Serum levels of 3α-androstanediol glucuronide in hirsute and non hirsute women

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Abstract

This study has evaluated the behaviour of 3α-androstanediol glucuronide (3α-diol G) in 170 women of whom 85 had polycystic ovary syndrome (PCOS), 35 had idiopathic hirsutism (IH) and 50 had regular cycles (control group). Of the women with PCOS, 45 were hirsute (PCOS-H) and 40 were non hirsute (PCOS-NH). Women in the control group were not hirsute. Hirsutism was assessed by the same physician using the Ferriman-Gallway score. The body mass index (BMI) was estimated in all of the women.

Plasma concentrations of 3α-diol G were elevated only in hirsute patients, both with PCOS and with IH. Even in PCOS-NH, concentrations of 3α-diol G were higher compared with controls (P<0.001), but significantly lower (P<0.001) than those of the PCOS-H and of the IH groups. The behaviour of 3α-diol G was not affected by BMI.

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Introduction

Hirsutism, affecting 5–8% of the whole female population of fertile age, is an important clinical and psychological problem. Hirsutism is associated with an increased production or action of androgens. Hyperandrogenism was found in 60–80% of hirsute women, while in 10–15% circulating levels of androgens and of 17α-hydroxyprogesterone (17OHP) were normal even after the adrenocorticotropin (ACTH) stimulation test (idiopathic hirsutism) (1, 2). Sixty-five to eighty-five percent of women with androgen excess had polycystic ovary syndrome (PCOS) or hyperthecosis (3–5). Despite hyperandrogenism, about 30% of women with PCOS did not present with hirsutism (6).

Several studies have shown that in all hirsute women, both with PCOS and idiopathic hirsutism (IH), the activity of 5α-reductase in the genital skin was steadily elevated (7–10).

3α-Androstanediol glucuronide (3α-diol G) is considered to be an excellent marker of peripheral androgen action and especially of 5α-reductase activity (11, 12). It has been shown that the skin can form C-19 conjugates directly (13). A primary alteration in 5α-reductase and in the androgen metabolism of the skin could be the cause of hirsutism in many cases.

The clinical use of 3α-diol G as a marker of peripheral androgen action is, however, controversial because many authors deduce that the origin of 3α-diol G, and therefore its plasma concentrations, reflect adrenal androgen production and hepatic metabolism (14, 15).

The aim of our study is to provide further contributions to the clinical activity of 3α-diol G by evaluating its behaviour in a broad series of normal and hyperandrogenic women, with and without hirsutism.

Materials and methods

Subjects

Since 1994 plasma assays of 3α-diol G have been carried out in 170 women aged 17 to 35 years. The patients were divided into the following groups: 50 normal females (control group), aged 18 to 35 years, body mass index (BMI) 21.6±2.5 kg/m²; 85 women with PCOS, aged 17 to 29 years, BMI 24.3±4.6 kg/m², of whom 45 were hirsute (PCOS-H) and 40 non hirsute (PCOS-NH); 35 women with IH, aged 17 to 25 years, BMI 22.5±5 kg/m². All subjects were healthy and had taken no medication during the previous three months. We excluded patients with Cushing’s syndrome, late onset congenital adrenal hyperplasia, prolactin secreting pituitary adenomas, and androgen secreting ovarian or adrenal neoplasia. The controls had regular ovulatory cycles (luteal phase serum progesterone levels >4 ng/ml) and no clinical evidence of hyperandrogenism. The diagnosis of PCOS was made according to the clinical (various cycle alterations, acne and hirsutism) and endocrine (chronic anovulation, elevated serum luteinizing hormone (LH), 17OHP and androgen levels, mean LH/follicle-stimulating hormone...
(FSH) ratio >2) data. Insulin resistance was present in 49 (57.6%) of 85 women with PCOS, of whom 27 (60%) were PCOS-H and 22 (55%) were PCOS-NH. The insulin resistance was measured by the oral glucose tolerance test (OGTT). A normal insulinaemic response to OGTT was considered as a maximum insulinaemic level of 100 μU/ml, as established by standard procedures in our laboratory, while a normal glycæmic response to OGTT was defined according to the criteria of the National Diabetes Data Group (16).

IH women had normal menstrual cycles and plasma levels of androgens and 170HP, both in basal conditions and after the ACTH stimulation test. The ACTH test (administration of a single i.v. bolus of 0.25 mg synthetic ACTH (Synacten), Ciba-Geigy, Varese, Italy) was performed in women with IH when early follicular phase serum 170HP levels were ≥30 nmol/l. Hirsutism was evaluated by the Ferriman-Gallway score (17) and only patients with a score ≥8 were considered hirsute. Women with BMI >25 kg/m² were considered overweight/obese.

**Hormone assays**

Plasma assays of 3α-diol G were carried out between 0800 and 0900 h for two consecutive days in all women in the follicular phase (days 4 to 7) of a spontaneous or induced cycle. The value of 3α-diol G in the follicular phase serum 170HP levels were ≥30 nmol/l. Hirsutism was evaluated by the Ferriman-Gallway score (17) and only patients with a score ≥8 were considered hirsute. Women with BMI >25 kg/m² were considered overweight/obese.

**Statistical methods**

All data, normally distributed in each group, are expressed as means ± s.d. Analysis of variance (ANOVA) was used to evaluate differences between 3α-diol G concentrations among the different groups. A P value <0.05 was considered statistically significant.

**Results**

The values for 3α-diol G in all groups of patients are summarized in Table 1. Plasma levels of 3α-diol G in all the women with PCOS (n = 85) were 4.8 ± 1.4 ng/ml, in women with IH (n = 35) they were 5.8 ± 1.1 ng/ml and in the controls (n = 50) they were 1.5 ± 0.5 ng/ml.

When the PCOS group was subdivided according to hirsutism, 45 (53%) of the patients were hirsute (Ferriman-Gallway score 12.2 ± 2.7) and 40 (47%) were non hirsute. The age of the PCOS-H patients was between 18 and 29 years with a BMI of 24.7 ± 4.7 kg/m², and the age of the PCOS-NH patients was between 17 and 27 years with a BMI of 23.8 ± 4.6 kg/m². The incidence of changes in the menstrual cycle (oligomenorrhea, amenorrhea) was not different in the two subgroups (PCOS-H: oligomenorrhea 67%, secondary amenorrhea 33%; PCOS-NH: oligomenorrhea 67.5%, secondary amenorrhea 32.5%). Obesity was also equally distributed in the two subgroups: 18 (40%) PCOS-H patients (BMI: 29.5 ± 3.2 kg/m²) and 14 (35%) PCOS-NH patients (BMI: 27.5 ± 1 kg/m²).

The endocrine profile for PCOS-H did not differ significantly from that for PCOS-NH in total testosterone (1.2 ± 0.4 ng/ml vs 1.1 ± 0.3 ng/ml), free testosterone (3.6 ± 0.9 pg/ml vs 3.3 ± 0.8 pg/ml) and SHBG (22.0 ± 8.0 nmol/l vs 24.2 ± 7.5 nmol/l), but it differed significantly in fasting insulin (11.7 ± 3.5 μU/ml vs 9.3 ± 3 μU/ml) (P < 0.01) and 3α-diol G levels (6.1 ± 1.7 ng/ml vs 3.5 ± 1.0 ng/ml) (P < 0.001). In the 35 women with IH (Ferriman-Gallway score 12 ± 2.3), obesity was present in 5 cases (14.3%) (BMI: 28.4 ± 5 kg/m²) and hormone values were similar to the control group for total testosterone (0.5 ± 0.1 ng/ml vs 0.4 ± 0.2 ng/ml), free testosterone

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>n</th>
<th>3α-diol G (ng/ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCOS-H</td>
<td>45</td>
<td>6.1 ± 1.7*</td>
</tr>
<tr>
<td>PCOS-NH</td>
<td>40</td>
<td>3.5 ± 1.0†</td>
</tr>
<tr>
<td>IH</td>
<td>35</td>
<td>5.8 ± 1.1†</td>
</tr>
<tr>
<td>Control</td>
<td>50</td>
<td>1.5 ± 0.5†</td>
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</tbody>
</table>

*P < 0.001 PCOS-H and IH vs PCOS-NH and control.
†P < 0.001 PCOS-NH vs control.
Table 2 Serum 3α-diol G concentrations in the PCOS-H, PCOS-NH and IH patients subdivided by weight into obese and normal weight patients. Values are means ± s.d.  

\[
\begin{array}{cccccc}
\text{PCOS-H} & & \text{PCOS-NH} & & \text{IH} & \\
\text{Obese} & \text{Normal} & \text{Obese} & \text{Normal} & \text{Obese} & \text{Normal} \\
\text{BMI (kg/m}^2\text{)} & 29 ± 3.2 & 21 ± 2.8 & 27.5 ± 1.0 & 21 ± 1.4 & 28.4 ± 5.0 & 21.2 ± 1.8 \\
3α-diol G (ng/ml) & 5.9 ± 1.5 & 6 ± 1.7 & 3.5 ± 0.9 & 3.4 ± 1.2 & 5.6 ± 0.8 & 5.8 ± 1.2 \\
\end{array}
\]

(2 ± 0.6 pg/ml vs 1.8 ± 0.6 pg/ml), SHBG (45.3 ± 6.1 nmol/l vs 47 ± 9.6 nmol/l) and fasting insulin (5 ± 1.9 µU/ml vs 5.1 ± 1.1 µU/ml). The levels of 3α-diol G in the women with IH were significantly greater than in the control group (5.8 ± 1.1 ng/ml vs 1.5 ± 0.5 ng/ml) (P < 0.001).

Statistical analysis (Table 1) showed that serum 3α-diol G levels in hirsute women, both with PCOS and IH, were significantly higher (P < 0.001) than those of PCOS-NH and controls. The serum 3α-diol G levels in PCOS-H were not different from those in IH while there were significant differences (P < 0.001) between PCOS-NH and controls.

Table 2 shows the values for 3α-diol G in PCOS-H, PCOS-NH and IH groups when each is divided into obese or normal weight patients according to their BMIs. In each group of patients, no significant variations in plasma levels of 3α-diol G were observed between obese and normal weight women.

**Discussion**

Our results have shown that higher levels of 3α-diol G are found only in hirsute patients, and are independent of androgen levels (hyperandrogenic subjects n = 45, normal androgenic subjects n = 35) and of BMI. Even values for 3α-diol G in PCOS-NH were higher compared with the controls although significantly lower than those in hirsute women.

Therefore, in women, different plasma concentrations of 3α-diol G can be established, ranging from normal (1.5 ± 0.5 ng/ml) to intermediate (3.5 ± 1.0 ng/ml) or very elevated values (≥5.8 ± 1.1 ng/ml). The different quantities of 3α-diol G probably express various degrees of 5α-reductase activity (or possibly different types of 5α-reductase) and different concentrations of dihydrotestosterone (DHT) in the pilosebaceous unit.

It is known that the activity of 5α-reductase can be stimulated not only by circulating levels of androgens, but also by genetic factors (19), insulin and the insulin-like growth factor-I/insulin-like growth factor-binding protein (IGF-I/IGFBP) system (20).

Many studies have proved that in PCOS and in IH there is an increased 5α-reductase activity in the genital skin and that plasma levels of 3α-diol G are correlated to the activity of 5α-reductase and to the production of DHT (21–23).

In the literature and in our series, 30% (20) and 47% of women with PCOS did not have hirsutism. Therefore, the concentrations of 3α-diol G (3.5 ± 1.0 ng/ml) found in the PCOS-NH group expressed an increase in 5α-reductase and in DHT which was not sufficient to induce hirsutism. In PCOS, the increase in androgens and in the insulin/IGF-I/IGFBP system probably contributes to the increase in 5α-reductase activity and the production of DHT, but is not the main cause of hirsutism.

Hirsutism only appears when plasma levels of 3α-diol G are very elevated, giving evidence of maximum 5α-reductase activity and of an elevated formation of DHT in the hair follicle.

The levels of 3α-diol G in IH and in PCOS-H, compared with PCOS-NH, suggests the importance of genetic factors in the regulation of 5α-reductase and the key role of peripheral events in the determination of hirsutism.

The correlation between 3α-diol G and hirsutism, and the values of 3α-diol G in controls and in PCOS-NH, suggests a cutaneous origin of 3α-diol G. Our results, obtained from a broad series, confirm the clinical usefulness of 3α-diol G as a marker of the peripheral metabolism of androgens. The 3α-diol G dosage can be employed to monitor various therapies for hirsutism.

**References**


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