Estetrol, a Fetal Steroid for the Treatment of Adults

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Estetrol (E₄) is a natural fetal estrogen. This steroid molecule has been discovered in 1985 by the group of Egon Diczfalusy at the Karolinska Institute in Sweden and as a drug for human use in 2001 by the group of Herjan Coelingh Bennink at Pantarhei Bioscience in the Netherlands. Estetrol is structurally closely related to the predominant natural estrogens estron (E₁), estradiol (E₂) and estriol (E₃), but with a number of different and potentially favorable features.

In comparison to E₂, E₄ displays much higher bioavailability upon oral administration and its elimination is considerably slower. Moreover, E₄ is a metabolic endproduct and not metabolized into other estrogenic metabolites as happens after oral intake of E₂. Consequently, stable therapeutic blood concentrations are rapidly achieved upon oral administration. In vitro E₄ has been shown to interact exclusively with the estrogen receptors with some preference for the alpha receptor. Estetrol interacts minimally with liver function and steroid- and drug-metabolizing liver enzymes, suggesting among others less interference with hemostasis compared to other estrogens and potentially a lower risk of venous thromboembolism (VTE). These features indicate the particular feasibility and anticipated safety of E₄ as an oral therapy in a once-daily dosing regimen.

Data from preclinical pharmacology studies support the safe use of E₄ in humans and suggest therapeutic effects such as menopausal hormone treatment (MHT) of vasomotor symptoms (VMS) and vulvovaginal atrophy (VVA), prevention of osteoporosis, as well as application in contraceptive regimens. Estetrol antagonized E₂ in in vitro models and prevented and inhibited growth of mammary tumors in an experimental rat model, suggesting a more breast-friendly profile compared to other estrogens and suitability of E₄ as estrogen add-back treatment during anti-hormonal endocrine therapy of breast cancer, endometriosis and prostate cancer.

After 28-days daily oral administration of 2, 10, 20, or 40 mg to postmenopausal women, E₄ has been shown to reduce the occurrence of VMS, to reverse the menopause-induced VVA and to exert bone-preserving changes by decreasing bone turnover, especially bone-resorption, suggesting positive bone formation. Endometrial proliferation, to an extent similar to 2 mg E₂-valerate (E₂V), was found at E₄ doses of 10 mg/day. Estetrol was safe and had minimal effects on the synthesis of lipoproteins, SHBG and parameters of hemostasis, supporting the favorable profile with respect to VTE. At present dose-finding studies with E₄ are prepared for the treatment of VMS and VVA.

Estetrol at a daily oral dose of 15 or 20 mg has been shown to be suitable as the estrogen component of combined oral contraceptives in a full phase II development program in collaboration with Jean-Michel Foidart in Belgium, demonstrating excellent efficacy, safety and cycle control, while minimally interfering with a number of metabolic parameters. Further phase III development of the oral contraceptive application of E₄ will be performed by Mithra Pharmaceuticals in Liège, Belgium. J Reproduktionsmed Endokrinol_Online 2015; (4): 399–401.

Key words: Estetrol, E₄, natural fetal estrogen, contraception, VMS, VVA, add-back treatment

Introduction

The estrogen Estetrol (E₄) is produced in large quantities by the fetal liver during human pregnancy only. The molecule was discovered in 1965 at the Karolinska Institute in Stockholm [1]. Estetrol differs from other natural estrogens by an additional alpha-hydroxy (OH) group at position 15 of the molecule. It has been demonstrated that this minor structural difference has important implications, since this single additional OH group as compared to estril (E₃) extends the elimination half-life in the human from 10 minutes for E₃ to 20–28 hours for E₄ [2]. The half-life of E₄ is also much longer than those of other natural estrogens, including natural 17β-estradiol (E₂) and micronized E₂, for which half-lives of 1–2 hours and 10–12 hours have been reported respectively. In addition, E₄ is more efficiently absorbed than E₂ upon oral administration, as it is much less subject to pre-systemic and first-pass metabolism. These features of E₄ are important prerequisites for the development of a once-a-day oral drug. Being a natural estrogen excreted abundantly in the urine of pregnant women, the development of a drug containing E₄ is not expected to carry additional environmental risks.

Preclinical Development

Pantarhei Bioscience has discovered that E₄ is suitable as a drug for human use. Pantarhei first demonstrated that E₄ is orally bioavailable in the rat with a remarkably long elimination half-life for the rat of 2–3 hours [3]. Subsequently the pharmacological profile of E₄ was characterized in detail in a number of studies. In these studies, E₄ was administered orally and compared to oral ethinyl estradiol (EE), a synthetic estrogen. Comparison with E₂ and E₃ was not feasible given the rapid deactivation of these natural estrogens by the rat liver. The results of Pantarhei’s pharmacological studies indicate that E₄ acts as an estrogen on the vagina [3], the uterus [3] and bone [4]. Estetrol shows limited interaction with the liver, both kinetically and dynamically [5]. Furthermore, E₄ was found to suppress the naloxone-induced tail skin temperature increase, an experimental model of hot flushes [6], and to inhibit ovulation [7]. Estetrol has a vasodilating effect on isolated rat arteries [8]. The effect on breast tumor tissue is summarized later in this paper. In in vitro studies, Pantarhei has demonstrated that E₄ is capable of binding to both ER-alpha as well as ER-beta, with a four- to fivefold preference for ER-alpha. Estetrol displayed a relatively low affinity compared to EE and E₂, but E₄ did not bind to other steroid receptors and to a panel of 130 other drug targets [5].

Metabolism of E₄ in human liver cells was found to be slow. Importantly, and in agreement with historical isotope studies carried out in the early seventies, no active metabolites of E₄ have been detected to date, and E₄ is excreted in an inactive form by the liver and kidney following conjugation to sulphate and/or glucuronide [5]. In this respect E₄ substantially differs from E₂, which after oral administration is extensively metabolized, predominantly into estrone (E₁) and estrone sulphate (E₁S), as well as into a large
number of other E1- and E2-derived metabolites [9].

As expected in view of the high levels of E4 during human pregnancy, E4 seems to be very safe. In animal pharmacology studies, in which doses of up to 10 mg/kg/day were used for four weeks, E4 did not cause any relevant side effect. The safety profile of E4 was further confirmed in a number of studies addressing the interaction of E4 with human hepatocytes [5], which is of particular significance given the known and well-documented side effects and interactions of estrogens on liver function. Contrary to EE and E2, E4 did not increase the synthesis of Sex Hormone Binding Globulin (SHBG) and did not change the activity of the five most relevant Cytochrome P-450-related liver enzymes [5]. Furthermore, and different from other estrogens, E4 appeared not to bind to SHBG [10].

Extensive information on the history and the preclinical and clinical profile of E4 is available in several review papers [11–14] and most of the pharmacological studies performed by Pantarhei have been published in Supplement I of the journal Climacteric in 2008.

### Toxicology

A complete toxicology program was performed in rat and monkey. The results showed that the toxicology of E4 is largely determined by its estrogenic action, leading to exaggerated pharmacological responses at excessively high exposures. No specific toxicity of E4 has been observed.

### Clinical Development Phase I/IIA

A single rising dose phase IA study has been performed in healthy post-menopausal women. Estetrol showed high and dose-proportional oral bioavailability with a long elimination half-life of 28 hours [2], thereby confirming its potential as an oral therapeutic. A dose-dependent peak was found to occur within 15 to 30 minutes after oral administration, which was followed by a sharp decline of the E4 blood level and a secondary rise and slow elimination of E4 thereafter, suggesting gastro-intestinal recirculation. No side effects were observed.

Pharmacokinetic simulations have shown that the 24-hour exposure of the human fetus to E4 at term pregnancy equals a daily human oral dose of 50–55 mg E4, suggesting that such a dose may be expected to be safe in the human.

A multiple rising dose phase IB/IIA study with E4 was performed in healthy postmenopausal women to evaluate safety, pharmacokinetics and pharmacodynamic parameters. Doses of 2, 10, 20 and 40 mg E4 were evaluated after daily oral administration for 28 days and the lowest 2 mg dose of E4 was compared head-to-head with 2 mg estradiol-valerate (E2V).

Estetrol at an oral dose of 10 mg/day for a short period of 28 days was shown to be effective in reducing (~40%) the frequency of hot flushes (HF) in women suffering from such complaints. Estetrol appeared somewhat more effective than E2V 2 mg/day. Full evaluation of the effect of E4 for vasomotor symptoms (VMS) requires treatment periods of at least 12 weeks.

Vaginal cytology revealed dose-dependent estrogenic effects (vaginal maturation), with a dose of 2 mg E4 per day showing similar effects as E2V 2 mg/day. In the case of vulvovaginal atrophy (VVA) the full estrogenic effect of E4 was obtained after 4 weeks treatment already.

Ultrasound measurement of endometrial thickness did not show an effect of E4 at 2 mg/day, in contrast to E2V 2 mg/day and E4 10 mg/day. Biopsies taken from subjects displaying a >50% increase in endometrial thickness revealed the expected proliferative changes. This data suggest that low dose oral E4 treatment of VVA may not require endometrial progesterin protection, but higher doses of E4 will require a progestin. To avoid the increased breast cancer risk related to the use of oral progestins, higher doses of E4 should preferably be combined with an intra-uterine levonorgestrel-releasing intra-uterine device (IUD) or with the progesterin dydrogesterone, which is the progesterin closest to natural progesterone.

Estetrol was associated with a dose-dependent decrease in the levels of osteocalcin and type I collagen telopeptide (CTX-1), parameters of bone formation and bone resorption respectively. Daily oral doses of 10 mg E4 decreased levels of CTX-1 to a similar extent as E2V 2.0 mg/day, whereas the decrease of osteocalcin with E4 was much less, suggesting a net effect and positive bone formation. This may qualify E4 not only for prevention, but also for treatment of osteoporosis.

Estetrol in the oral dose range of 2–10 mg/day for a period of 28 days had minimal effects on liver-protein synthesis. At 2.0 mg/day no effect on SHBG was observed, while at 10 mg/day similar effects as induced by 2.0 mg/day E2V were observed. E4 did not affect the synthesis of triglycerides, in contrast to E2V, and was furthermore associated with no changes or small decreases in LDL-cholesterol (considered favorable) and total cholesterol, a small and favorable increase in HDL-cholesterol and a resulting small decrease in the ratio cholesterol/HDL-cholesterol. Hemostatic factors and activities, including F1+2, tPA and nAPCr, were all minimally influenced, suggesting a limited effect on the risk of VTE.

No serious adverse events occurred at any E4 dose, and no significant changes were observed in vital signs, body weight, physical examination or ECG-readings either.

Estetrol may be suitable as the estrogen in combined oral contraceptives (COCs), for the treatment of menopausal symptoms, for prevention of osteoporosis and for estrogen add-back therapy during treatment with aromatase inhibitors and tamoxifen in women with breast cancer and in men with prostate cancer treated with GnRH analogues.

### Combined Oral Contraception (COC)

A complete phase II clinical development has been performed for oral contraception. In summary, E4 inhibits ovulation effectively when combined with a standard COC dose of a progestin [15]. Estetrol COCs have better cycle control than the E2/dienogest comparator. Its safety profile is favorable in phase I and phase II clinical trials. No relevant side effects have been observed in more than 300 women taking 15 or 20 mg E4 for six COC cycles in combination with a progestin.
Estetrol has significantly less effect on liver [16] and hemostasis parameters compared to EE and E2, whatever the progestin used in the combination, suggesting a lower risk of VTE compared to other COCs. Estetrol seems a more breast-friendly estrogen, since it exhibits estrogen-antagonistic effects in preclinical and clinical studies, especially in the presence of E2. Moreover, in contrast to orally administered E2, E4 does not yield a large pool of E1S, which constitutes a potential source of unwanted E2-resynthesis in the breast.

**Menopausal Hormone Therapy (MHT)**

According to the present standard of care for MHT, Pantarhei has focused on oral E4 treatment of early post-menopausal women with moderate to serious complaints due to estrogen deficiency such as hot flushes and sweatings, urogenital atrophy, dyspareunia caused by vaginal dryness, arthralgia, loss of bone mass and an increased risk of fractures and decreasing cognition.

Major clinical advantages of E4 in MHT compared to presently used estrogens are a lower incidence of side effects and lower risks of VTE and gallbladder disease. In addition the estrogen-antagonistic effect of E4 on the breast may result in a better safety profile in relation to breast cancer (BC).

Since the oral synthetic progestins seem to be more important than the estrogens for the risk to develop BC, the objective is to develop MHT drugs without addition of a progestin. This will be achieved by developing a low dose of oral E4 for VVA that does not stimulate the endometrium and therefore does not require addition of a progestin. For VMS a higher dose of oral E4 may be required, that will induce endometrial proliferation. To protect the endometrium and to avoid oral progestins and their increased BC risk, an intra-uterine levonorgestrel-releasing IUD is preferred.

**Vasomotor Symptoms (VMS)**

The therapeutic potential of E4 for the treatment of VMS is supported by Figures 1 and 2.

**Vulvovaginal Atrophy (VVA)**

The therapeutic potential of E4 for the treatment of VVA is supported by Figure 3 and Table 1.

**Add-back Treatment**

The terminology “add-back treatment” is used for adding back an estrogen after complete pharmacological suppression of endogenous estrogen synthesis by anti-estrogenic treatment of diseases such as breast and prostate cancer and serious...
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endometriosis. Since the side effects of removing estrogens are often unacceptable and interfere with compliance to the anti-estrogenic drugs, adding back an estrogen at a low dose has been introduced as a solution for this problem. Actually one may consider add-back treatment as a special type of MHT.

As Pantarhei has demonstrated in pharmacological and clinical studies that Estetrol acts as an estrogen agonist on vagina [3], bone [4] and brain [6], whereas Estetrol has estrogen-antagonistic effects on breast tumor tissue (see below), the mixed agonistic/antagonistic profile of Estetrol seems highly attractive for its use as estrogen add-back treatment in combination with anti-estrogenic treatments such as aromatase inhibitors, tamoxifen and GnRH analogues.

Preclinical Studies related to Breast Cancer

During the pharmacological profiling of Estetrol in human breast cancer (BC) cell lines and in the DMBA rat model, Pantarhei has demonstrated that Estetrol can act as an estrogen antagonist in breast tumor tissue.

The estrogen antagonism of Estetrol has been confirmed in in vitro models by the groups of Gompel in Paris, Simoncini and Genazzani in Pisa and Greene in Chicago.

In three separate experiments in the DMBA animal model, Pantarhei has shown that Estetrol can dose-dependently prevent and treat breast tumors [17, 18]. Figure 4 shows data from the DMBA treatment study demonstrating that Estetrol at the highest dose (10 mg/kg) removes breast tumors as effectively as OVX. Even when this effect would have been obtained by complete suppression of ovarian function and extinction of estrodiol only, it shows that Estetrol at a high dose does not promote tumor growth. However it is more likely that the effect of Estetrol at this dose is a cytotoxic effect, also known from other estrogens such as EE, E2 and DES at high doses. A major difference with these other estrogens is the expected superior tolerability of Estetrol at higher doses, allowing the clinical use of Estetrol at such high dose levels.

Very recently the group of Foidart in Liège has demonstrated that Estetrol is acting as an estrogen via the genomic pathway, whereas it acts as an anti-estrogen via the non-genomic pathway [19]. This unique combination of properties classifies Estetrol as the first known natural SERM (selective estrogen receptor modulator) and explains why in preclinical and clinical studies Estetrol exhibits anti-estrogenic effects on breast cancer. It implies that Estetrol might be safer for the breast than other estrogens. This, in combination with the liver-friendly profile of Estetrol and its very favorable safety profile, suggests that Estetrol containing new drugs are expected to exhibit a very beneficial benefit-risk ratio.
Clinical Study in Women with Breast Cancer

A prospective, double-blind, placebo-controlled, randomised, 14 days, pre-operative, neo-adjuvant study was performed in 15 pre- and 15 postmenopausal women with estrogen-receptor positive early BC in the “Vienna General Hospital”, Austria. Results have been published recently [20] and showed that E4 had a significant pro-apoptotic effect on tumor tissue while Ki67 expression remained unchanged. Estetrol increased SHBG significantly thereby reducing the concentrations of bioavailable E2. FSH levels decreased in postmenopausal women only and LH levels remained unchanged. Systemic IGFB-1 levels decreased significantly. The most intriguing finding of the study was that intratumoral epithelial ER-alpha expression decreased significantly and a trend was found towards an increase of E2 and tamoxifen. The combination of E4 with an AI seems especially attractive, since the mechanism of action of both drugs is entirely different i.e. receptor antagonism and inhibition of synthesis respectively. The combination might even prove to be complementary when E4 would have estrogen-antagonistic effects under these conditions.

Estetrol add-back in Prostate Cancer treated with GnRH Agonists

GnRH agonists are used for antihormonal treatment of prostate cancer (PC) by inhibition of the gonadotrophins FSH and especially LH, which stimulates the synthesis of testosterone, that stimulates tumor growth. Also in males this type of treatment causes typical “climacteric-like” complaints caused by estrogen deficiency such as hot flushes and sweatings, arthralgia, loss of bone mass, an increased fracture risk and cognition problems. These “climacteric-like” problems might be counteracted by E4 treatment.

In addition, the inhibitory effect of E4 on gonadotrophins may support the effect of the GnRH agonist. Estetrol may even suppress or inhibit the unwanted initial rise of gonadotrophins occurring at the start of GnRH agonist treatment and therefore E4 seems the perfect match for estrogen add-back in men with PC.

Conflict of Interest

H. J. T. Coelingh Bennink is the inventor of E4 and CEO and shareholder of Pantarhei Bioscience, the company developing E4 for several human applications in collaboration with Mithra Pharmaceuticals, consulted by J.-M. Foidart.

References:

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