Testosterone Therapy in Men With Hypogonadism

Diagnosis, treatment candidacy, contraindications, and monitoring of testosterone therapy in hypogonadal men.

2018 Endocrine Society
Testosterone Therapy in Men — Clinical Practice Guideline
Bhasin et al. · JCEM 2018;103:1715–1744

GRADE — 1 · Strong | 2 · Suggest For | 2- · Suggest Against | Ungraded / Best Practice

1 Diagnosis

1 — Diagnose hypogonadism only with **symptoms/signs of T deficiency** plus unequivocally and consistently **low total and/or free testosterone** (confirmed on repeat, accurate assay).

1 — **Against** routine population screening for hypogonadism.

1 — Distinguish **primary (testicular) vs. secondary (pituitary-hypothalamic)** hypogonadism by measuring LH and FSH.

2 — Further evaluate to identify the **etiology** of hypothalamic, pituitary, and/or testicular dysfunction.

2 Treatment Candidacy & Contraindications

1 — **Testosterone therapy** in hypogonadal men to induce/maintain secondary sex characteristics and correct symptoms of deficiency.

1 — **Against** testosterone in: near-term fertility plans; breast or prostate cancer, palpable prostate nodule/induration, PSA >4 ng/mL (or >3 with high prostate-cancer risk, without further urologic evaluation); elevated hematocrit; untreated severe OSA; severe LUTS; uncontrolled heart failure; MI or stroke within 6 months; or thrombophilia.

2 — Age **55–69 with life expectancy >10y**: discuss prostate cancer risk/monitoring via shared decision-making; assess risk before and 3–12 months after starting. Age **40–69 at increased prostate-cancer risk** (Black men, first-degree relative with prostate cancer): discuss risk and offer monitoring.

1 — **Against** routinely prescribing testosterone to all men ≥65y with low T alone. If symptomatic (low libido, unexplained anemia) with confirmed low AM testosterone, offer therapy **individually** after explicit risk/benefit discussion.

2 — Consider **short-term testosterone** in HIV-infected men with low T and weight loss (other causes excluded), to support weight and lean-mass gain.

1 — **Against** testosterone therapy solely to improve glycemic control in men with T2DM and low testosterone.

3 Monitoring

GPS — Evaluate the patient after initiating therapy to assess **treatment response, adverse effects, and adherence**.

2 — **Urology referral** in the first 12 months if: confirmed PSA rise >1.4 ng/mL above baseline; confirmed PSA >4.0 ng/mL; or an abnormal DRE. After 1 year, follow standard age/race-based prostate cancer screening.

Bhasin S, Brito JP, Cunningham GR, et al. Testosterone Therapy in Men With Hypogonadism: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab.* 2018;103(5):1715–1744.