High Estradiol Levels During Postmenopause – Pitfalls in Laboratory Analysis

Hohe Östriolspiegel in der Postmenopause – Fallstricke der Laboranalytik

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- menopause
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Abstract
A 54-year-old woman was admitted with a result of high serum estradiol levels (> 4300 pg/ml) and typical postmenopausal symptoms. She had a history of an adnexectomy (normal histopathology) due to the elevated estradiol levels. After surgery, estradiol levels were as high as before. Analyzing the anti-mullerian hormone (AMH), inhibin B, DHEA-S and estrone, typical postmenopausal levels were found. Serum estradiol levels were controlled several times with rabbit-derived polyclonal as well as monoclonal antibodies to optimize the selectivity of the test system. Secondary, a radioimmunoassay was performed to exclude interferences of the detection system. It was performed with a selectivity test that was done using sheep-derived antibodies, which proved a postmenopausal hormone level (< 5 pg/ml). This case depicts the pitfalls of estradiol measurement detecting false elevated estradiol levels in a postmenopausal woman.

Zusammenfassung
Eine 54-jährige Patientin (167 cm, 60 kg) stellte sich mit klimakterischer Beschwerdesymptomatik (Hitzewallungen, Schlafstörungen) bei der behandelnden Gynäkologin vor. Im Rahmen der Diagnostik erfolgte eine Laborkontrolle, die einen deutlich erhöhten Estradiolwert (> 4300 pg/ml) zeigte. Da eine Estradiolproduktion im Rahmen einer Neoplasie vermutet wurde, wurde die Patientin zur operativen Abklärung in ein peripheres Krankenhaus eingewiesen und erhielt eine beidseitige Adnexektomie mit nachfolgend unauffälligem histopathologischem Ergebnis. In der postoperativen Kontrolle zeigte sich der Estradiolwert erneut deutlich erhöht. Die übrigen Hormonwerte entsprachen einem unauffälligen postmenopausalen Befund. Zur Optimierung der Sensitivität des Labortests wurde zunächst ein monoklonaler Antikörper eingesetzt. Auch eine Analyse mittels Radioimmunoassay ergab bereits niedrigere, dennoch weiterhin erhöhte Werte (186 pg/ml). In der Annahme, dass möglicherweise eine Kreuzreaktivität gegen irreguläre Antikörper vorliegen könnte, wurde eine Kontrolle mit Schafsantikörpern durchgeführt, die nun einen typisch postmenopausalen Estradiolspiegel ergaben (< 5 pg/ml). Ein Fluoreszenz-Enzym-Immunoassay konnte in der Tat das Vorliegen irregulärer Antikörper bestätigen (> 200 mg/l; Referenz < 30 mg/l). In diesem Fallbericht werden somit mögliche Fehlerquellen der Estradiolmessung bei postmenopausalen Frauen aufgezeigt.
One of the common and stressful symptoms of menopause are hot flushes (HF), which occur in > 75% of menopausal women [2]. The episodic sensations of heat, intense sweating and flushing can recur with varying frequency and intensity [3]. Likewise, the age at onset of HF is varying from woman to woman. Even though the pathophysiology of HF is not entirely understood, several authors propose that HF are due to a changed thermoregulation set point of the hypothalamus evoked by the lowered estrogen levels during menopause [3,4]. Thereby, estrogens seem to interact with several neurotransmitters like norepinephrine, serotonin and endogenous opioids [5,6]. Vasomotor symptoms can also occur in women with abrupt drop in sex steroid hormones such as after removal of the ovaries of premenopausal women or in breast cancer patients with chemically induced menopause [3]. However, estradiol levels do neither explain the presence of HF nor correlate with their frequency and intensity [3,7]. Thus, measurement of estradiol levels during menopause rarely reveals clinical benefits. Even after an adequate restoration of estradiol levels by hormone replacement therapies, women can still experience vasomotor symptoms. Rarely, high levels of circulating estradiol have been reported in postmenopausal women so far and have often been attributed to estradiol-producing neoplasia. In this case report, we describe a postmenopausal woman with persisting postmenopausal symptoms in whom high estradiol levels have been measured.

Case Report

We report the case of a 54-year-old woman of normal weight (167 cm, 60 kg), who presented with extremely high serum levels of estradiol (> 4300 pg/ml). Apart from the typical vasomotor symptoms, she did not have any complaints nor an aberrant physical examination. The blood sample was initiated by her local gynecologist just to confirm her menopausal status. Due to the highly elevated estradiol level, she had been sent to a local hospital for a bilateral adnexectomy expecting an estradiol producing ovarian neoplasia. The ovarian histology was completely unsuspicuous. After surgery, the estradiol levels did not change at all and the patient was sent to our institution for further analysis. Clinically, the patient complained of the typical symptoms of hormone deficiency like hot flushes, night sweats, vaginal dryness, sexual dysfunction and poor performance. Her last menstruation had occurred one year ago. Any hormone, drug or alcohol consumption was denied. Physical examination showed a vaginal atrophy and a postmenopausal vaginal smear. Hormonal analysis was repeated at our institution and revealed a high serum estradiol level above range (> 4300 pg/ml). The first test (immunoassay) was done using a biotinylated rabbit-derived polyclonal antibody for estradiol. However, testing other sex steroids and glycoprotein hormones indicating an ovarian or extra-ovarian production, typical blood levels of a postmenopausal woman were found (estrone 13.4 ng/l; progesterone < 0.10 ng/ml; testosterone < 0.03 ng/ml; FSH 70.8 mIE/ml, LH 30.5 mIE/ml; inhibin B < 10 ng/l; AMH < 0.08 ng/ml).

To increase the selectivity of the antibody-ligand reaction, first, an immunoassay with rabbit-derived monoclonal antibodies was done using a biotinylated rabbit-derived polyclonal antibody for estradiol. However, testing other sex steroids and glycoprotein hormones indicating an ovarian or extra-ovarian production, typical blood levels of a postmenopausal woman were found (estrone 13.4 ng/l; progesterone < 0.10 ng/ml; testosterone < 0.03 ng/ml; FSH 70.8 mIE/ml, LH 30.5 mIE/ml; inhibin B < 10 ng/l; AMH < 0.08 ng/ml). To increase the selectivity of the antibody-ligand reaction, first, an immunoassay with rabbit-derived monoclonal antibodies was performed. However, detecting still high estradiol levels, we changed the detection system to exclude interferences of the immunoassay label. Applying a radioligand assay, lower but still elevated estradiol levels (186 pg/ml) could be detected. Another reason for false positive results are cross-reacting molecules which can be induced by structural similarities of the epitopes [8]. Hypothesizing a cross-reactivity with irregular antibodies, we changed the host and applied sheep-derived antibodies which revealed typical postmenopausal estradiol levels (< 5 pg/ml). Our hypothesis of false positive results has been con-
molecules exist that are structurally similar to the principal binding of the detection system or when endogenously produced topes (in the case of polyclonal primary antibodies), by unspecific shielding, mostly monoclonal or polyclonal antibody assays [10]. However, applying automated immunoassays, non-specific re-
lar levels [9]. To date, a variety of immunoassays have been estab-
are performed to detect estradiol concentrations at low picomo-
Clinical diagnostics require an accurate measurement of hor-
Discussion
Clinical diagnostics require an accurate measurement of hormone levels. In postmenopausal women, even high sensitive methods like liquid chromatography-mass spectrometry (LC-MS) are performed to detect estradiol concentrations at low picomol-
In this case, we report a cross-reactivity caused by Human Anti-
HAAA are also known to induce a cross-reactivity within immu-
Thereof, the most common hormonally active are granulosa cell tu-
Apart from method-specific bias of the immunoassays elevated estradiol levels in postmenopausal women can be due to horm-
Rare cases of estrogen producing tumors like sex cord stromal tumors including granulosa cell tu-
Due to their hormone production, most of them can be detected in an early stage. Germ cell tumors (ovarian carcinoid) as well as Brenner tumors are only rarely associated with endocrine manifestations [14–16]. Femi-
Adrenocortical adenoma and carcinoma which can lead to an increase of estradiol levels [18, 19]. Several reports demonstrated the presence of high aromatase enzyme activity and an overexpression of CYP19 mRNA [20, 21]. In adrenocortical adenoma, estradiol peaks could even be found at 120 pg/ml [22]. Apart from neoplasia, liver cir-
Finally, contamination of nutrition (e.g. Fusarium toxin-cont-
Generally, measurement of estradiol levels in postmenopausal women is not considered and rarely reveals clinical benefits. If clinical symptoms are not in line with the detected hormone lev-
exclusion of method-specific bias or interferences of the test system should be considered. Otherwise misinterpretation of the results can lead to unnecessary interventions – as observed in our case.

Authors’ Roles
IM drafted the manuscript and performed the data collection. MK participated in the experimental concept and carried out the laboratory tests. MG revised the manuscript. CK participated in editorial support; SES participated in the design of the study and re-
Conflict of Interest
None.
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