

TRANSDERMAL ESTRADIOL (TDE) ANDROGEN DEPRIVATION THERAPY

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

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.

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

Oregon Health & Science University

[Cancer Care Center](#)

Center for Health & Healing, 7th floor

3303 S.W. Bond Ave.

Portland, OR 97239

Phone: 503 494-6594

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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 tadpole@dal.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 it 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: www.ppml-info.org/TDE.pdf. The case against transdermal estradiol of course is that it 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>