The sex difference of plasma homovanillic acid is unaffected by cross-sex hormone administration in transsexual subjects

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Abstract

There is a close relationship between the brain and the endocrine system. The brain expresses receptors for sex steroids and is capable of metabolizing these hormones. We explored (1) sex differences in homovanillic acid (HVA), a metabolite of the neurotransmitter dopamine, and (2) the effects of cross-sex steroid administration in transsexual subjects. First, we compared plasma HVA levels between 38 male and 34 female healthy volunteers (not using hormone replacement therapy) of a mean age of 72 years (range 65–84 years). Secondly, we measured plasma HVA levels in 15 male-to-female transsexuals treated with 100 µg ethinyl estradiol/day and 100 mg cyproterone acetate/day for 4 months, and in 17 female-to-male transsexuals treated with testosterone esters (250 mg/2 weeks i.m. for 4 months). Plasma HVA levels were lower in elderly men than in elderly postmenopausal women (geometric mean 25·4 nmol/l (P10 4·9; P90 69·8) vs 39·0 nmol/l (19·0; 76·1); P=0·027). In transsexuals before cross-sex hormone administration, genetic males also had lower plasma levels of HVA than genetic females (geometric mean 14·8 nmol/l (P10 7·0; P90 35·0) vs 34·3 nmol/l (21·8; 61·4); P<0·001). Cross-sex hormone administration did not affect plasma HVA in either group (P>0·5). The pretreatment sex difference in plasma HVA was unaffected after 4 months of cross-sex hormone administration (P=0·003). The sex difference in plasma HVA was not reversed by cross-sex hormone administration in transsexuals, and was also preserved in elderly subjects. This indicated that differences in dopamine gene expression were largely unaffected by exposure to sex hormone levels in adulthood, but must rather be explained by a sex difference in genetic factors or by the organizing effects of sex hormones during early development.


Introduction

Sex differences in schizophrenia, with an earlier onset (Hambrecht et al. 1992, Albus & Maier 1995, Szymanski et al. 1995, Halbreich & Kahn 2003) and a higher prevalence (Aleman et al. 2003) in men than in women, may indicate that sex hormones are implicated in its expression, etiology and course. The brain contains receptors (Kruijver et al. 2001, 2003, Toran-Allerand 2004) for androgens and estrogens, and is capable of synthesizing and metabolizing these steroids (Puy et al. 1995, Poletti & Martini 1999, Stoffel-Wagner 2003, Altman 2004). Dopamine is synthesized from tyrosine by dopaminergic neurons, and is also the precursor to norepinephrine in noradrenergic nerves. Dopamine is metabolized in the brain, liver and kidney to its inactive metabolite homovanillic acid (HVA; Fig. 1), and in human (Amin et al. 1995, Amin et al. 1998) and animal (Bacopoulou et al. 1979) research its plasma concentration was found to be indicative of brain dopamine turnover. Plasma HVA is not only elevated in neuroblastomas and pheochromacytomas, but also in schizotypical personality disorders (Siever et al. 1991). In some (Pickar et al. 1986, Davidson & Davis 1988, Maas et al. 1988, Davidson et al. 1991, Koreen et al. 1994, Sumiyoshi et al. 1997a) but not all (Sumiyoshi et al. 1997b) studies, the baseline and/or change in plasma HVA was related to psychopathology and treatment response in schizophrenic patients.

Sex steroids have been found to affect neurotransmitters and neurotransmitter receptors of the dopaminergic systems in complex ways, at least in cell and animal studies (Becker 1999, Eaton et al. 1999, Andersen et al. 2002, Landry et al. 2002, Halbreich & Kahn 2003, D’Astous et al. 2004). In humans, the potential effects of sex
hormone administration on dopaminergic activity have not yet been studied extensively (Lobo et al. 1984, Hannan et al. 1991, Paolletti et al. 2001). Administration of testosterone, which endogenously is partially aromatized to estrogens, did not affect serum HVA in a small group of men (Hannan et al. 1991), although nandrolone decanoate, only a weakly aromatizable synthetic anabolic steroid, did increase serum HVA. A consistent sex difference has been described for plasma HVA levels. Higher plasma levels of HVA are found in female patients with schizophrenia (Koreen et al. 1994, Davila et al. 1995, Szymanski et al. 1995, Sumiyoshi et al. 1997b), in female patients with psychotic disorders (Bowers et al. 1983, Bowers & Swigar 1987), in female patients with tardive dyskinesia (Glazer et al. 1983), as well as in healthy female controls (Koreen et al. 1994, Sumiyoshi et al. 1997b) as compared with their male counterparts. This sex difference in plasma HVA implies sex differences in dopamine metabolism but not necessarily in dopamine levels.

Studies in transsexual subjects have shown that cross-sex hormones affect psychological variables of aggression, mood, sexual motivation and sex-related cognitive functions, such as verbal fluency and visuospatial functions (Van Gooren et al. 1995, Slabbeekoor et al. 1999). Studies of the brains of transsexuals have shown that certain sex dimorph areas of the brain have a differentiation of the opposite sex (female in male-to-female transsexuals and vice versa). These anatomical brain structures were not affected by the administration of cross-sex hormones (Zhou et al. 1995, Kruijver et al. 2000). In the present study, we have investigated whether changes in sex hormones affect the sex difference in plasma HVA, to test the hypothesis as to whether human dopamine metabolism is under sex steroidal influence. Blood samples were collected as part of a study on the effects of sex hormones on cardiovascular risk factors (Giltay et al. 2000, 2003). We measured fasting plasma HVA levels because of the better reproducibility and smaller variability as compared with urinary HVA (Donnelly et al. 1996, Amin et al. 1998). It is also a less invasive approach than sequentially obtaining cerebrospinal fluid.

Materials and Methods

First, the sex difference in HVA and 5-hydroxyindoleacetic acid (5-HIAA) were studied in 38 male and 34 female healthy volunteers of the Arnhem Elderly Study, a population-based cohort study that started in 1991 (Giltay et al. 2004). In total, 641 independently living men and women aged 65–84 years in the city of Arnhem agreed to have a venipuncture. Plasma HVA and 5-HIAA was assessed in a random sample of 72 subjects. None of these postmenopausal women were using hormone replacement therapy. The body mass index (BMI; weight/height²) was assessed. All subjects provided written informed consent. The study was approved by the ethical committee of Wageningen University.

Secondly, the effects of cross-sex hormone administration on HVA and 5-HIAA were studied in transsexual subjects in blood samples collected from 1996 to 1998 (Giltay et al. 2000, 2003). Psychological criteria for the diagnosis and treatment followed the guidelines provided by the Harry Benjamin International Gender Dysphoria Association. Fifteen male-to-female (M→F) transsexuals were treated with ethinyl estradiol (Lynoral; 100 µg/day; Organon, Oss, The Netherlands) in combination with cyproterone acetate (Androcur; 100 mg/day; Schering,
Berlin, Germany), an anti-androgen that blocks androgen receptors. Seventeen female-to-male (F→M) transsexuals were treated with testosterone esters (Sustanon; 250 mg/2 weeks i.m.; Organon) according to our standard treatment. To monitor the anabolic/catabolic effects on body composition, the BMI was assessed, and lean body mass and total body fat were estimated using bioelectrical impedance analysis (BIA 101/S; RJL Systems, Clinton Twp, MI, USA). Informed consent was obtained from all subjects, and the study was conducted according to the principles of the Declaration of Helsinki and approved by the Ethical Review Committee of the Vrije Universiteit University Medical Center.

Laboratory tests

A single non-fasting blood sample was first obtained from elderly subjects. Venipuncture was performed between 0800 and 1730 h using citrate collection tubes. Samples were stored at −80 °C, and only thawed once before analysis. Secondly, in transsexual subjects, blood was sampled before and 2 and 4 months after initiation of cross-sex hormone administration. Blood was drawn from genetic women before testosterone treatment between days 5 and 9 of the follicular phase and again during testosterone treatment, within 5 to 9 days after the testosterone injection. All blood was sampled after a 12-h fast, immediately placed on ice, centrifuged at 3500 g for 30 min at 4 °C, stored within 1 h at −80 °C and never thawed until analysis. EDTA plasma samples (Becton Dickinson Vacutainer Systems, Franklin Lakes, NJ, USA) were obtained. Serum measurements were made of 17β-estradiol (by radioimmunoassay; Sorin Biomedica, Saluggia, Italy) and testosterone (by radioimmunoassay; Coat-A-Count; Diagnostic Products, Los Angeles, CA, USA), luteinizing hormone (LH; by immunometric luminescence assay; Amerlite; Amersham Pharmacia Biotech, Aylesbury, Bucks, UK) and follicle-stimulating hormone (FSH; by immunometric luminescence assay; Amerlite). Since estrogens increase the secretion of prolactin by the pituitary gland and prolactin release is tonically inhibited by dopamine, we measured prolactin levels (by immunoradiometric assay; Biosensor Technologies, Inc., Fleurus, Belgium). HVA and 5-HIAA are cleared by the kidney so plasma HVA remained present after adjusting for age plasma HVA remained present after adjusting for age. To measure HVA and 5-HIAA, the major metabolite of serotonin, samples were mixed with an equal volume of perchloric acid (1 M) to precipitate proteins. After centrifugation, the supernatant (250 μl) was loaded on a Hypersil ODS HPLC column (Thermo Electron Corporation, Breda, The Netherlands) at 30 °C. The mobile phase consisted of ammonium acetate (0·02 M), sodium-EDTA (0·25 mM), sodium chloride (6·5 mM) and methanol (9·5%) at pH 4·95. The flow was set at 1·25 ml/min by using an isocratic Sp8810 pump (Thermo Electron Corporation). Detection was performed by using an electrochemical detector (INTRO; Antec Leyden, Zoeterwoude, The Netherlands; potential: 0·525 mV). Chromatographic data were recorded by using PC1000 software (Thermo Electron Corporation). The intra-assay coefficient of variation (C.V.) for HVA was 2·0% at a concentration of 156 nM (n=9) and interassay C.V. was 2·7% at a concentration of 160 nM (n=7). The intra-assay C.V. for 5-HIAA was 3·8% at a concentration of 93 nM (n=9) and the interassay C.V. was 5·5% at a concentration of 55 nM (n=7).

Statistical analysis

Data are presented as means (with s.d.) or geometric means (with percentiles; P10 and P90) for right-skewed data (i.e. total homocysteine, folate and HVA). HVA and 5-HIAA values were correlated with other variables using Spearman’s correlation coefficient. For the comparison at baseline between the two groups, a t-test for independent samples or analysis of covariance was used. For M→F transsexuals, a two-factor repeated measures ANOVA with interaction was used to study the effects of estrogens plus anti-androgens in time, as well as to compare the effects of the two treatment regimens in time. Post-hoc comparisons were made using a Sidak test to identify significant differences between time-points. For F→M transsexuals, a Student’s t-test for paired samples was used to study the effects of androgen administration in time. A two-tailed P<0·05 was considered statistically significant. The software used was SPSS 10·0, Chicago, IL, USA.

Results

Comparison between elderly men and women

Men were, on average, 72·5 years old (s.d. 4·9; range 65–84) and women were 72·8 years old (s.d. 5·8; range 65–83; for sex difference P=0·79). The BMI was a mean of 24·6 (s.d. 3·0) in men and 26·1 (s.d. 5·0) in women (for sex difference P=0·15). Plasma HVA levels were lower in elderly men than postmenopausal women (geometric mean 25·4 nmol/l (Pn10 4·9; P90 69·8) vs 39·0 nmol/l (19·0; 76·1); P=0·027). Plasma HVA was positively associated with age (r=0·26, P=0·026). The sex difference for plasma HVA remained present after adjusting for age (P=0·033). Plasma 5-HIAA levels were similar in elderly men and women (P=0·42), also when one outlier (323 nmol/l) was excluded from the analysis (21·6 nmol/l (s.d. 15·3) vs 21·9 nmol/l (s.d. 24·6); P=0·94).
Intervention studies with sex steroids

Pretreatment values

The mean age of M→F transsexuals was 32·4 (S.D. 6·6; range 20–43) years with a BMI of 22·8 (S.D. 2·7) kg/m² and that of F→M transsexuals was 27·1 (S.D. 6·3; range 18–37) years with a BMI of 23·9 (S.D. 4·3) kg/m². Of the M→F transsexuals, nine (60%) were smokers and of the F→M transsexuals ten (59%) were smokers.

In M→F transsexuals, baseline HVA levels were inversely associated with testosterone levels (r=−0·61, P=0·017) and LH levels (r=−0·70, P=0·003), whereas baseline 5-HIAA levels were positively associated with creatinine levels (r=0·53, P=0·050). Smokers had significantly lower HVA levels as compared with non-smokers (P=0·003), and similar levels of 5-HIAA (P=0·18). In F→M transsexuals, baseline HVA and 5-HIAA levels were not correlated with levels of hormones, creatinine or folate, and baseline HVA levels were not correlated with levels of total homocysteine. Smokers had similar levels of HVA and 5-HIAA as compared with non-smokers (P=0·50 and P=0·54 respectively). Age was unrelated to plasma HVA or 5-HIAA in either group (P>0·20).

At baseline, plasma HVA was significantly lower in genetic men as compared with women (geometric mean 14·8 nmol/L (P10 7·0; P90 35·0) vs 34·3 (P10 21·8; P90 61·4); P<0·0005; Fig. 2 and Table 1). The sex difference remained statistically significant for plasma HVA (P=0·003) and not for 5-HIAA (P=0·981). At 4 months, the sex difference remained statistically significant for plasma HVA (P=0·003).

![Figure 2](image-url)

Individual values of HVA on a logarithmic scale and 5-HIAA in 15 M→F transsexuals (●) at baseline and after 2 and 4 months of administration of ethinyl estradiol plus cyproterone acetate and 17 F→M transsexuals (□) at baseline and after 4 months of administration of testosterone esters. Back-transformed mean values (with confidence intervals) at 0 and 4 months are identified by diamonds. P values were assessed by ANOVA for repeated measurements for M→F transsexuals and by t-test for paired samples for F→M transsexuals. At baseline, sex differences were statistically significant for plasma HVA (P<0·0005) and not for 5-HIAA (P=0·981). At 4 months, the sex difference remained statistically significant for plasma HVA (P=0·003).
Table 1 Hormone and metabolic data before and after 2 and 4 months in 15 M→F transsexuals randomized for administration of ethinyl estradiol plus cyproterone acetate and in 17 F→M transsexuals treated with intramuscular testosterone esters. Data are means ± s.d. or geometric means (P10 and P90) for right-skewed data (i.e. total homocysteine, folate and HVA).

### Oral ethinyl estradiol and cyproterone acetate in M→F transsexuals

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Baseline</th>
<th>2 months</th>
<th>4 months</th>
<th>P value&lt;sup&gt;1&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serum testosterone (nmol/l)</td>
<td>22.9 ± 6.3&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.1 ± 0.1&lt;sup&gt;b&lt;/sup&gt;</td>
<td>1.0 ± 0.1&lt;sup&gt;b&lt;/sup&gt;</td>
<td>&lt;0.0005</td>
</tr>
<tr>
<td>Serum 17β-estradiol (pmol/l)</td>
<td>97.3 ± 31</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Serum LH (IU/l)</td>
<td>3.2 ± 1.6&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.3 ± 0.0&lt;sup&gt;b&lt;/sup&gt;</td>
<td>0.3 ± 0.0&lt;sup&gt;b&lt;/sup&gt;</td>
<td>&lt;0.0005</td>
</tr>
<tr>
<td>Serum FSH (IU/l)</td>
<td>3.4 ± 2.0&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.5 ± 0.0&lt;sup&gt;b&lt;/sup&gt;</td>
<td>0.5 ± 0.0&lt;sup&gt;b&lt;/sup&gt;</td>
<td>&lt;0.0005</td>
</tr>
<tr>
<td>Serum prolactin (IU/l)</td>
<td>0.13 ± 0.03</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>22.8 ± 2.7</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Total body fat (kg)</td>
<td>12.2 ± 3.7</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Lean body mass (kg)</td>
<td>62.4 ± 7.8</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Plasma creatinine (µmol/l)</td>
<td>90.4 ± 11.4</td>
<td>90.9 ± 8.1</td>
<td>87.2 ± 7.4</td>
<td>&lt;0.007</td>
</tr>
<tr>
<td>Plasma total homocysteine (µmol/l)</td>
<td>10.9 (6.4; 25.6)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>7.8 (4.9; 15.7)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>7.6 (5.1; 12.5)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>&lt;0.0005</td>
</tr>
<tr>
<td>Plasma folate (nmol/l)</td>
<td>2.8 (1.7; 5.0)</td>
<td>2.5 (1.1; 5.2)</td>
<td>2.0 (1.1; 8.6)</td>
<td>0.036</td>
</tr>
<tr>
<td>Plasma HVA (nmol/l)</td>
<td>14.8 (7.0; 35.0)</td>
<td>16.7 (6.6; 74.9)</td>
<td>15.2 (6.1; 37.5)</td>
<td>0.742</td>
</tr>
<tr>
<td>Plasma 5-HIAA (nmol/l)</td>
<td>19.5 ± 7.2</td>
<td>22.5 ± 6.8</td>
<td>19.2 ± 6.1</td>
<td>0.063</td>
</tr>
</tbody>
</table>

<sup>1</sup>P value by ANOVA test for repeated measurements for the main effect of time or t-test for paired samples.

### Intramuscular testosterone esters in F→M transsexuals

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Baseline</th>
<th>4 months</th>
<th>P value&lt;sup&gt;1&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serum testosterone (nmol/l)</td>
<td>2.0 ± 0.8</td>
<td>33.0 ± 9.1</td>
<td>&lt;0.0005</td>
</tr>
<tr>
<td>Serum 17β-estradiol (pmol/l)</td>
<td>189.90</td>
<td>127.36</td>
<td>0.111</td>
</tr>
<tr>
<td>Serum LH (IU/l)</td>
<td>5.6 ± 3.4</td>
<td>2.4 ± 2.1</td>
<td>0.005</td>
</tr>
<tr>
<td>Serum FSH (IU/l)</td>
<td>4.3 ± 1.0</td>
<td>2.8 ± 1.1</td>
<td>0.002</td>
</tr>
<tr>
<td>Serum prolactin (IU/l)</td>
<td>0.25 ± 0.13</td>
<td>0.31 ± 0.14</td>
<td>0.14</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>23.9 ± 4.3</td>
<td>25.2 ± 4.3</td>
<td>&lt;0.0005</td>
</tr>
<tr>
<td>Total body fat (kg)</td>
<td>19.6 ± 6.6</td>
<td>19.1 ± 6.8</td>
<td>0.429</td>
</tr>
<tr>
<td>Lean body mass (kg)</td>
<td>46.7 ± 6.2</td>
<td>50.9 ± 7.2</td>
<td>&lt;0.0005</td>
</tr>
<tr>
<td>Plasma creatinine (µmol/l)</td>
<td>74.3 ± 9.5</td>
<td>81.5 ± 9.1</td>
<td>&lt;0.0005</td>
</tr>
<tr>
<td>Plasma total homocysteine (µmol/l)</td>
<td>10.1 (6.4; 17.7)</td>
<td>11.9 (7.3; 27.7)</td>
<td>0.004</td>
</tr>
<tr>
<td>Plasma folate (nmol/l)</td>
<td>5.7 (2.0; 10.6)</td>
<td>5.2 (1.8; 10.5)</td>
<td>0.108</td>
</tr>
<tr>
<td>Plasma HVA (nmol/l)</td>
<td>34.3 (21.8; 61.4)</td>
<td>31.7 (14.6; 72.7)</td>
<td>0.569</td>
</tr>
<tr>
<td>Plasma 5-HIAA (nmol/l)</td>
<td>19.5 ± 7.4</td>
<td>22.1 ± 7.8</td>
<td>0.074</td>
</tr>
</tbody>
</table>

<sup>2</sup>Since ethinyl estradiol was administered 17β-estradiol was not assayed.

<sup>3</sup>Mean values within a row not sharing a common superscript letter were significantly different (P<0.05 by post-hoc Sidak test).

### Discussion

Subjects in our study were (1) elderly men and postmenopausal women (sex-appropriate levels of sex steroids in both groups) and (2) adult eugonadal male and female transsexuals with sex-appropriate levels of sex steroids (genetic mean) as compared with plasma F→M transsexuals (genetic mean) (13.2 ± 2.0 pmol/l; 17β-estradiol, 61.4 ± 14.6 pmol/l; P=0.05; Fig. 2 and Table 1).

### Oral ethinyl estradiol and cyproterone acetate in F→M transsexuals

In F→M transsexuals, estrogen administration substantially increased plasma levels of HVA as compared with the estrogens used in the present study. In female transsexuals, there was a tendency for plasma 5-HIAA to increase, although the change in plasma 5-HIAA was of borderline significance (P<0.05). After 4 months of cross-sex hormone administration, there was no treatment effect on plasma HVA or 5-HIAA.

### Intramuscular testosterone esters in F→M transsexuals

In M→F transsexuals, estrogen administration substantially increased plasma levels of HVA as compared with the estrogens used in the present study. In male transsexuals, there was no treatment effect on plasma HVA or 5-HIAA.
milieus. However, this idea is not supported by our data. First, HVA levels in plasma were lower in elderly men than in postmenopausal women. This suggested that the sex difference is not affected by the decline in sex steroid levels as the physiological manifestations of aging, particularly following menopause. Remarkably enough, aging men have higher circulating levels of estradiol than postmenopausal women (Vermeulen et al. 2002). Secondly, administration of a high dose of oral ethinyl estradiol plus cyproterone acetate to genetic men and of testosterone to menopausal women (Vermeulen et al. 2002). Secondly, administration of a high dose of oral ethinyl estradiol plus cyproterone acetate to genetic men and of testosterone to genetic women did not affect plasma HVA. Therefore, the male/female difference in plasma HVA cannot be explained by the male/female difference in sex steroid milieus, although an inverse correlation between HVA and testosterone levels was found in the genetic male group at baseline. These results are in line with the findings that testosteron administration in healthy young men did not affect HVA levels (Hannan et al. 1991), that women with polycystic ovary syndrome, which is associated with hyperandrogenism, have similar plasma levels of catecholamines and urinary levels of HVA as compared with female controls (Garcia-Rudaz et al. 1998), and that estrogen administration to postmenopausal women did not affect urinary HVA levels (Lobo et al. 1984).

What mechanism may explain the sex difference in HVA? Since sex steroids did not affect HVA, a putative explanation may be a sex differences in gene expression. MAO A and especially MAO B are responsible for the oxidative deamination of dopamine (Fig. 1), and are both coded for on the X chromosome (i.e. Xp11 region). There is evidence that MAO A and especially MAO B escape X-chromosome inactivation (Good et al. 2003). Since (genetic) women have two X chromosomes and MAO may be expressed from both X chromosomes, this would result in higher MAO activity and consequently higher HVA levels in women than in men. Alternatively, there are sex differences in the brain which develop and mature until early adulthood (Gogtay et al. 2004) and sex steroids may have produced lasting, so-called organizational, effects on dopamine-producing tissue during fetal, perinatal and pubertal periods. Previous studies in transsexuals also suggest that sexually dimorphic brain structures are resistant to exposure to cross-sex hormones and are not influenced by gonadal steroids during adulthood, but they have rather originated by direct action of the genetic factors (e.g. difference in gene dosage) or by the organizational effects of gonadal steroids during early development (Zhou et al. 1995, Kruijver et al. 2000).

We found that M→F transsexuals who were smokers had significantly lower plasma HVA as compared with non-smokers, which is in accordance with the finding that male smokers had lower cerebrospinal fluid levels of HVA (Geracioti et al. 1999). Cigarette smoke may have substantially inhibited the central nervous system MAO activity, leading to increased dopaminergic activity (Fig. 1) (Brody et al. 2004) as well as lower plasma HVA. Alternatively, men with low HVA levels may be more prone to become smokers (i.e. reverse causation). The increase in prolactin levels in M→F transsexuals upon estrogen administration is likely the reflection of a direct estrogenic enhancement or lower dopaminergic inhibitory effects on prolactin secretion. In previous studies in postmenopausal women, estrogen replacement therapy increased prolactin and cortisol responses to the serotonin agonist metachlorophenylpiperazine (Halbreich et al. 1995) and hormone replacement therapy increased prolactin secretion in response to the dopamine-blocking agent sulpiride (Paolletti et al. 2001). The findings were thought to reflect changes in serotoninergic and dopaminergic activity upon estrogen administration (Halbreich et al. 1995, Paolletti et al. 2001).

These estrogenic effects may be confined to the pituitary gland and the hypothalamic structures that control the pituitary production of prolactin, but the effects of sex hormones are likely to differ from one brain region to another. Dopamine degradation proceeds by MOA and COMT, which catalyze the transfer of a methyl group from methionine to dopamine, resulting in homocysteine and HVA (Fig. 1). Because the synthetic pathways are coupled, it is of note that the profound decrease and increase in plasma total homocysteine in M→F and F→M transsexuals respectively (Giltay et al. 2003) were not paralleled by changes in plasma HVA.

Methodologically, the use of plasma levels of HVA has its limitations. Plasma levels of HVA are dependent upon the balance between both delivery into the plasma and clearance from the plasma (half-life: ± 40 min) (Goldstein et al. 2003). Only 12–40% of HVA in plasma is of central nervous system origin (Swann et al. 1980, Maas et al. 1988, Lambert et al. 1991, Lambert et al. 1993, Amin et al. 1995, 1998); much more is derived from central and peripheral sympathetic nerves and the adrenal medulla. It is possible that sex steroids affected biosynthesis, transport, concentration, uptake, receptor potentiation and density, postsynaptic responsivity, blood–brain barrier, degradation, or clearance of dopamine and serotonin (Halbreich & Kahn 2001). Potential effects on dopamine and serotonin activity may have been obscured by compensatory (i.e. negative feedback) mechanisms, and by the indirect assessment of monoamine status in plasma samples. Finally, alterations in renal clearance may cause concomitant changes in the plasma HVA. However, the increase in plasma creatinine upon testosterone administration is not caused by a decrease in renal function, since creatinine clearance was unaffected by testosterone administration in another study of cross-sex hormone administration to transsexuals (Giltay et al. 1998). The increase in plasma creatinine is rather a reflection of the anabolic effect of testosterone in genetic females, as indicated by the increase in lean body mass.

The interpretation of our results is limited by the inclusion of a relatively small numbers of subjects. Furthermore, the intervention study had a relatively short follow-up of 4 months, had an open-label design and
lacked a true placebo group, due to the nature of the study population and the treatment indication. Moreover, different effects may have been found in hypogonadal men and women undergoing sex-appropriate hormone replacement. Yet, the dose of cross-sex hormone administration was high and the levels of HVA were consistently lower in men than in women as well as in M→F transsexuals than in F→M transsexuals, both before and after cross-sex hormone administration.

We found that fasting plasma levels of HVA, the major metabolites of dopamine, was not significantly changed by administration of high-dose cross-sex hormone administration in F→M and M→F transsexual subjects. Our results have suggested that the sex difference in plasma HVA – with higher HVA levels in females than in males – is related to mechanisms other than exposure to sex steroids in adulthood, and may rather be the result of a sex difference in genetic factors or of organizing effects of sex hormones during early development.

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