INFORMATIONAL; PREPARED BY INNER BALANCE FOR PROVIDERS

Clinical reference: lab interpretation *for* patients on Oestra®

Purpose

Lab panels are one of the most common sources of confusion and sometimes alarm for patients and providers unfamiliar with systemic-dose vaginal hormone therapy — an estradiol result that looks "very high" relative to standard reference ranges can prompt a patient to stop treatment, or a provider to advise against it, without the context needed to interpret it correctly. This reference explains our lab philosophy, our dosing-to-lab-value framework, and how to interpret results without the most common misreadings.

1 Labs are a data point, not a gatekeeper

We do not require labs to start or monitor Oestra®. Our stance: Hormone levels are dynamic, tissue-distributed, and fluctuate throughout the day; symptom response is often a more immediate and reliable guide to dosing than a single blood draw. Labs are useful for context, trend-tracking, and addressing patient or provider concern and not as a precondition for care.

2 Timing matters: peak vs. steady state

A single-draw estradiol or progesterone level can look dramatically different depending on when it's drawn relative to the last application. Vaginal application produces a peak roughly 10–12 hours post-application; a level drawn during that window will read substantially higher than a steady-state level, and is frequently the source of alarming-looking results that don't reflect the patient's actual sustained exposure.

INSTRUCTION FOR PATIENTS

Skip the Oestra® dose for 24–48 (24 hours is ideal) hours before a blood draw (skip applications) to obtain a steady-state reading rather than a peak.

3 Our clinical dosing-to-lab framework

The following reflects Inner Balance's clinical protocol, developed through iterative dose titration and patient symptom response over time; *not an established, externally validated reference range*. We present it as our framework, not as a claim that these are universally "optimal" levels; outcome data validating specific target ranges does not yet exist for this therapy.

OESTRA DOSE	ESTRADIOL (STEADY STATE)	PROGESTERONE
Starting dose	100–300 pg/mL	1.0–3.0 ng/mL
Highest titration dose	Up to 400–600 pg/mL	Up to 6.0 ng/mL

Why these targets, and why they're higher than FDA-approved HRT products typically achieve

Most FDA-approved transdermal and oral estradiol products are dosed to reach roughly 40–100 pg/mL. A substantial proportion of patients remain symptomatic at that range. Oestra® is intentionally dosed higher, specifically for patients who have not achieved adequate symptom relief on standard-dose therapy — that's the clinical rationale for the product's existence, and it's why patients typically arrive at Oestra® after standard-dose options haven't worked for them.

Context for an estradiol result that looks "high"

A result in the 100–300 pg/mL range is well within, and a result up to ~500 pg/mL is near the upper bound of, the periovulatory peak reference range commonly reported for premenopausal women by clinical laboratories — that is, levels a normally cycling ovary produces at certain points in a natural cycle. This is offered as reference-range context, not as a claim that sustained exposure at this level over time carries the same profile as a brief natural peak; we don't have data establishing that equivalence, and don't assert it.

Progesterone dosing rationale

Our protocol maintains progesterone at a level substantially higher than estradiol (roughly 10–30x by our internal convention) as a matter of dosing philosophy intended to ensure adequate opposition to the estrogen dose. This is our clinical rationale, not an externally established or literature-confirmed ratio requirement — there is no established optimal progesterone reference range in the literature at all, a point worth making explicitly to any provider citing a specific number as if one exists.

4 FSH as the primary marker for dosing adequacy

We weight FSH more heavily than absolute estradiol or progesterone values when assessing whether a patient's hormone need is being met, because FSH reflects an integrated, roughly 30-day signal from the pituitary rather than a single day's fluctuating hormone level.

FSH RESULT	INTERPRETATION
> 8	Signals inadequate hormone exposure from the pituitary's perspective — supports dose titration upward
< 7	Consistent with adequate hormone exposure
Near 0	May indicate over-suppression; reassess dosing

With adequate dosing, we typically observe FSH declining from elevated (sometimes >100 in significant ovarian insufficiency) to the target range over months and adequate dosing.

5 Addressing "estrogen dominance"

Patients frequently present having been told they have "estrogen dominance" and can't tolerate estrogen therapy. Our reframe: an elevated FSH indicates the opposite; that the pituitary is signaling that it perceives *insufficient*, not excess, hormone availability. True estrogen-dominant states (relative estrogen excess without adequate progesterone opposition) are a distinct clinical picture from ovarian insufficiency with a compensatory FSH rise, and Oestra®'s progesterone-forward dosing ratio is specifically intended to avoid creating one.

A related question we hear often: "Won't starting HRT make pre-existing estrogen dominance worse?"

In patients with residual ovarian function, most relevantly, perimenopausal patients — what's often labeled "estrogen dominance" reflects erratic, anovulatory cycles: unpredictable estrogen surges without the progesterone the ovary would normally produce after ovulation. Introducing adequately-dosed exogenous estrogen and progesterone suppresses FSH and LH via negative feedback, which in turn suppresses the ovary's own erratic production. The result is not necessarily a lower total estrogen exposure in every case and that depends on how high the patient's own unopposed peaks were running. However, it replaces an unpredictable, unopposed pattern with a stable, consistently-opposed one, which is the actual driver of most estrogen-dominance symptoms rather than the peak level itself. For a fully postmenopausal patient with minimal remaining endogenous production, this concern is largely moot, since there's little native output left to suppress or stabilize.

6 A note on birth control transitions

Combined hormonal contraceptives suppress endogenous estradiol, progesterone, and testosterone production. Patients transitioning from birth control to Oestra® may experience a "reawakening" of hormonal sensitivity as endogenous signaling resumes, and lab values and symptoms in the initial transition period should be interpreted with that context in mind rather than compared directly to a stable baseline.

Summary for referring providers

1. Labs are optional for Oestra and are one data point among several — not a precondition for treatment.
2. Draw labs 24–48 hours after skipping a dose to avoid peak-level readings that overstate sustained exposure.
3. Elevated-looking estradiol values (100–300, up to ~500 pg/mL) are within or near the upper bound of the periovulatory reference range reported for premenopausal women — offered as context.
4. There is no established optimal progesterone reference range in the literature; treat specific-number claims from other sources with the same skepticism.
5. FSH, not absolute E2/P4 values, is our primary marker for whether dosing is adequate.