ESTRADIOL PATCH

PHYSICIAN PRESCRIPTION GUIDE & CLINICAL REFERENCE

by Paul Schellhammer, MD | November 15, 2026

❖ Official PATCH protocol:

- Apply four, 0.1 mg/24 hr estradiol patches (generic permitted) simultaneously to upper buttocks or hips, changed twice weekly. Reduce number of patches to three when T < 50 ng/dl.

❖ Monitoring and Practical Considerations:

- Measure T and PSA monthly for 3 months, then increase to quarterly measurements.
- Optionally adjust the number of patches to reach a desirable T < 20 ng/dl.
- Clean application site with rubbing alcohol to remove skin oils before applying patches.
- Optionally pre-treat application site with a steroid nasal spray (e.g., Nasalcort™ or Flonase™) to reduce any skin irritation.
- Optionally rotate patch site location to reduce any skin irritation.
- Optionally use electron beam breast irradiation prior to applying patches. [refs]
- Optionally apply 1% diclofenac gel, and/or hot packs, to breasts and nipples. [ref]
- Experiencing mastalgia symptoms indicates that a significant serum level of estradiol has been reached.
- Do not use tamoxifen, as it will block estradiol's ability to suppress testosterone.
- Strongly suggest getting a baseline DEXA scan.
- Advise that using bone protective drugs may not be needed with estradiol patch ADT.
- Offer to write a letter to the patient's insurance company, referencing the 2026 NEJM paper, to obtain insurance coverage.

❖ NCCN GUIDELINE UPDATE:

- The NCCN Prostate Cancer Guidelines were recently updated to Version 1.2027. Transdermal estradiol is now recommended as an option for ADT when combined with radiation therapy.

PATCH / STAMPEDE Phase-III RCT

SUMMARY OF PHASE-III CLINICAL RESULTS

Results of the combined PATCH/STAMPEDE Phase-III trial were published by Langley et al. in the *New England Journal of Medicine* (2026) and are summarized below: https://pubmed.ncbi.nlm.nih.gov/41880608/.

OUTCOME	RESULTS
TESTOSTERONE SUPPRESSION	Transdermal estradiol (tE2) ADT suppressed testosterone below traditional castrate threshold level (T < 50 ng/dl) in 94% of men after one year. Same results for LHRHa ADT.
PSA REDUCTION	tE2 ADT reduced PSA by 50% in 99% of men, and it reduced PSA by 90% in 85% of men. Same results for LHRHa ADT.
SURVIVAL RATES	tE2 ADT was non-inferior compared to LHRHa ADT in terms of 3-year Metastasis-Free Survival and 5-year Overall Survival rates (81.1% with tE2 ADT versus 79.2% with LHRHa ADT).
SAFETY	tE2 ADT was equally as safe as LHRHa ADT, in terms of thromboembolic and cardiovascular events.
BONE DENSITY	tE2 ADT increased bone mineral density by 6%, versus a loss of -1.5% with LHRHa ADT, after one year.
FRACTURE RATES	tE2 ADT reduced fracture rates by 50% when compared to LHRHa ADT, at both 5 and 10 years.
HOT FLASHES	The fraction of men experiencing moderate to severe hot flashes was 7% for tE2 ADT versus 37% for LHRHa ADT.
METABOLIC SYNDROME	Lipid profiles, blood glucose, and blood pressure are better with tE2 ADT compared to LHRHa ADT.
FATIGUE	The fraction of men experiencing significant fatigue was 16% for tE2 ADT versus 25% for LHRHa ADT.
GYNECOMASTIA	The fraction of men experiencing symptomatic gynecomastia was 38% for tE2 ADT versus 9% for LHRHa ADT.

For more information: www.estradiolinitiative.org

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