The use of hormonal therapy in "andropause": the con side

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Three physicians are out duck hunting without a license, a family doc, an internist and a surgeon. Not much is happening but they're not going home empty handed. I know you've heard it, but bear with me, there's a point here. After a while, a flock of birds fly over the docs as they hide in the tall grass. The family doc stands up, and with his pistol, shoots at what he thinks is a duck … wings it, but it keeps flying. Another shot, a few feathers fly, but no birds fall. "You're not very good," says the internist. "You need a rifle anyway."

Hours later and another bunch of birds, the internist jumps up with his high-powered sighted rifle, lines up a bird, then another and another … not sure if they are ducks, he doesn't want to kill a pigeon. By the time he decides on his target, it's out of range. "I need more time," says the internist, "and maybe a better rifle."

Hours pass and it's almost evening. What looks like birds appear in the twilight sky and now it's the surgeon's turn. With his blunt, 12 gauge shotgun, he sprays the flock. All 3 docs are pelted with dead birds, among them sparrows, pigeons and geese. "There's a duck there somewhere," the surgeon boasts. "Now can we go home?"

Why the old joke? Unfortunately the use of testosterone replacement therapy continues to be a bit of a duck hunt. I cannot completely disagree with Dr. Morales. The end organ effects of testosterone are remarkable. Improved strength, better mood, stronger muscles, increased libido, the list goes on. If we only knew where to use this weapon! In the truly hypogonadal patient, one cannot argue the benefits of testosterone replacement therapy. Fortunately for our patients, and unfortunately for the manufacturers of testosterone therapies, hypogonadal symptomatic males are few and far between, and would never support the infrastructure around the present testosterone replacement therapy market. There just aren't enough ducks to keep everyone in business, and Dr. Morales wants us to consider treating pigeons under the guise of andropause.

My position is that andropause is primarily a market-driven concept, largely promoted by industry, accepted by a handful of physicians and embraced by some patients who are looking for an antidote to aging. We need to resist the marketing efforts and consider the science.

Briefly summarized, we know plenty about the effects of testosterone but little about the indications, benefits and long-term safety *in the population targeted with the andropause shotgun*.

The range of normal testosterone levels is quite broad; levels depend on time of day and no consensus exists on what measurement of testosterone (total, free or bioavailable) correlates best with symptoms or treatment success. There is a gradient between the truly hypogonadal patient and the softer andropausal male. Clinical judgment is necessary to determine who will benefit from treatment.

But the symptom complex associated with andropause (or the "newer" term symptomatic late-onset hypogonadism) is ill-defined and shares similar characteristics with depression, normal aging and, for lack of appropriate medical terminology, just being overweight and lazy! There are no good validated instruments to help the physician determine who will improve on treatment or measure the treatment effects.

Add to the mix the lack of good randomized prospective clinical data on the long-term effects and no information on the cost benefits — why do physicians continue to prescribe testosterone replacement therapy to essentially eugonadal men?

One answer would be that industry is driving the market and recent prescription data would support this. Sales visits to physicians are way down and testosterone sales are flat. It's expensive to support a concept as nebulous as andropause! Another might be that physicians are lazy and would rather end the interview with a prescription than a lifestyle lecture! I think most of us remain confused on who's likely to benefit and are experimenting a bit.

Few physicians have incorporated screening for hypogonadal patients into their routines despite the cry from Dr. Morales and his band of testosterone-

toting docs. We are all narrowing our sights; metabolic syndrome (i.e., obesity and diabetes) and conditions that are associated with low testosterone where there is the possibility that testosterone might improve clinical outcomes is where most physicians are hunting today. Industry has begun to follow suit and the currently available educational kits are more focused but still suggest a shotgun-like approach.

Also, if there is a symptom complex that will respond to exercise better than andropause, I don't know of it. Educational material produced by industry mentions exercise in passing and testosterone docs spend little time educating their patients on the health benefits of physical activity. Here's an idea for your patients: tell them to take the $1200 they'll spend on testosterone per year and join a health club; buy a Stairmaster — they'll have money leftover for their new clothes!

Until industry supports the science behind testosterone replacement therapy, it will always be a therapy used "in good faith." I need more long-term controlled data before I can recommend testosterone replacement therapy to my male patients with soft symptoms and borderline testosterone levels. I need tools to measure progress and some idea of the cost-effectiveness. Finally, we all need industry to pay for a license (proper trials) and to stop asking us to hunt for them. Until then andropause remains a pigeon masquerading as a duck and no one, especially the other birds, want us to hunt like surgeons.

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Competing interests: Dr. Casey is a member of the Solvay Pharmaceuticals Advisory Board and of the Paladin Labs Advisory Board.

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