Plasma oestrogens in men with chronic liver disease

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Summary A highly specific radioimmunoassay was used to measure the total plasma concentrations of the three principal unconjugated oestrogens: oestrone E₁, oestradiol E₂, and oestriol E₃ in normal males and in 21 males with various forms of chronic liver disease. In addition, the unbound concentration of plasma E₂ was established in the same group. About half of the patients with liver disease had overt feminising changes. Total and unbound plasma E₂ concentrations were within the normal range in all patients. Total plasma E₁ was significantly elevated only in those patients with liver disease and gynaecomastia, and a similar trend was seen for total plasma E₃.

Feminisation of some males with chronic liver disease has long been recognized (Corda, 1925). Disturbed metabolism of oestrogens has been postulated as the cause of these changes (Glass et al., 1940; Engel, 1944; Rakoff et al., 1944; Schiller and Pincus, 1944; Gilder and Hoagland, 1946). Measurements of unconjugated plasma oestrogens in these patients have been largely confined to oestradiol (E₂) but results have been conflicting (Korenman et al., 1969; Cedard et al., 1970; Chopra et al., 1973; Galvao-Teles et al., 1973; Kent et al., 1973; Lourens, 1973; Adlercreutz, 1974; Van Thiel, et al., 1974).

An extension of the study to include the other two major oestrogens, oestrone (E₁) and oestriol (E₃), appeared logical in this complex situation. We have therefore studied, for the first time, the basal total plasma concentrations of unconjugated E₁, E₂, and E₃ in the same plasma sample; in addition, we estimated the unbound concentration of E₂. Observations were made in 21 patients with various types of chronic liver disease and in a group of normal controls.

Methods

Patients

Twenty-one male patients (mean age 46-9 years, range 27-59 years) were studied. Three had haemochromatosis, five had alcoholic fatty livers, nine had alcoholic cirrhosis, and four non-alcoholic cirrhosis.

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Received for publication 26 February 1976
logical conditions of temperature and pH and is performed on undiluted plasma.

**Results**

Basal total plasma E₁ concentrations are shown in Fig. 1. The normal controls had a mean plasma E₁ of 66.4 ± 3.8 pg/ml (mean ± 1 SEM). Patients with chronic liver disease were divided into two groups on the basis of the presence or absence of gynaecomastia. Those without gynaecomastia had a mean plasma E₁ of 69.8 ± 3.5 pg/ml, which was not significantly different from normal Those with gynaecomastia had a mean plasma E₁ of 117.7 ± 13.4 pg/ml, which is both significantly higher than normal controls (p < 0.005)

Observations on patients with alcoholic liver disease appeared evenly scattered throughout both groups.

Total basal plasma oestradiol (E₂) concentrations are shown in Fig. 2. The mean total plasma E₂ for normal controls was 29.7 ± 2.3 pg/ml. Patients with liver disease were divided as before and those without gynaecomastia had a mean total plasma E₂ of 30.3 ± 2.8 pg/ml, while the mean value for patients with gynaecomastia was 33.5 ± 3.9. There was no significant difference between these groups and normal controls and again observations on those patients with cirrhosis of an alcoholic aetiology were evenly scattered throughout both groups.

Unbound plasma E₂ concentrations are shown in Fig. 3. All observations except one fall within the normal range, and there are no significant differences between patients with or without gynaecomastia. Observations on patients with alcoholic liver disease were once again evenly distributed throughout both groups.

Total plasma oestriol (E₃) concentrations are shown in Fig. 4. The mean plasma E₃ of patients with gynaecomastia (50.2 ± 5.2 pg/ml) was sig-

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1. Median test and Mann Whitney u statistic.

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**Fig. 1** Basal total plasma oestrone (E₁) concentrations in normal men and in liver disease patients with and without gynaecomastia. Brace: mean ± 1 SEM. ● = non-alcoholic aetiology. ▲ = alcoholic aetiology.

**Fig. 2** Basal total plasma oestradiol (E₂) concentrations in normal men and in liver disease patients with and without gynaecomastia. (Key as in Fig. 1).
significantly elevated ($p < 0.05$) above normal controls (36.8 ± 3.6 pg/ml), while patients without gynaecomastia (mean 41.9 ± 3.96 pg/ml) appeared to form an intermediate group which was not significantly different from either normal controls or patients with gynaecomastia.

Discussion

The occurrence of testicular atrophy and gynaecomastia in some males with chronic liver disease has long been recognized, but the endocrine basis of such changes remains to be established. The conventional hypothesis, first proposed by Glass et al. (Glass et al., 1940) is that the damaged liver fails to inactivate the endogenous oestrogens which are known in normal males to derive both from peripheral conversion of androgens to oestrogens (Longcope et al., 1969) and also from direct testicular secretion (Kelch et al., 1972). The hyperoestrogenic state thus induced in cirrhotic males would then explain both the hypogonadism (by direct suppression of pituitary gonadotrophins) and also the feminisation.

Many studies have recently confirmed the hypogonadism by demonstrating reduced circulating unbound plasma testosterone concentrations and oligospermia or azoospermia in cirrhotic males (Chopra et al., 1973; Galvao-Teles et al., 1973; Mowat et al., 1976), but studies on oestrogens and their metabolites are less conclusive (Adlercreutz, 1974). The early finding of increased urinary oestrogens during the course of acute liver disease using biological assay methods (Gilder and Hoagland, 1946; Llamosa and Gomez Mont, 1953) was not confirmed when biochemical methods of measurement were used (Gregoris, 1957; Müller, 1958). More recently, the measurement of plasma oestrogens (by competitive-binding or immunoassay) has been applied. These studies have been largely confined to the most potent oestrogen, oestradiol (E2),

Fig. 3 Unbound (free) plasma oestradiol (E$_2$) concentrations in liver disease patients with and without gynaecomastia compared with the normal range. (Key as in Fig. 1).

Fig. 4 Basal total plasma oestriol (E$_o$) concentrations in normal men and in liver disease patients with and without gynaecomastia. (Key as in Fig. 1).
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but results have also been conflicting (Korenman et al., 1969; Cedard et al., 1970; Chopra et al., 1973; Galvao-Teles et al., 1973; Kent et al., 1973; Lourens, 1973; van Thiel et al., 1974) with the majority of studies reporting normal total plasma E₂ concentrations in cirrhotic males.

In this complex situation, it seemed possible that there might be deranged metabolism of oestrogen metabolites other than E₂ in cirrhotic males which might contribute to the observed endocrine changes. This study was therefore designed to measure the three principal unconjugated oestrogens normally present in male plasma, oestrone (E₁), oestriadiol (E₃), and oestriol (E₄). E₁ is the immediate precursor of E₂, while E₃ is the major degradation product of the oestrogens in normal males, being excreted mostly as the glucuronide or sulphate conjugate.

The basal total and unbound plasma E₂ concentrations in our 21 patients with liver disease of varying aetiologies do not differ significantly from our normal range, regardless of the presence or absence of gynaecomastia. This is in agreement with a previous collaborative study of ours (Galvao-Teles et al., 1973) in which E₂ concentrations were measured by protein-binding rather than radioimmunoassay. It is of interest that unbound E₂ concentrations are normal despite marked changes in steroid binding proteins associated with chronic liver disease.

Our new data concern the other two main oestrogens, E₁ and E₃. There are two recent reports of plasma E₁ concentrations in patients with liver disease. Kley et al. (1975) found that plasma E₁ was significantly raised in patients with liver disease regardless of aetiology or the presence or absence of gynaecomastia. Van Thiel et al. (1975) report a similar rise but in their patients, all of whom had alcoholic liver disease, those with gynaecomastia had significantly higher plasma E₁ than those without gynaecomastia. Our findings confirm that there is a significant rise of plasma E₁ concentrations in patients with gynaecomastia when compared with normal males and with patients with no gynaecomastia. This is true irrespective of the aetiology of the liver disease. Although plasma E₁ tends to rise with age after 60 years (Kley et al., 1974), all our patients were younger than this, making it unlikely that this factor contributed significantly to the increase. Furthermore, there was no significant age difference between the patients with or without gynaecomastia.

The elevated plasma E₁ concentration must be due either to increased formation of E₁ or to a decreased elimination or both. Thijssen et al. (1971) in a preliminary report, found elevated plasma androstenedione in men with cirrhosis of the liver. This could be a source for elevated plasma E₁.

Impaired elimination of E₁ is also a possibility, although the tracer studies of Zumoff et al. (1968) have shown that conversion of E₁ to 16α-hydroxyoestrone (the first step in the major degradative pathway) is not impaired in cirrhotic patients. The contribution of elevated plasma E₁ to feminisation is difficult to assess. A direct feminising action seems unlikely as E₁ is a biologically weak oestrogen (Vermeulen and Verdonck, 1968). An indirect action—for instance, at hypothalamic-pituitary level—is another possibility. Pituitary function tests performed in these patients have suggested that, in feminised patients only, there may be a circulating inhibitor of gonadotrophin releasing hormone (Mowat et al., 1976). It might be that E₁ acts in this way.

We have also found elevated plasma E₃ concentrations in patients with gynaecomastia. The only other recent study on this plasma steroid in liver disease (Pentikainen et al., 1975) reports that plasma E₃ was raised in men with liver disease, but found no correlation with gynaecomastia in this exclusively alcoholic series. Conversion of E₁ to E₃ via 16α-hydroxyoestrone is known to be relatively impaired in patients with cholestasis but whose liver function is otherwise normal (Adlercreutz et al., 1974). This effect is attributed to the interruption of the enterohepatic circulation in cholestasis, since Breuer and Breuer (1973) showed in vitro that the ability of liver microsomes to metabolise E₁ to E₃ was not impaired in cirrhotic livers. Impaired conjugation of E₃ is an unlikely explanation for our findings, as oestrogen conjugation has been shown to remain unimpaired even in advanced hepatic failure (Adlercreutz and Tenhunen, 1970). It may be that our finding of elevated levels merely reflects a normal rate of degradation of the elevated E₁. It is uncertain how much oestrogenic activity E₃ has, and its importance in causing feminisation is uncertain.

In conclusion, we have found raised plasma E₁ and E₃ concentrations in association with normal total and unbound plasma E₂ concentrations in the men with liver disease and gynaecomastia, and this suggests that the increase of one or both of these oestrogens may be of aetiological importance in causing feminisation in these patients. There is no association between these abnormalities of oestrogen metabolism with any aetiological factor, notably alcohol.

We are grateful to the Wellcome Research Foundation and the North East Thames Area Health Authority for financial support. We are also grateful to Professor J. Landon for the use of his laboratory and to Miss Monica Leighton for help with the statistical analyses of results. We are also gratefu
to the following for their provision of the antibodies for the assays: Dr. A. Boulton for E₁ antisera, Dr. B. Furr for the E₂ antisera, and Miss Shahla Khoshroo for the E₃ antisera.

References


