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DT56A, A NON-HORMONAL BOTANICAL THERAPY , AS FIRST LINE TREATMENT FOR MENOPAUSAL SYMPTOMS

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As menopause is also associated to a new equilibrium of the endocrine system with a great impact on several functions of the whole female organism, it is our role as gynecologists and endocrine specialists to treat climacterics, as it leads to a dramatic reduction in the quality of life of our patients and increases post-menopausal diseases.
The deprived estrogen receptors (ER) are at the core of the hormonal changes, whether in the brain, in the bone, in the skin or in the reproductive tract. Without estrogen, these receptors cause a chain of events that have a strong impact on women's quality of life.
Three aspects need to be dealt with to give maximum support to our patients. The diagnosis, we are proficient in; the psychological state of women, is more complicated, however here lies the essence of the success of the treatment and allows the individualization of the treatment to accommodate the needs of our patient; and last, increasing the awareness of women of the symptoms and conditions in the pre-menopause, menopause and post-menopause phases.
As leading physicians in this field, we must be especially sensitive to our patients. Estrogen provides life and vitality, and with its decline, women are faced with a new reality. To ensure that we have a positive impact on their lives, we must make sure that they will visit our office and leave it with a treatment that both they and we, can feel confident with.
Looking at the treatments available, DT56a, a non-hormonal botanical therapy, was shown to have the same efficacy as hormone therapy (HT). In a head to head study, we have seen that DT56a has a similar impact on the neuro-endocrine system in the brain, increasing ?endorphin and allopregnanolone levels, similar to the effect of E2; In addition, DT56a was shown to increase BMD through new bone formation, and to relieve vaginal dryness. Although the effect was similar to that of HT, one major difference was seen in all the studies, the effect was selective and did not target the breast or uterus nor did it show any effect on clotting even in thrombophilic women.
We have in our arsenal hormone and estrogen therapy, these are worthy therapies, but let us offer women a first line treatment, a treatment that has the scientific foundation that we feel comfortable to recommend, which offers the necessary efficacy by targeting the estrogen receptors, while minimizing risks. With such therapeutic options, we will be able to bring women back into our clinics, embrace them and offer them long-term treatment and thereby gaining healthier aging female population.

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