LETTER TO THE EDITOR
Response to: Efficacy of changing testosterone gel preparations (Androgel or Testim) among suboptimally responsive hypogonadal men


The article by Grober et al.1 provides valuable clinical information regarding the two Food and Drug Administration-approved formulations of testosterone (T) gels, Androgel and Testim. The authors are to be credited for pointing out that a sizable percentage of men (20% in this study) either do not absorb gels adequately, or may object to them for other reasons. The authors have also shown that switching from one brand of gel to the other may resolve these problems, and have thus provided the first solid rationale for trying a different T-gel brand rather than moving immediately to T injections.

However, I wish to offer an alternative view to one of the primary conclusions of the authors. The authors write that switching from Androgel to Testim may resolve a suboptimal biochemical response (inadequate serum T), but switching from Testim to Androgel is unlikely to offer the same benefit. This latter conclusion appears to be contradicted by the authors’ own data.

Of men with T concentrations less than 300 ng per 100 ml with their first gel, a switch to Testim left 17% below this threshold, whereas a switch to Androgel left 27% below this threshold. Given the very small numbers involved in the group that initially used Testim, this difference is highly unlikely to be significant statistically or clinically. More importantly, these data reveal that 73% of men whose original T levels were suboptimal with Testim had improved T concentrations with Androgel. This strongly suggests that it is worthwhile considering treatment with Androgel when Testim has provided inadequate T concentrations, just as it is worthwhile considering Testim when Androgel has been ineffective. This is an important point with practical implications, and is consistent with clinical experience.

Additional comments suggesting that Testim provided better T concentrations than Androgel are misleading, since the Androgel-first group consisted almost entirely (92%) of men with low T concentrations, whereas the Testim-first group was heterogeneous, with only 30% having low T concentrations. These groups are so dissimilar that any comparison of T concentrations would be like comparing apples and oranges. In addition, almost two-thirds of men (63%) who were switched from Androgel did so after a dose of only 5 g, so it is impossible to know what their final T concentrations might have been with a full dose (10 g).

Nonetheless, the article by Grober et al. provides an important service. The take-home message is that men treated with T gel must be monitored early in the course of treatment to identify suboptimal biochemical responses, and switching gel brands can ‘rescue’ T concentrations in a majority of cases. In our own practice, T concentrations are obtained 2 weeks following initiation of T gel therapy (5 g), with an immediate increase in dose (10 g) if T concentrations are suboptimal. If T concentrations remain inadequate, patients will be switched from one gel to the other, or to injections. We are fortunate to have two effective T gel products available in the US market.

Conflict of interest
I have received honoraria from Auxilium, Solvay, Watson and Indevus pharmaceutical companies for lectures, research, consulting and/or scientific advisory boards.

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References