THE ROLE OF PHYTOTHERAPY IN THE CORRECTION OF CLIMACTERIC SYNDROME IN WOMEN: AN OVERVIEW OF CURRENT EVIDENCE

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Introduction. Climacteric syndrome is a symptom complex arising during the menopausal transition and postmenopause as a result of declining ovarian oestrogen production. It affects the vasomotor, neuropsychiatric, urogenital and metabolic domains and can markedly reduce quality of life. Although menopausal hormone therapy is the most effective treatment for moderate-to-severe symptoms, concerns about its risks and the preferences of women seeking non-hormonal options have sustained interest in traditional and herbal medicine, which has deep historical roots in Central Asia.

Aim. To summarise current evidence on the plant-based and traditional-medicine methods most frequently used for the correction of climacteric syndrome and to identify the symptom domains for which this evidence is strongest.

Materials and methods. A review of the literature was conducted using PubMed, ScienceDirect, the Cochrane Library and Google Scholar, with combinations of the terms "climacteric syndrome", "menopause", "phytotherapy", "phytoestrogens" and "herbal medicine". Priority was given to systematic reviews, meta-analyses and randomised controlled trials. Symptom severity in the underlying trials was most often assessed using the Kupperman Index, the Menopause Rating Scale and the frequency of hot flushes.

Results. The most extensively studied botanicals are phytoestrogen-containing plants, particularly soy (Glycine max) isoflavones, together with black

cohosh (Cimicifuga racemosa), St John's wort (Hypericum perforatum), sage (Salvia officinalis) and fennel (Foeniculum vulgare). The balance of evidence indicates a modest but reproducible reduction in the frequency and severity of hot flushes with soy isoflavones and with black cohosh, whereas red clover (Trifolium pratense) shows weak and inconsistent effects. The vasomotor domain is by far the most frequently studied outcome; evidence for neuropsychiatric, urogenital, metabolic and sexual-function outcomes is more limited and heterogeneous. Mechanistically, phytoestrogens act through oestrogen receptors with preferential affinity for the beta subtype, while plants such as Hypericum may act via serotonergic pathways. A recurring methodological limitation is the large placebo response characteristic of menopausal trials, together with inconsistent product standardisation.

Conclusion. Traditional-medicine and phytotherapeutic methods represent a promising but evidentially uneven option for the correction of climacteric syndrome, with the most consistent benefit for vasomotor symptoms. They may be reasonable for women who prefer non-hormonal treatment, provided product quality, dosing and potential interactions are considered. Well-designed, standardised and adequately powered trials — including studies of the botanicals used in Central Asian practice — are needed before firm clinical recommendations can be made.

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