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Although chemotherapy is no complete substitute for psychotherapy in the treatment of impotence of the male patient, nevertheless, in cases where psychologic and/or somatic failure plays a role as etiologic agent then indeed chemotherapy is indicated.

—T. Jakobovits

Our Fertility and Sterility no longer focuses on issues related to the clinical condition variably referred to as andropause, male menopause, or late-onset hypogonadism (LoH). In fact, the Food and Drug Administration, as evidenced by their 2015 Safety Advisory for testosterone supplements, argues that this condition may not even exist (1). While this controversy rages on, Dr. Thomas Jakobovits, working in Boston, MA, provides us with evidence for an impressive treatment response to empiric hormonal therapy among such men (2). Although this article is thin on methodology and scientific rationale, it is a precious double-blind, placebo-controlled trial examining treatment effects of combination methytestosterone-thyroid supplementation on male sexual dysfunction.

The language Dr. Jakobovits uses to describe this controversial clinical entity is both flowery and archaic—“climacteric,” “eunuchism.” Men present with “lazitude” and other symptoms we would be hard pressed to associate with LoH, such as tinnitus and palpitations. In fact, the description of LoH is all that we find distasteful by our present standards and feeds into an outmoded myth—that testosterone deficiency among aging men is the multi-purpose boogey-man, and its correction is a fountain of youth.

In the trial, methytestosterone is given orally, three times daily. We would understandably scoff at even the concept of oral supplementation—conjuring nightmares of sky-rocketing liver function test results. Yet, just this year, we are finally the recipients of the Food and Drug Administration-approved oral testosterone undecanoate supplement, dosed twice daily. Despite our reasonable concerns about cardiovascular adverse events with this new formulation, we are actively revisiting our past experiences with oral testosterone supplementation.

While our current preferred nomenclature is testosterone supplementation, we are in fact replacing a deficit based on abnormally low serum testosterone—our various guidelines (and insurance carrier policies) insist on multiple low starting values before considering therapy. As is often seen in other historical trials in the fertility realm, this trial is squarely in the empiric therapy camp—both treatment and placebo groups present with baseline normal-range thyroid and steroid tests. Notwithstanding this trial’s findings, I suspect most—if not all—of us will not supplement thyroid or testosterone hormones if the levels are adequate to start. Thus, I doubt this study is an unearthed jewel that will change our practices today.

Among the 100 men enrolled in the trial, Dr. Jakobovits cited a 78% favorable response regarding sexual function (vaguely defined here) in the treatment arm versus a 40% favorable response in the placebo group. No cross-over arm, here. No statistical results of any kind. No funding disclosures. No subject drop-out or compliance information. These schematized results seem quaint in retrospect, but the previous state-of-the-art therapy for sexual dysfunction must be kept in mind. There were no simple phosphodiesterase 5 inhibitor prescriptions to be had. Dr. Jackobovits’ null hypothesis—against which he is clearly struggling—was that men with sexual dysfunction may be offered nothing more than psychotherapy. Thus, his conclusion that “chemotherapy”
may alter the fortunes of men with impotence, was quite rev-
olutionary for the time. Truly, he operated at the forefront of
male sexual dysfunction at the dawn of the 1970s, arguing for
an intervention that we take wholly for granted today—
pharmacotherapy.

REFERENCES
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