two Randomised Single-Blinded Placebo-Controlled Clinical Trials (RSBPCT) using NS crushed seeds powder or oil/aqueous extract, showed an improvement in clinical symptoms and pulmonary function test in adult asthmatics (Boskabady et al., 2007; Kalus et al., 2003; Kardani et al., 2013; Koshak et al., 2017; Salem et al., 2017). In addition, a reduction of blood eosinophilia was found in RDBPCT by Koshak et al. (2017). Also, a decrease in total serum IgE and FeNO, and an increase in serum INF-gamma cytokine were shown in the RSBPCT trial of Salem et al. (2017).

A Randomised Double-Blinded Clinical Trial (RDBCT) showed a short bronchodilatory effect in patients with asthma after administration of a single dose of NS (Boskabady et al., 2010). Two studies used NS in combination with other treatments showed an improvement in ACT and PFT scores (Al Ameen et al., 2011; Kardani et al., 2013) (Table 2).

However, these clinical trials appeared to have some important limitations (Table 2). In many of these studies, the standard of design was poor as three studies only were RDBPCT. The phytochemical characterisation of the investigational NS product was not shown in many studies. The sample size was comparatively small in most studies. The largest trial by Koshak et al. (2017) included 80 adult asthmatic patients. The measured outcomes were generally limited to symptoms or pulmonary function in several studies.

Therefore, there is a need for a longer, larger and high standard multicentre clinical trial (more than 80 asthmatic patients) with phytochemically well-characterised NS product. Also, to use validated asthma control measurement tools with consideration of additional asthma outcomes and biomarkers such as FeNO, Sputum eosinophils, total blood eosinophils, total serum IgE, allergen-specific IgE and urinary LTE4 (Szefler et al., 2012). Additionally, measuring serum inflammatory cytokines may be worth considering, since asthma is regulated by multiple inflammatory cytokines and some were associated with asthma control (Akiki et al., 2017).

4. Conclusion

This literature review showed that various preparations derived from Nigella sativa have a potential role for the clinical use in asthma. Preclinical studies of NS preparations showed bronchodilation, anti-histaminic, anti-inflammatory, anti-leukotrienes and immunomodulatory effects in animal or cellular models of asthma. Clinical studies of NS preparations showed an improvement of asthma symptoms control, lung function and asthma biomarkers. However, these studies have study design limitations and limited phytochemical characterisation of NS preparations used. Consequently, the current clinical evidence for the use of NS in patients with asthma is evolving in strength. In future, larger, longer, well-designed clinical trials including additional biomarkers and using phytochemically characterised NS preparation are required for assessing the clinical use of NS in asthma. Eventually, NS may offer a cost-effective and clinically proven effective add-on therapeutic option for asthmatics with fewer side, which may be used as integrative medicine within the Saudi healthcare system and beyond.

Table 1 (continued)

<table>
<thead>
<tr>
<th>Study reference</th>
<th>Study material</th>
<th>Study design</th>
<th>Control</th>
<th>NS dose</th>
<th>Duration</th>
<th>Sample</th>
<th>Effects</th>
<th>Advantages (+) and limitations (-)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salem et al. (2017)</td>
<td>NS powder</td>
<td>RSBPCT</td>
<td>Placebo</td>
<td>1 and 2 g/day</td>
<td>3 months</td>
<td>76 adult asthmatics</td>
<td>† ACT</td>
<td>* Large sample size but still comparatively small&lt;br&gt;• Longer duration&lt;br&gt;• Single-Blinded&lt;br&gt;• NS was not chemically characterised&lt;br&gt;• The largest study conducted but still a comparatively small&lt;br&gt;• NS chemically characterised&lt;br&gt;• High standard study design&lt;br&gt;• Short duration&lt;br&gt;• Small sample size&lt;br&gt;• NS not chemically characterised and was used in combination&lt;br&gt;• Outcomes limited to symptoms only&lt;br&gt;• Very small sample size&lt;br&gt;• NS was not chemically characterised and was used in combination&lt;br&gt;• Low standard study design&lt;br&gt;• Outcomes were very limited and compared between same group before and after treatment, and not between groups. &lt;br&gt;• No symptoms measurement&lt;br&gt;• No change in FEV1&lt;br&gt;</td>
</tr>
<tr>
<td>Koshak et al. (2017)</td>
<td>NS fixed oil</td>
<td>RDBPCT</td>
<td>Placebo</td>
<td>1 g/day</td>
<td>4 weeks</td>
<td>80 adult asthmatics</td>
<td>† ACT</td>
<td>No change in number of Th17 cells</td>
</tr>
<tr>
<td>Kardani et al. (2013)</td>
<td>NS powder + IM (House dust mite)</td>
<td>RSBPCT</td>
<td>IM + placebo</td>
<td>15 mg/kg/day</td>
<td>14 weeks</td>
<td>31 Child asthmatics</td>
<td>† ACT</td>
<td>No change in number of Th17 cells</td>
</tr>
<tr>
<td>Al Ameen et al. (2011)</td>
<td>Whole NS seeds + bee honey Non RCT open-label</td>
<td>N/A</td>
<td>2 g of NS seeds + 1 tsp honey</td>
<td>3 months</td>
<td>5 adult asthmatics 22 non-asthmatics</td>
<td>† FVC in asthmatics&lt;br&gt;‡ FEV1 (predicted)&lt;br&gt;‡ FEV1 (predicted)&lt;br&gt;PEF in non-asthmatics&lt;br&gt;No change in FEV1</td>
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<tr>
<td>Boskabady et al. (2010)</td>
<td>Aqueous extract of NS</td>
<td>RDBCT crossover</td>
<td>Theophylline Single dose of 50 mg/kg</td>
<td>150 min</td>
<td>15 adult asthmatics</td>
<td>† FEV1&lt;br‡ MMEF&lt;br‡ PEF</td>
<td></td>
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<tr>
<td>Boskabady et al. (2007)</td>
<td>Aqueous extract of NS</td>
<td>RDBPCT Placebo</td>
<td>15 mL/kg of 0.1 g%</td>
<td>3 months</td>
<td>29 adult asthmatics 15 active 14 control</td>
<td>Improved asthma symptoms&lt;br‡ FEV1&lt;br‡ FEV1&lt;br‡ PEF&lt;br‡ MMEF</td>
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<tr>
<td>Kalus et al. (2003)</td>
<td>NS fixed oil</td>
<td>RDBPCT</td>
<td>Placebo</td>
<td>40–80 mg/kg/day Three times daily</td>
<td>3 weeks</td>
<td>63 adults: 31 allergic rhinitis, 3 bronchial asthma, 6 atopic eczema</td>
<td>Improved subjective severity of symptoms&lt;br‡ eosinophils (not significant)&lt;br‡ serum IgE (not significant)</td>
<td></td>
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</table>

Funding

This research is part of the PhD thesis of Mr. Abdulrahman Koshak funded by the Ministry of Education in Saudi Arabia. It did not receive any specific external grant from funding agencies in the public, commercial, or not-for-profit sectors.

References


