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

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The authors' are grateful to Dr Morgentaler and the editorial team of the *International Journal of Impotence Research* for their important insights into this research. A few points however require clarification.

Prior to treatment with either gel, all patients had clinical symptoms of hypogonadism and a total serum testosterone (T) level of $<300\,ng\,dl^{-1}$. Among patients initially treated with Testim, the mean T was $544\,ng\,dl^{-1}$ and the proportion with T $<300\,ng\,dl^{-1}$ was only 15%. Following substitution by Androgel, mean T was $522\,ng\,dl^{-1}$ and the proportion with sub-therapeutic T levels ($<300\,ng\,dl^{-1}$) increased to 27%. This does not mean that '73% of men whose original T levels were suboptimal with Testim had improved T concentrations with Androgel' as suggested by Dr Morgentaler. In fact, our data suggest that an additional 12% had sub-therapeutic T levels following a switch to Androgel.

Dr Morgentaler wisely queried as to whether a dose escalation from 5 to 10 g of T gel prior to changing formulations would have allowed some patients to remain on their original gel. Among those originally starting on Testim, the majority required a change to Androgel due to specific properties of the gel (scent, skin reaction). Consequently, a dose increase under these circumstances does not make much sense. Among patients originally starting on Androgel, about two-thirds were switched at the 5-g dose and one-third following dose escalation to 10 g of Androgel. As reported in table 1 of the paper, T levels of these two groups are really not different.

The authors appreciate Dr Morgentaler's insight in that one should be cautious about comparing the two treatment groups as they had several obvious significant differences prior to gel substitution. Reflecting this sentiment, the paper was not designed to directly compare these two groups, but simply to gain insight into the reasons for suboptimal clinical responses to T gel therapy and evaluate the evolution of biochemical and symptomatic change following gel substitution with both Food and Drug Administration-approved products.

On the basis of Dr Morgentaler's letter to the editor, it is clear that we both agree that 'a change in T gel preparation among initially unresponsive hypogonadal men is justified prior to abandoning or considering more invasive T replacement therapy.'

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