TRANSDERMAL ESTRADIOL (TDE) ANDROGEN DEPRIVATION THERAPY

by Charles (Chuck) Maack – Prostate Cancer Advocate/Activist

DISCLAIMER: Please recognize that I am not a Medical Doctor. I have been an avid student researching and studying prostate cancer as a survivor and continuing patient since 1992. I have dedicated my retirement years to continued research and study in order to serve as an advocate for prostate cancer awareness, and, from a activist patient's viewpoint, to voluntarily help patients, caregivers, and others interested develop an understanding of prostate cancer, its treatment options, and the treatment of the side effects that often accompany treatment. There is absolutely no charge for my mentoring – I provide this free service as one who has been there and hoping to make your journey one with better understanding and knowledge than was available to me when I was diagnosed so many years ago. Readers of this paper must understand that the comments or recommendations I make are not intended to be the procedure to blindly follow; rather, they are to be reviewed as my opinion, then used for further personal research, study, and subsequent discussion with the medical professional/physician providing your prostate cancer care.

Transdermal Estradiol (TDE) androgen deprivation therapy (ADT) with patches or gel can have the same effect as an LHRH agonist/antiandrogen combo, cause less side effects, and would be much less expensive. Patients interested should visit with a Medical Oncologist to discuss this alternative. Recognizing that the physician makes more money prescribing LHRH agonists and antiandrogens, many have not taken time to look into treating with transdermal estradiol patches or gel. Accordingly, it is often difficult to find a Medical Oncologist willing to work with the patient in prescribing this treatment rather than LHRH agonist and antiandrogen ADT.

SPECIAL NOTE: With the FDA now requiring labeling on the package material of LHRH/GnRH agonists/antagonists regarding the effect of low testosterone on patients with heart and/or diabetic issues as well as those susceptible to stroke, the physician has now been alerted and now has a responsibility to thoroughly check and determine other health issues his/her patient may be experiencing, and not just prescribe LHRH/GnRH agonists, antagonists, **or for that matter, Transdermal Estradiol (TDE) patches or gels**, without doing so. The physician additionally

has the responsibility to discuss what these drugs and the lowering of testosterone might - not necessarily will - have on that patient with heart, diabetes, and possible stroke health issues. It would behoove all patients experiencing any of the foregoing ailments to notify their physician when LHRH/GnRH agonists, antagonists or Transdermal Estradiol (TDE) patches or gels are being considered as treatment. (See: http://tinyurl.com/27q3qra).

Medical Oncologist Tomasz Beer, Principal researcher of transdermal estradiol/TDE, is an expert in this protocol. Contact info:

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"In the Oregon study, patients progressing after primary hormonal therapy received transdermal estradiol at a rate of 0.6 mg per 24 hours (administered as six 0.1 mg per 24-hour patches replaced every 7 days). Serum prostate-specific antigen (PSA) and hormone levels, coagulation factors, markers of bone turnover, bone density measurements, and a hot flash diary were collected at regular intervals. Median time to disease progression was 12 weeks."

See: http://www.psa-rising.com/med/hormonal/estradiolpatch5.html

Since this treatment is much less expensive and would certainly be a suitable option for patients without health insurance, if interested, I also recommend contact with Professor Richard Wassersug in Canada who has become very experienced in this treatment protocol having initially been treated with an LHRH agonist and antiandrogen and, not comfortable with the side effects, researched then changed to transdermal estradiol patches (or possibly gel). He has done well with this protocol for many years and authored papers in this regard. Professor Wassersug may be contacted at richard.wassersug@ubc.ca for further information. This procedure can then be discussed with one's oncologist. If the oncologist is not familiar with the administration of estrogen patches, phone calls would be in

order to other oncologists in the area asking if they prescribe estrogen patches for androgen deprivation therapy. If unable to find an oncologist with such experience, it would be reasonable to take information collected to one's oncologist and request he/she look into this treatment option since if is the treatment option preferred.

Professor Wassersug provided these comments: "The case for transdermal estradiol is well stated in:

Norman G, **Dean ME**, **Langley RE**, **Hodges ZC**, **Ritchie G**, **Parmar MK**, **Sydes MR**, **Abel P**, **Eastwood AJ**. 2008. **Parenteral oestrogen in the treatment of prostate cancer: a systematic review.** Br J Cancer. 2008 98(4):697-707. I have been on this treatment for about five years. I like the fact that I don't have to worry about osteoporosis. I don't have hot flashes. I have better quality sleep than I ever had during the years I was on Lupron. Furthermore I retain some libido and the ability to have orgasms. Lastly estradiol is cognitively protective. I greatly favor the gel over patches as it is much easier to manage. Talk this option over with your MD. He is welcome to contact me for more information. I summarized the information on this topic for a prostate cancer conference about a year ago and that summary can be found at: http://www.ppml-info.org/TDE.pdf . The case against transdermal estradiol of course is that is cuts back greatly the amount of money an MD can make compared to giving LHRH agonists injections. So lots of MDs will favor the LHRH injections. You should only go on estradiol with an MDs supervision. However the titrating is MUCH easier with the gel than the patches."

Here is another reference regarding transdermal estrogen (TDE) therapy:

http://www.ncbi.nlm.nih.gov/pubmed/18422771