



Editorial

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Phytotherapy in the Treatment of Benign Prostatic Hyperplasia (BPH): Between Evidence and Empiricism

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The treatment of Benign Prostatic Hyperplasia (BPH) has been recently approved by different international guidelines like AUA, EAU, NICE, WHO consultation, etc, and drugs as the alpha-blockers and the 5-alpha-reductase inhibitors are widely indicated for this disease [1].

Moreover, little space is given to the anti-cholinergics and recently to the phosphodiesterase type 5 inhibitors.

In this field of application, the phytotherapies, in particular *Serenoa repens*, are less or not recommended, because they are not supported by adequate scientific evidence.

However, the use of these molecules is widely diffuse all over the world, achieving the first choice of treatment in some Nations such as the Asians.

One needs only to consider that in the United States the business of the dietary supplements/phytotherapies has exceeded that of the pharmaceutical industry. In Europe it has been spent over 5.7 billion euros for these products and in Italy the business has grown from 2003 until now by more than 70% with a turnover of 1500 million euros in the 2009. In detail, the business of *Serenoa repens* is about 15 million euros for the treatment of BPH [2-3].

However we are starting to wonder. Why this wide diffusion of these products? What often makes them preferable to conventional drugs? Why the lack of scientific evidence is not enough to limit their use? It is not easy to answer these questions. At first, we think that these molecules possess either an empirical efficacy or an absolute tolerability. The side effects of *Serenoa repens* are truly equivalent to 0%. In particular it does not determine side effects on the cardiovascular system nor on the gastrointestinal and in details it does not injure any aspect of male sexuality like impotence or ejaculatory disorders.

In our opinion, a second point of view consists on the specificity of the treatment. We all know how it does not exist a definitive and curative possibility to cure BPH. The use of alpha-blockers or 5-alpha-reductase inhibitors is only related with an improvement of the micturition symptoms or with a reduction of the prostate volume that does not mean resolution of the disease.

The association between the “lack of efficacy” and the “lack of side effects” has probably contributed to the diffusion of these molecules although they do not determine a symptomatic relief. In fact, phytotherapies are preferred by physicians and patients, who are influenced by the absence of definitive treatment, thanks to the better tolerability profile of these molecules.

Then, we may affirm that the diffusion of Phytotherapy is due to the absence of essential alternatives.

We must not forget the lack of adherence of physicians and urologists to the international guidelines. In particular it is obvious to use all available diagnostic information to compose an as exact as possible algorithm for treatment (i.e. IPSS symptom score, micturition diaries, multiple flow measurements, PSA determination, sexual

examination and erectile function evaluation) [4]. Doing so, the urologist will be able to identify the patients who may receive medical treatment and even Phytotherapy or combination.

All these considerations are also connected to the poor knowledge and information about the treatment of BPH. Which will be the future?

We think that scientific evidences about phytotherapies should be demonstrated and well conducted clinical studies are needed to clarify the efficacy of these molecules on BPH. Furthermore, it should be intensified the knowledge about the mechanisms of action of these phytotherapies, not only in vitro but also in animals and in humans [5-6].

Last but not least it should be better regulated the wide use of different phytotherapies because, being them extractive products and not synthetic products, they may elicit a great variability within molecules and different therapeutic results between many compounds.

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