Short-term effects of transdermal estradiol in men undergoing androgen deprivation therapy for prostate cancer: a randomized placebo-controlled trial

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Abstract

Objective: There is increasing recognition that, in men, some biological actions attributed to testosterone (TS) are mediated by estradiol (E2). This study used two low doses of daily transdermal E2 gel to assess the effects on circulating E2 concentrations in men with prostate cancer with suppressed endogenous E2 production arising from androgen deprivation therapy (ADT). Secondarily, we aimed to assess short-term biological effects of E2 add-back without increasing circulating TS.

Design: 28-day randomised, placebo-controlled trial.

Methods: 37 participants were randomised to either 0.9 or 1.8 mg of 0.1% E2 gel per day or matched placebo gel. Fasting morning serum hormones, quality of life questionnaires, and treatment side effects were evaluated at baseline, days 14 and 28. Hot flush diaries and other biochemical measurements were completed at baseline and study end.

Results: Transdermal E2 significantly raised serum E2 from baseline to day 28 compared to placebo in the 0.9 mg dose group (median: 208 pmol/L; interquartile range: 157–332) and in the 1.8 mg dose group (median: 220 pmol/L; interquartile range: 144–660). E2 treatment reduced hot flush frequency and severity as well as beta carboxyl-terminal type 1 collagen telopeptide.

Conclusion: In men with castrate levels of E2 and TS, daily transdermal E2: 0.9–1.8 mg increased median serum E2 concentrations into the reference range reported for healthy men, but with substantial variability. E2 treatment reduced hot flushes and bone resorption. Larger studies will be required to test whether low-dose E2 treatment can mitigate ADT-associated adverse effects without E2-related toxicity.

Introduction

The benefits for disease control and the bone and metabolic adverse effects of androgen deprivation therapy (ADT) with gonadotropin-releasing hormone (GnRH) analogues in the treatment of prostate cancer (PCA) are established (1, 2). GnRH analogues produce castrate levels of testosterone (T), and its metabolite estradiol (E2) in men. Over decades since Huggins’ Nobel Prize-winning report of castration as an effective palliative treatment for advanced prostate cancer in the 1940s, surgical castration has progressively been replaced by medical castration,
initially using high-dose oral estrogens but more recently using GnRH analogs to achieve castrate T levels (3, 4). High-dose oral estrogen treatment has been largely superseded due to increased thromboembolic events attributed to hepatic first pass metabolism of ingested estrogens with consequent upregulation of liver-derived clotting factors (3, 5).

The long natural history of PCa combined with recognition that some components of medical castration are due to estrogen deficiency as well as androgen deficiency (6) has renewed interest in the use of non-oral E2 to mitigate the bone, brain and metabolic adverse effects of ADT (7, 8). Two alternative approaches are the use of high-dose transdermal E2 as a sole mode of ADT (replacing GnRH analogs) or low-dose E2 ‘add-back’ in addition to GnRH analogs to restore E2 to levels sufficient to mitigate adverse effects (9). The former approach is used in the PATCH study, a phase 2 single-blinded randomised controlled trial (RCT) designed to assess the safety and efficacy of ADT comparing high-dose E2 via transdermal patches alone to produce castrate T levels with standard ADT using GnRH analogs (8). Only two small RCTs, enrolling 12–25 men have tested the low-dose E2 ‘add-back’ approach (10, 11, 12), and these RCTs used oral E2. Transdermal E2, in contrast to oral E2 is not subject to pro-thrombotic hepatic first pass metabolism, however, even transdermal E2, if given at supraphysiologic doses may have other undesirable effects, such as gynecomastia or nausea. Furthermore, little is known about steady-state circulating E2 achieved by transdermal E2 dosing in older men.

This RCT was designed to assess the effects of two low doses of daily transdermal E2 gel (providing respectively 0.9 and 1.8 mg E2 per day) compared with placebo on circulating E2 concentrations in men with PCa with suppressed endogenous E2 production due to GnRH analog treatment. This provided the opportunity to assess biological effects of E2 occurring in the presence of castrate circulating T concentrations. We hypothesised that E2 treatment would improve hot flushes and quality of life, reduce biomarkers of bone resorption, reduce insulin resistance and lower insulin-like growth factor 1 (IGF-1).

**Subject and methods**

We conducted a 28-day, randomised, blinded, placebo-controlled, multi-arm, parallel-group trial at Austin Health, a tertiary referral hospital affiliated with The University of Melbourne. Participants were recruited from outpatient clinics from June 2016 to July 2017. Men aged 55–85 years were eligible for the study if they had been receiving GnRH agonists or antagonists for non-metastatic PCa for a minimum of 4 weeks. Exclusion criteria were diabetes mellitus; impaired performance status (Eastern Cooperative Oncology Group Performance Status [ECOG] >1); past or current venous thromboembolism (VTE); breast cancer; human immunodeficiency virus infection; osteoporosis, antiresorptive or strontium ranelate use; systolic blood pressure >160 or diastolic blood pressure >100; symptomatic heart failure; stroke, transient ischaemic attack, myocardial infarction or angina within 12 months; glucocorticoid treatment; alcohol or illicit drug abuse.

The trial protocol was approved by the local ethics committee (HREC/16/Austin/89) and each participant provided written informed consent. The trial was preregistered with the Australian New Zealand Clinical Trials Registry (identifier 12616000373471). We followed the CONSORT checklist of information to include when reporting a randomised trial.

Participants were randomly allocated, in a concealed fashion, to one of four intervention groups: E2 1 mL (0.9 mg) per day or matching placebo 1 mL per day or E2 2 mL (1.8 mg) per day or matching placebo 2 mL/day. Randomisation (Fig. 1) occurred as follows: first, participants were stratified by body mass index (BMI) into categories below or above the clinic median (<29 or >29 kg/m²); secondly, using simple randomisation (coin toss), participants were then allocated in a 1:1 ratio to a daily gel volume of 1 or 2 mL; thirdly, within each volume group, participants were allocated by restricted randomisation, using blocks of size 3, to E2 or placebo in a ratio of 2:1. The final allocation to E2 or placebo was performed using a computer-generated randomization scheme administered by an investigator (MC) with no clinical involvement in the trial.

E2 gel was Sandrena 1 mg/g estradiol (Aspen Pharmacare, St Leonards, NSW, Australia). Placebo gel was a-gel (Fresenius Kabi, North Ryde, NSW, Australia) and matched the E2 gel for colour, smell and consistency. E2 and placebo were re-packaged into identical metered-dose syringes by pharmacy and dispensed to patients labelled as ‘estradiol or placebo’, with instructions to use the specified volume once daily on the skin of the chest or upper arms. This process concealed treatment allocation within each volume group and maintained blinding of participants, investigators and clinicians for the duration of the study. Blinding was removed...
immediately prior to data analysis, after the database had been cleaned and locked.

Participants were seen at baseline, and days 14 and 28 of the intervention. At each visit, men completed the FACT-P questionnaire (12) and were interviewed to ascertain treatment side effects. FACT-P total score grades quality of life from 0 to 156, with higher scores indicating better quality of life. Participants completed a hot flush diary as described by Loprinzi et al. (13) for the 7 days prior to gel commencement and during days 21–28 of the intervention. Average daily hot flush score was derived from hot flush frequency and severity as described (13).

Gel syringes were collected at day 28 and residual volume was recorded to assess adherence. Men were given standard written advice recommending a daily dietary calcium intake of 1300mg and advised not to make changes to their Vitamin D or calcium supplementation status. Adverse events were graded according to Common Terminology Criteria for Adverse Events, version 4.03 (14).

Fasting morning pre-dose blood samples were drawn at each visit. Serum was stored at −80°C for batched analysis of sex steroid profile by liquid chromatography mass spectrometry (LC–MS) (15). Limits of quantification and detection were 18 and 11 pmol/L respectively for E2; 11 and 4 pmol/L for estrone (E1); 0.10 and 0.03 nmol/L for T and 0.35 and 0.17 nmol/L for dihydrotestosterone (DHT). CVs were 5–10%, 4–9%, 2–8% and 7–13% respectively for within-run reproducibility at three levels of quality control samples.

At baseline and day 28, hematology and biochemistry including hemoglobin, hematocrit, luteinising hormone (LH), follicle-stimulating hormone (FSH), insulin, glucose, c-peptide, IGF-1, triglycerides and total and high-density lipoprotein (HDL) cholesterol were measured using standard methodologies at the Biochemistry Department, Austin Health. Updated homeostatic model assessment of insulin resistance (HOMA2-IR) (16) and low-density lipoprotein (LDL) cholesterol were calculated using standard methodologies. At baseline, 25-OH Vitamin D3 was measured by chemiluminescent immunoassay (Roche Cobas 8000, Roche Diagnostic International), with inter assay CV 3.9–19.5%.

Serum beta carboxyl-terminal type 1 collagen telopeptide (CTX) and pro collagen type 1 amino-
terminal propeptide (P1NP) were measured at baseline and day 28 on a Roche Cobas e602 platform (Roche Diagnostic International) with inter assay CVs of 2.5–3.9%. CTX and P1NP are biomarkers reflecting different components of coupled bone remodelling by basic multicellular units, with CTX primarily reflecting osteoclastic activity and P1NP reflecting subsequent osteoblastic bone formation.

**Study design and pre-specified outcomes**

The pre-specified primary outcomes were the serum E2 concentration from baseline to day 28 measured by LC–MS and the change in the daily hot flush score. We report serum E2 concentrations in the 4 groups from baseline to day 28 in each E2 group with its respective placebo group and combined the groups for the symptomatic outcome. Pre-specified secondary outcomes were changes, baseline to study end, in other serum sex steroids measured by LC–MS (T, DHT, E1), gonadotrophins, HOMA2-IR, IGF-1, bone remodelling markers, hot flushes and prostate cancer-specific quality of life.

**Power analyses**

We determined that 8 men per group would provide the trial with a power of 80% to detect a difference in circulating E2 concentrations between E2 and placebo-treated men based on data from the literature (10, 12) reporting a substantial increase in E2 levels of 150 pmol/L with a pooled standard deviation of 100 pmol/L, at an alpha level of 0.05. For the secondary outcome of hot flushes, we aimed to detect a change in daily frequency of 7 with a standard deviation of 7, requiring 17 participants (17). This appeared to be achievable by combining the two E2 groups, provided their outcomes were similar, as expected.

**Statistical analysis**

Main outcomes were non-normally distributed, and data are reported as median (interquartile range). Undetectable steroid concentrations were assigned the limit of detection value for data analysis. Between-group differences were tested using the exact unpaired Wilcoxon–Mann–Whitney test for two groups, Kruskal–Wallis test for more than two groups or Fisher’s exact test in case of frequency data. For further analysis, the two E2 groups showing comparable outcomes were combined to increase power and compared with the combined placebo groups. The combined E2 group is subsequently referred to as the E2 group. We used a robust linear mixed model to account for both within-subject variation and outliers and adjusted for baseline values (18). Degrees of freedom were determined by Satterthwaite’s method (19). Outcomes refer to the change from start to the end of the trial between the E2 group and the placebo group and are reported as robust mean adjusted difference (robust MAD) plus 95% confidence interval. Two-sided P values <0.05 denoted statistical significance. Analyses were conducted using the statistical base package R, version 3.4.3 for Mac (18) with the added packages robustlmm 2.1–4 (19) and lmerTest 2.0–36 (20).

**Results**

In our clinic database, we identified 48 men meeting the inclusion criteria of the study. Eleven men were excluded on the basis of prior venous thromboembolism (n=1), ECOG >1 (n=1), inability to consent in English (n=2) or refusal to participate (n=7). Thirty-seven were randomised with 1 loss to follow-up after the day 14 visit (Fig. 1).

Baseline characteristics by group are shown in Table 1. Participant age range was 60–83 years with 18 (49%) receiving ADT for more than 3 months (median: 3 months, range: 1–120 months). Baseline median T was 0.2 nmol/L (range of 0.04–0.9 nmol/L) and E2 was 11 pmol/L (range undetectable to 65 pmol/L). Seven men (19%) were receiving medication from classes used to treat hot flushes, but these medications or their doses were not altered during the study.

Both doses of E2 significantly raised serum E2 from baseline to day 28 compared to placebo (Fig. 2 and Table 2). Day 28 serum E2 concentration ranged from 106 to 870 pmol/L in the 0.9 mg dose group (median: 208 pmol/L; interquartile range: 157–332), and 96–1814 pmol/L in the 1.8 mg dose group (median: 220 pmol/L; interquartile range: 144–660). There was no association between day 28 E2 concentration and participant BMI, age or duration of ADT at enrolment (data not shown). Based on inspection of returned syringes from the 36 participants who completed follow-up, 1003 of 1008 prescribed doses were administered. Because there were comparable E2 concentrations in the placebo groups and in the E2 groups respectively, these groups were combined to increase power in the analysis of secondary outcomes.
Hot flushes

Averaged daily hot flush scores are shown in Fig. 3A. The score declined in the E2 group, compared with the placebo group (robust MAD: −2.2 (95% CI: −3.6 to −0.8; \( P=0.02 \)). There was no association between ADT duration at enrolment and baseline score (data not shown). At day 28, blinded participants were asked to indicate if their assigned treatment improved hot flushes or not. Although there was 100% compliance with hot flush diary return in completing participants, this additional question was not answered by all participants. Thirteen of 18 participants from the placebo arm answered this question, with 3 (23%) indicating that their treatment was helpful. There was 1 drop out and 2 participants who did not answer this question in the E2 arm for a total of 21 participant answers of which 16 (76%) indicated that the treatment was helpful (\( P=0.007 \)).

Quality of life

Baseline median (IQR) scores were 122 (118–133) in the E2 group and 124 (120–128) in the placebo group. At day 28, there were no significant changes between E2 and placebo groups in FACT-P total score or subscales measuring

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**Table 1** Baseline characteristics by group. Data are presented as median (IQR).

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>( P ) value (overall)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>76.2 (73.4–79.4)</td>
<td>74.9 (68.9–75.5)</td>
<td>72.7 (66.7–74.5)</td>
<td>71.4 (68.7–79.1)</td>
<td>0.617</td>
</tr>
<tr>
<td><strong>Prior stroke or MI</strong></td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1.000</td>
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<td><strong>ECOG</strong></td>
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<td></td>
<td>0.174</td>
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<td><strong>PCa stage</strong></td>
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<td>Localised</td>
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<tr>
<td>Biochemical recurrence/salvage</td>
<td>2</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td></td>
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<td><strong>GnRH analogue duration (months)</strong></td>
<td>8.5 (2.3–18.5)</td>
<td>3.0 (1.8–10.2)</td>
<td>2.0 (1.0–9.5)</td>
<td>12.0 (1.0–20.2)</td>
<td>0.573</td>
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<td><strong>Medications</strong></td>
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<tr>
<td>Vitamin D</td>
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<td>5</td>
<td>1</td>
<td>3</td>
<td>0.501</td>
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<tr>
<td>Calcium</td>
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<td>1</td>
<td>1</td>
<td>2</td>
<td>1.000</td>
</tr>
<tr>
<td>SSRI/SNRI</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>0.401</td>
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<tr>
<td>Antiandrogen</td>
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<td>0</td>
<td>1</td>
<td>0.000</td>
</tr>
<tr>
<td>Clonidine</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>1.000</td>
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<td>Gabapentinoid</td>
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<td>0</td>
<td>0</td>
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<td>6</td>
<td>2</td>
<td>2</td>
<td>0.378</td>
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<tr>
<td>Fibrate</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
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<tr>
<td>Ertizimibe</td>
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<td>1</td>
<td>0</td>
<td>1</td>
<td>1.000</td>
</tr>
<tr>
<td>Fish oil</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0.485</td>
</tr>
<tr>
<td><strong>BMI (kg/m(^2))</strong></td>
<td>29.3 (27.6–32.0)</td>
<td>28.8 (27.0–34.4)</td>
<td>29.0 (26.2–29.9)</td>
<td>29.0 (26.6–29.7)</td>
<td>0.766</td>
</tr>
<tr>
<td><strong>SBP (mmHg)</strong></td>
<td>138 (127–140)</td>
<td>126 (120–142)</td>
<td>147 (141–148)</td>
<td>131 (129–141)</td>
<td>0.131</td>
</tr>
<tr>
<td><strong>DBP (mmHg)</strong></td>
<td>80 (76–82)</td>
<td>80 (78–83)</td>
<td>82 (78–87)</td>
<td>78 (74–81)</td>
<td>0.590</td>
</tr>
<tr>
<td><strong>Hot flush scores</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average daily frequency</td>
<td>2.1 (0.00–5.1)</td>
<td>1.1 (0.11–4.1)</td>
<td>1.7 (1.3–5.4)</td>
<td>3.3 (2.6–6.8)</td>
<td>0.609</td>
</tr>
<tr>
<td>Average daily score</td>
<td>2.7 (0.00–6.2)</td>
<td>1.4 (0.21–6.6)</td>
<td>1.9 (1.6–5.4)</td>
<td>4.3 (3.1–13.0)</td>
<td>0.494</td>
</tr>
<tr>
<td><strong>TS (nmol/L)</strong></td>
<td>0.25 (0.22–0.53)</td>
<td>0.14 (0.11–0.22)</td>
<td>0.21 (0.16–0.31)</td>
<td>0.17 (0.16–0.19)</td>
<td>0.063</td>
</tr>
<tr>
<td><strong>LH (IU/L)</strong></td>
<td>0.30 (0.23–0.82)</td>
<td>0.10 (0.10–0.32)</td>
<td>0.10 (0.10–0.40)</td>
<td>0.10 (0.10–0.20)</td>
<td>0.208</td>
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<tr>
<td><strong>FSH (IU/L)</strong></td>
<td>2.9 (2.2–4.7)</td>
<td>3.6 (2.7–4.3)</td>
<td>3.0 (2.4–4.4)</td>
<td>3.6 (2.3–4.2)</td>
<td>0.996</td>
</tr>
<tr>
<td><strong>E2 (pmol/L)</strong></td>
<td>11 (11–11)</td>
<td>11 (11–11)</td>
<td>11 (11–11)</td>
<td>11 (11–11)</td>
<td>0.892</td>
</tr>
<tr>
<td><strong>E1 (pmol/L)</strong></td>
<td>164 (134–194)</td>
<td>151 (116–216)</td>
<td>124 (98.0–216)</td>
<td>115 (83.0–138)</td>
<td>0.312</td>
</tr>
<tr>
<td><strong>25OH-Vit D3 (nmol/L)</strong></td>
<td>77.0 (68.8–106.0)</td>
<td>77.0 (61.8–99.2)</td>
<td>72.0 (60.5–73.0)</td>
<td>88.5 (74.2–121)</td>
<td>0.449</td>
</tr>
</tbody>
</table>

*FACT-P total score is a prostate cancer-specific quality of life score ranging from 0 to 156, with higher scores indicating greater quality of life. 25OH-Vit D3, 25-hydroxy Vitamin D3; BMI, Body Mass Index; DBP, Diastolic blood pressure; E1, Estrone; E2, Estradiol; ECOG, Eastern Cooperative Oncology Group Performance Status; FACT-P, Functional Assessment of Cancer Therapy – Prostate; FSH, Follicle-stimulating hormone; GnRH, Gonadotrophin-releasing hormone; IQR, Interquartile range; LH, Luteinizing hormone; MI, Myocardial infarction; PCa, Prostate Cancer; SSRI, Selective serotonin reuptake inhibitor; SNRI, Selective serotonin-noradrenaline reuptake inhibitor; SBP, Systolic blood pressure; TS, Testosterone.*
social well-being, physical well-being, emotional well-being, functional well-being or prostate cancer-specific symptoms (data not shown).

**Laboratory secondary endpoints**

For hematological and biochemical secondary endpoints, changes from baseline to day 28 were not different between combined E2 and placebo groups for T and DHT (Table 3). E2 treatment increased serum E1 and SHBG and decreased serum FSH with a possible small increase in serum LH. There was no change in haemoglobin, glucose, insulin, HOMA2-IR, IGF-1 or lipids. CTX decreased significantly in the E2 group compared to placebo, with a smaller relative increment in P1NP (Fig. 3B and C and Table 3).

**Table 2** E2 (pmol/L) median and interquartile range by treatment assignment and time point. Values below the lower limit of detection were assigned the value of the limit of detection (11 pmol/L).

<table>
<thead>
<tr>
<th></th>
<th>A (Placebo 1 mL; n = 6)</th>
<th>B (E2 1 mL; n = 12)</th>
<th>C (Placebo 2 mL; n = 7)</th>
<th>D (E2 2 mL; n = 12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>11 (11–11)</td>
<td>11 (11–11)</td>
<td>11 (11–11)</td>
<td>11 (11–11)</td>
</tr>
<tr>
<td></td>
<td>11–65</td>
<td>11–50</td>
<td>11–18</td>
<td>11–17</td>
</tr>
<tr>
<td>Day 14</td>
<td>11 (11–11)</td>
<td>139 (99–175)</td>
<td>11 (11–11)</td>
<td>170 (113–586)</td>
</tr>
<tr>
<td></td>
<td>11–103</td>
<td>74–525</td>
<td>11–13</td>
<td>87–1083</td>
</tr>
<tr>
<td></td>
<td>11–11</td>
<td>106–870</td>
<td>11–27</td>
<td>96–1814</td>
</tr>
</tbody>
</table>

**P value**

A vs B: <0.001
C vs D: <0.001

CI, Confidence interval; E2, Estradiol; IQR, Interquartile range.

**Adverse effects**

One participant (8%) in the E2 1 mL group, 2 (17%) in the E2 2 mL group and none in the placebo group developed grade 1 nipple tenderness by day 14, which persisted until day 28. No participant developed breast swelling. There were no incident cardiovascular or VTE events.

**Discussion**

This short-term RCT found that transdermal E2 gel in daily doses of both 0.9 and 1.8 mg increased serum E2 concentrations in men with castrate T levels due to GnRH analogue treatment. Due to the inherent indication for ADT, it was not possible to include a matched group of men with PCa not undergoing ADT. Therefore, we compared our findings to reference ranges for serum E2 that have been derived from population-based cohorts of young and older men using the same laboratory and LC–MS assay.

In the Raine Birth Cohort Study of 382 healthy young Australian men aged 19–22, median serum E2 was 147 pmol/L (95% confidence interval 57–273 pmol/L) (21). In a study of 325 healthy older Australian men, median serum E2 was 86 pmol/L (95% CI 39–153 pmol/L) (22). In a pooled analysis of over 10 000 samples from 3 Australian population-based studies reporting smoothed age-specific centiles, derived male reference ranges for E2 were 38–196 pmol/L (men aged <65 years), 23–154 pmol/L (65–75 years), 22–166 pmol/L (75–85 years) and 22–174 pmol/L (>85 years) (23).

In our study, minimum and median E2 concentrations in the intervention groups were within the reported reference ranges for young and older men. Maximum
concentrations ranged from 3 to 7 times the upper reference limits. Overall, these serum E2 concentrations are substantially lower than those achieved with high-dose intramuscular polyestradiol phosphate used previously for ADT in men with PCa, reported to range from 1400 to 4500 pmol/L (24). Reported E2 concentrations in the transdermal E2 arm of the PATCH trial were also higher (median 685 pmol/L, 5th–95th percentile: 350–1788 pmol/L) (25).

In the context of in vivo E2 synthesis by tissue aromatase occurring in healthy men, serum E2 only reflects the proportion of total synthesised E2 that has escaped local tissue metabolism and diffused into the blood (26). In the context of pharmacologic E2 add-back in men receiving GnRH analogues employed here, in vivo E2 synthesis is minimal due to the suppression of circulating TS, and serum E2 reflects that component of transcutaneously absorbed E2 that has not been distributed to tissues or metabolised.

We are aware of only one study assessing the effects of transdermal E2 gel on serum E2 concentrations in men. A single 2 mg dose of transdermal E2 gel (Divigel, Orion Pharma) in 8 healthy young men produced significantly elevated serum E2 levels compared with placebo at 1 h and peak serum E2 levels at 2 h (mean 290 pmol/L, range up to 514 pmol/L) (27). Those findings are likely to overestimate serum E2 both because the measurements were performed with an E2 immunoassay, which overestimates male serum E2 compared with LC–MS measurements used in this study (28) as well as the fact that the non-castrate participants had higher endogenous E2 levels.

We are unable to definitively explain the mechanism for the substantial variability in circulating E2 levels observed in this study. Notably, the variability in circulating E2 levels observed here is consistent with reports of E2 gel application in postmenopausal women (29, 30). Even with steady-state dosing of E2 gel in women (30), and T gel in men (31), there are 2-fold differences between mean Cmin and Cmax and wide variability in circulating levels achieved.

**Figure 3**

Box-and-whisker plots. The dark lines show the median, the lower and upper borders of the boxes are the 25th and 75th percentiles respectively. The whiskers extend 1.5 times the interquartile range below and above the bottom and top of the box. The points are individual outliers. (A) Average daily hot flush score at baseline and end (median 95% CI). Robust mean adjusted difference between E2 group compared and placebo group was $-2.2 (-3.6$ to $-0.8)$, $P=0.02$. (B) CTX at day 0 and day 28 (median 95% CI). Robust mean adjusted difference of E2 group compared with placebo group was $-107$ ng/L ($-130$ to $-84$), $P<0.001$. (C) P1NP at day 0 and day 28 (median 95% CI). Robust mean adjusted difference of E2 group compared with placebo group was $8.9 \mu$g/L (5.0–12.7), $P<0.01$. 

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Table 3  Change from baseline to end in men receiving E2 compared with men receiving placebo. Data are presented as median (IQR).

<table>
<thead>
<tr>
<th></th>
<th>Combined E2 groups (n = 24)</th>
<th>Combined placebo groups (n = 13)</th>
<th>Robust MAD (95% CI)</th>
<th>P value For MAD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>D0</td>
<td>D28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TS (nmol/L)</td>
<td>0.16 (0.13–0.20)</td>
<td>0.17 (0.13–0.24)</td>
<td>0.03 (–0.01 to +0.07)</td>
<td>0.16</td>
</tr>
<tr>
<td>DHT (nmol/L)</td>
<td>0.17 (0.17–0.17)</td>
<td>0.17 (0.17–0.17)</td>
<td>N/A*</td>
<td></td>
</tr>
<tr>
<td>E1 (pmol/L)</td>
<td>131 (91–160)</td>
<td>706 (435–923)</td>
<td>671 (583–758)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>LH (IU/L)</td>
<td>0.1 (0.1–0.2)</td>
<td>0.1 (0.1–0.4)</td>
<td>0.18 (0.05–0.32)</td>
<td>0.01</td>
</tr>
<tr>
<td>FSH (IU/L)</td>
<td>3.6 (2.3–4.2)</td>
<td>0.9 (0.7–1.5)</td>
<td>–2.3 (–2.9 to –1.7)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>SHBG (nmol/L)</td>
<td>65 (45–70)</td>
<td>82 (51–89)</td>
<td>11.6 (6.6–16.5)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>FBGL (mmol/L)</td>
<td>4.8 (4.5–5.2)</td>
<td>4.9 (4.6–5.4)</td>
<td>0.06 (–0.19 to 0.30)</td>
<td>0.66</td>
</tr>
<tr>
<td>Insulin (IU/L)</td>
<td>10.8 (9.1–14.0)</td>
<td>10.8 (7.9–15.8)</td>
<td>1.0 (–0.6 to 0.7)</td>
<td>0.43</td>
</tr>
<tr>
<td>HOMA2-IR</td>
<td>1.48 (1.23–1.82)</td>
<td>1.36 (1.00–1.96)</td>
<td>–0.14 (–0.32 to 0.04)</td>
<td>0.14</td>
</tr>
<tr>
<td>IGf-1 (nmol/L)</td>
<td>21.3 (17.6–24.1)</td>
<td>18.8 (16.2–23.7)</td>
<td>–0.37 (–2.3 to 1.5)</td>
<td>0.71</td>
</tr>
<tr>
<td>LDL-C (mmol/L)</td>
<td>2.9 (2.2–3.6)</td>
<td>2.5 (2.0–3.6)</td>
<td>0 (–0.15 to 0.15)</td>
<td>0.98</td>
</tr>
<tr>
<td>HDL-C (mmol/L)</td>
<td>1.6 (1.3–1.8)</td>
<td>1.6 (1.5–1.7)</td>
<td>–0.16 (–0.26 to –0.07)</td>
<td>0.001</td>
</tr>
<tr>
<td>TG (mmol/L)</td>
<td>1.4 (1.2–2.0)</td>
<td>1.3 (1.2–1.7)</td>
<td>–0.19 (–0.39 to 0.01)</td>
<td>0.08</td>
</tr>
<tr>
<td>CTX (ng/L)</td>
<td>552 (488–757)</td>
<td>433 (334–541)</td>
<td>–107 (–130 to –84)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>P1NP (µg/L)</td>
<td>58 (38–68)</td>
<td>66 (45–82)</td>
<td>8.9 (5.0–12.7)</td>
<td>&lt;0.01</td>
</tr>
</tbody>
</table>

*MAD was not estimable due to singularity. CI, Confidence interval; CTX, beta carboxyl-terminal type 1 collagen telopeptide; D0, Day 0; D28, Day 28; DHT, Dihydrotestosterone; E1, Estrone; E2, Estradiol; FBGL, Fasting blood glucose level; FSH, Follicle-stimulating hormone; HDL-C, High-density lipoprotein cholesterol; HOMA2-IR, Updated Homeostatic Model Assessment of Insulin Resistance; IGF-1, Insulin-like growth factor 1; IQR, Interquartile range; LDL-C, Low-density lipoprotein cholesterol; LH, Luteinizing hormone; MAD, Mean adjusted difference; P1NP, pro collagen type 1 amino-terminal propeptide; SHBG, Sex hormone-binding globulin; TS, Testosterone; TG, triglycerides.

Observed variability is likely due to differences in transcutaneous absorption and metabolism of E2. In addition, while participants in our study were instructed to withhold their dose prior to their days 14 and 28 morning blood test, it is possible that some men may have applied the disallowed morning dose or had applied the gel at various times during the previous day so that the time between last dose and blood sampling may have contributed to the between-person variability in serum E2. Age did not correlate with serum E2 levels, and there was substantial overlap in levels achieved with 0.9 and 1.8 mg doses.

Other factors contributing to E2 variability might include duration of prior hypogonadism and fat mass. In our study, BMI and duration of ADT were not correlated with E2 levels, but our study was not designed to rigorously examine these hypotheses. Future studies should do so, as they may have clinical implications regarding optimal E2 dosing considerations in such men.

Nipple tenderness was noted in 1 of 12 men receiving 0.9 mg, 2 of 12 men receiving 1.8 mg and none using placebo gel in this study. In the PATCH trial, 75% of men receiving a high-dose transdermal E2 regimen, sufficient to induce castrate TS concentrations without GnRH analogues, experienced gynaecomastia compared to 19% of men receiving GnRH analogues (8). It is unknown to what extent long-term low-dose transdermal E2 add-back will increase the incidence of breast adverse effects above that caused by GnRH analogues alone.

The increase in circulating E1 observed here is expected given E2 and E1 undergo interconversion by 17 hydroxysteroid dehydrogenase. While E2 is the sole potent bioactive oestrogen, some observational studies have associated low E1 with adverse health outcomes. For example, in a longitudinal study of 1637 community-dwelling men, low circulating E1 but not E2 predicted a deterioration in self-rated health status (32). Larger and longer-term studies are needed to determine whether increasing circulating E1 has relevance for clinical outcomes in men with PCa receiving ADT.

Hot flushes and quality of life

There were substantial improvements in the robust MAD for daily hot flush score (Fig. 2A) with E2 treatment corroborated by the fact that more men receiving E2 reported beneficial effects than those receiving placebo. This beneficial effect occurred despite the study not selecting men for troublesome hot flushing or excluding men continuing to receive other medications for hot flushing. Yet, despite previous reports associating increased hot flushes with sleep disturbance (33) and reduced quality of life in men undergoing ADT (34, 35), these benefits did not translate into a detectable...
improvement in overall quality-of-life scores. This disparity may be due to a lack of power because of the short duration of this study or because baseline quality of life was already relatively high in our cohort by comparison with other men with PCa (36).

These data are consistent with an experimental study of induced hypogonadism in healthy young men with graded TS add-back with or without aromatase inhibition, indicating that E2 deficiency, not androgen deficiency, is the predominant trigger for vasomotor symptoms in men (37). However, that study inferred E2 effects indirectly by drug-induced aromatase inhibition but without a placebo control for the drug, whereas our study tested the effects of E2 in the absence of TS directly. Uncontrolled studies (38, 39) and a small RCT (40) of diethylstilbestrol, a synthetic non-steroidal estrogen, in men undergoing non-estrogen ADT for PCa have also suggested a benefit in treating vasomotor symptoms. Furthermore, data from PATCH indicate less severe declines in global quality of life in men receiving transdermal E2 rather than GnRH analogues for treatment of locally advanced or metastatic PCa (34). This effect seemed to be driven primarily by a difference in hot flushes between arms, although men assigned to E2 had less decline in physical and sexual function at the cost of more gynecomastia.

Androgens and gonadotrophins

Although baseline TS and DHT were fully suppressed by the pre-study GnRH analogue treatment and unaffected by study E2 treatment, the low baseline serum FSH was further reduced in men receiving E2 but not placebo (Table 3). So-called 'FSH escape' has been described during long-term GnRH agonist use and attributed to loss of negative feedback on FSH from the progressive long-term decline in inhibin B seen during GnRH agonist treatment (41, 42). These present findings indicate that exogenous E2 has FSH-suppressive effects in men who have castrate levels of T. Whether this FSH escape is a clinically relevant phenomenon is not known. Direct roles of FSH in tumour progression and bone and metabolic side effects of ADT have been proposed (43). However, the proposed direct non-reproductive biological roles of FSH remain controversial (44).

Biomarkers of bone remodelling

There were significant reductions in CTX and increases in P1NP with E2 treatment, without changes in PTH, calcium or phosphate levels or in Vitamin D supplementation. The acute effect with E2 add-back seen here is consistent with the fact that acutely, medical castration produces the reverse, i.e. an increase in bone resorption and transient decrease in bone formation in older otherwise healthy men (45). This pattern of change in bone remodelling suggests an antiresorptive effect of E2 add-back in men receiving GnRH analogues. In men, sex steroid deficiency results in accelerated bone remodelling, and multiple lines of evidence suggest this is largely but not solely an E2-dependent effect (46). Notably, preliminary data from the PATCH study have indicated a beneficial effect on bone density for men receiving high-dose transdermal E2 compared with GnRH analogue (25). For the alternative approach of low-dose E2 add-back in addition to GnRH analogue treatment, longer-term treatment will be necessary to determine whether this strategy will improve or preserve bone density.

Hepatic protein synthesis

Due to first pass metabolism, oral estrogens expose hepatocytes to non-physiological estrogen concentrations, while high parenteral E2 doses can achieve similar effects with supraphysiologic hepatic estrogen exposure. Oral (or high parenteral) doses of estrogens increase hepatic synthesis of SHBG, clotting factors, inflammatory cytokines and binding proteins (5, 47). Our study showed a small, but significant increase in SHBG consistent with hepatic E2 effect. We did not measure clotting factors in this study but prior studies have observed a lack of coagulation and inflammatory factor activation with transdermal E2 (48). Moreover, high-dose transdermal E2 in the PATCH trial was not associated with an increased risk of thromboembolic events, although larger studies are needed to confirm that E2 treatment is safe (8).

Insulin resistance and lipid metabolism

We observed no differences in fasting lipids, blood glucose, insulin, c-peptide or insulin resistance estimated by HOMA2-IR. ADT reduces muscle mass and increases fat mass (49) and is associated with worsening insulin sensitivity (50) and incident diabetes mellitus (51). Combined deficiency of androgens and estrogens is likely to contribute to these body composition and metabolic effects (6). Theoretically, E2 add-back might have beneficial effects by reducing visceral fat accumulation (6, 52). While our study does not provide data to support this hypothesis, it may have been too short to detect such effects.
Strengths and limitations of the study

Strengths of the study include its unique randomised design of relatively low-dose transdermal E2 add-back given to men with prostate cancer receiving GnRH analogue-based ADT, which is in contrast to using high-dose E2 as a sole mode of ADT (8). The latter strategy leads to supraphysiologic E2 concentrations, which may be associated with an increased risk of undesirable effects. Moreover, the study design allowed us to evaluate direct actions of E2 in the absence of T, whereas previous seminal work inferred E2 effects indirectly by drug-induced aromatase inhibition (6, 37). In addition, a relatively large number of outcomes were assessed, and E2 concentrations were measured by validated LC–MS/MS technology.

The principal limitations are the short duration and small sample size of this study, preventing definitive conclusions about the presence or durability of any clinical benefits from a strategy of E2 add-back. Our study was too short to evaluate the oncologic outcomes of E2 treatment. While preclinical data are not conclusive (9), a systematic review of 20 RCTs of the use of high-dose parenteral E2 as ADT for locally advanced or metastatic PCa found no evidence that E2 treatment differed in efficacy from GnRH analogues or orchiectomy when comparing overall mortality (53).

Conclusion

Our study demonstrates that in men who have castrate levels of both E2 and TS, daily transdermal E2 0.9–1.8 mg increases median serum E2 concentrations into the reference range reported for healthy young or older men, but with substantial variability. E2 gel treatment reduces vasomotor symptoms and bone remodelling in older men with PCa, and further suppresses partially suppressed serum FSH in the absence of TS. These findings provide a rationale to test the hypothesis that such E2 add-back will benefit men by mitigating bone and, possibly metabolic adverse effects of ADT due to GnRH analogue treatment in a longer-term RCT. Further trials would reasonably proceed with a 0.9 mg E2 dose rather than 1.8 mg dose, based on the largely overlapping serum levels achieved here and the hypothesis that a lower dose may result in fewer adverse effects.

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