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## REPORT

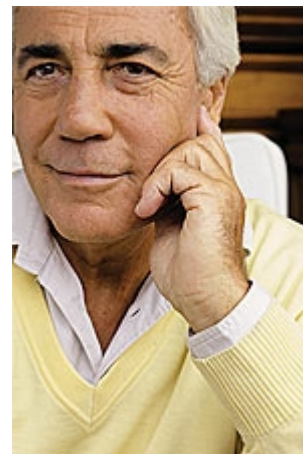
### Destroying the Myth About Testosterone Replacement and Prostate Cancer

By Abraham Morgentaler, MD, FACS Introduction By William Faloon

For decades, the medical establishment erroneously conjectured that testosterone replacement therapy increases one's risk of prostate cancer.

Harvard-based Abraham Morgentaler, MD, FACS, has demonstrated this theory to be mistaken. Contrary to the notion that restoring testosterone to youthful levels is somehow risky, Dr. Morgentaler meticulously shows an increased risk of prostate cancer in aging men with low testosterone. This same information about the dangers of low testosterone was long ago uncovered by the **Life Extension Foundation**.

In this exclusive excerpt from his book, *Testosterone for Life*, Dr. Morgentaler recounts how it takes years, even decades, to correct a medical myth. In this case, the medical establishment's misconception about testosterone and prostate cancer has condemned millions of aging men to suffer degenerative diseases caused by testosterone deficiency.



Until just a few years ago, it was almost universally believed that T [testosterone] therapy would lead to some degree of increased risk of prostate cancer. During that time testosterone therapy was seen to represent the proverbial pact with the devil, by trading short-term sexual and physical rewards for the ultimate development of a malignant cancer. Fortunately, this belief has been shown to be incorrect, and medical opinion has begun to shift quite dramatically, with good evidence that testosterone therapy is quite safe for the prostate. There is even now a growing concern that low testosterone is a risk for prostate cancer rather than high testosterone.

How the original fear about T and prostate cancer came to be is a fantastic story involving Nobel Prize winners, medical breakthroughs, and a critical paradox that took two-thirds of a century to solve. In the end, it is also a cautionary tale of how it may take years—even decades—to correct a medical “truth” once it has been established. I have taken great pleasure in participating myself in the evolution of attitudes regarding T and prostate cancer, and here describe how this all took place.

The relationship of testosterone to prostate cancer has undergone a significant reevaluation, and all recent evidence has reinforced the position that testosterone therapy is safe for the prostate. I've been fortunate to have participated in the evolution of this idea, which is of critical importance to anyone considering testosterone therapy.

#### ORIGINS OF THE CONCERN

The basis for the fear that testosterone therapy increases the risk of prostate cancer originated with the work of Charles B. Huggins, a urologist at the University of Chicago. Huggins was initially interested in the medical condition called benign enlargement of the prostate, called benign prostatic hyperplasia (BPH), which causes frequent and urgent urination and also can occasionally cause complete obstruction of the urine passageway. Benjamin Franklin was reported to have suffered from BPH and was credited with inventing a tube he inserted through the urine channel to relieve the obstruction.



Curiously, dogs are the only species we know of other than humans that naturally develop prostate problems on a regular basis. At the turn of the twentieth century, there were reports that castration was successful in treating some men with severe obstruction from BPH, and Huggins began experimenting on the effects of castration on BPH in dogs. Not only did the dogs' prostates shrink after castration, but Huggins made an additional far-reaching observation.

Huggins noticed that the microscopic appearance of prostates of some of these dogs contained areas that were indistinguishable from human prostate cancers. Even more importantly, after castration, dogs with

these cancerous-appearing areas also demonstrated shrinkage of their prostates. Indeed, when their prostates were removed, the dogs had no further evidence of the cancerous-appearing areas.

Huggins and his coworkers then applied his dog results to humans. By this time, it was known that the key effect of castration was to reduce testosterone levels in the bloodstream. He took a group of men who had prostate cancer that had already spread to their bones and lowered their testosterone levels, either by removing the testicles or by administering estrogen. A blood test called acid phosphatase was high in men with metastatic prostate cancer, and Huggins and his coworkers showed that acid phosphatase dropped substantially within days of lowering testosterone. Of even greater consequence for the future of testosterone therapy, Huggins also reported that administration of testosterone injections to men with prostate cancer caused acid phosphatase to rise. Huggins and his coworkers concluded that reducing testosterone levels caused prostate cancer to shrink and raising testosterone levels caused “enhanced growth” of prostate cancer.

This demonstration of the androgen dependence of prostate cancer was incredibly important, because until that time in the early 1940s prostate cancer was untreatable. From that point forward, lowering testosterone by castration or by estrogen became the standard treatment for advanced disease and remains a mainstay of treatment to this day. Because estrogen treatment caused heart attacks and blood clots in some men, and because most men did not care for the idea of having their testicles removed, a new type of medication—LHRH agonists—was introduced in the 1980s. Injections of this medication are now the usual way testosterone is lowered in men with prostate cancer.

Huggins was eventually awarded the Nobel Prize in 1966 for his work showing that prostate cancer grew or shrank depending on testosterone levels. Until recently, this prevailing wisdom regarding prostate cancer and testosterone had not been seriously questioned.

### **MY INVOLVEMENT IN THE STORY**

By the time I performed my urology training in the mid 1980s as a resident at the Harvard Program in Urology, based at the Brigham and Women’s Hospital in Boston, one of the unassailable assumptions held by all the urologists I trained under was that prostate cancer shrunk with low testosterone and grew with high testosterone.

In my training, we learned that men who had been castrated early in life never developed prostate cancer. In the laboratory, prostate tumors could be placed under the skin on the back of mice, and the tumors would grow to a large size. Pieces of these tumors could then be transferred under the skin of another male animal and would again grow to a large size. If the males were castrated or given estrogen (which lowers testosterone), the tumor would shrink rapidly or not even take root.

The tumor would not grow at all, however, if it was transferred under the skin of a female. On the other hand, if the female were given testosterone, the tumor would grow just as well as if it had been placed in a male. All these studies indicated that testosterone was a critical element in allowing prostate cancer growth. There seemed to be good reason to believe that it would be dangerous to give testosterone supplementation to a man with prostate cancer. I believed that, and so did everyone around me.

My fellow residents and I thus learned to repeat the comments of our teachers to our patients in the clinics. Whenever issues of testosterone would come up, we would say the relationship of testosterone to prostate cancer was like “pouring gasoline on a fire” or providing “food for a hungry tumor.” These phrases are still in use throughout the medical world.

In those days, we all spoke about testosterone and prostate cancer as if there were a simple, direct relationship, but the truth is not quite so simple.

### **A FATEFUL INTERACTION**

Once I finished training, I began my specialization in the treatment of “guy stuff,” primarily male infertility and sexual problems. I also began diagnosing and treating a large number of men with low testosterone. This was not a common practice at the time; in fact, I had very little experience with testosterone therapy during my training. This was because there was little research showing that testosterone treatment helped the symptoms seen in men with low testosterone. Indeed, one of the most bothersome symptoms—erectile dysfunction—was believed at the time not to improve with testosterone treatment (later research has shown this belief to be incorrect). Doctors also were reluctant to prescribe testosterone because of the fear of promoting a prostate cancer that might be lurking silently inside the man’s prostate gland.

At the end of my second year of practice, I ran into one of my former teachers at the national meeting of the American Urological Association. He asked me if it were true that I was treating men with testosterone. I replied that I was and explained that I had



been pleasantly surprised to find so many good responders despite my earlier training.

"I wouldn't do that anymore, if I were you," he said. "I just had a patient diagnosed with prostate cancer within a year after beginning testosterone treatment. If you're going to continue treating men with testosterone, and I recommend you don't, you should at least do a prostate biopsy first to make sure they don't have cancer."

Naturally, this was a disconcerting conversation, especially coming from a former teacher of mine whom I respected greatly. So I followed his suggestion and began performing prostate biopsies before initiating testosterone therapy. At least with a biopsy, I could rule out the presence of cancer.



At the time, the only reasons to do a prostate biopsy were for an abnormal-feeling prostate, as determined by digital rectal exam (DRE), or for an abnormally high result for the prostate-specific antigen (PSA) blood test, which can indicate an increased risk of prostate cancer. Surprisingly, despite a normal DRE and PSA, one of the very first men I biopsied had cancer. This was very strange, because it was assumed at the time, as I've explained earlier, that a man with low testosterone should have been protected against prostate cancer. It didn't take long to find several more cancers in men with low testosterone despite normal DRE and PSA results. Indeed, of the first thirty-three men I biopsied, six had cancer. This was a very high

cancer rate, especially for a group of men without known risk factors. After presenting these results at the national urology meeting, one of the academic chiefs, a well-respected man, declared in his trademark booming voice, "This is garbage! Everyone knows that high testosterone causes prostate cancer, not low testosterone. You guys just got unlucky. I bet if you biopsy the next 100 men, you won't find another cancer."

It was a dramatic moment—I was a young unknown being castigated on a national stage by a major figure in the field. And he was right—given what we knew about testosterone and prostate cancer, the results made no sense.

All I could do was to respond, "These are the results we obtained. We present them here because they do fly in the face of conventional wisdom, which is why we believe they may be of interest to this audience."

When the size of the group we had biopsied was fifty men and the cancer rate was unchanged, my colleagues and I submitted a manuscript to the *Journal of the American Medical Association*, one of the top medical journals in the world. The associate editor soon called me up to say, "Our editorial board finds your data very interesting, because it runs counter to what we would expect. But our concern is that your numbers are small, and perhaps you may have just had an unlucky run with your biopsies. If you gather additional men and your cancer rate holds up, we will seriously consider publishing your manuscript." Before long I submitted data on seventy-seven men, eleven of whom had cancer, and the paper was published.

At the time, in 1996, the 14 percent cancer rate we reported was several times greater than any previously reported cancer rate in men with normal PSA (4.0 ng/mL or less). Several studies had reported biopsy results in men with normal PSA with cancer rates of 0 percent or 2 percent, with the highest value reported being 4.5 percent. The much higher cancer rate in our population certainly seemed to suggest there was something different about prostate cancer risk in men with low testosterone.

Frankly, most experts just didn't know what to make of our results. A high cancer rate among men with low testosterone didn't fit into the existing way of thinking regarding testosterone and prostate cancer. And because we hadn't biopsied a control group of men (men with normal T and no other risk factors), it was impossible to say whether men with normal T would have had a different cancer rate than our patients with low testosterone.

In retrospect, though, that paper was the first direct evidence in a major medical journal that standard assumptions about testosterone and prostate cancer might not be correct. At a minimum, it was obvious that low testosterone could not be considered protective against the development of prostate cancer, as had been assumed for so long. And it made me wonder whether other assumptions about testosterone and prostate cancer were also incorrect.

## THE NEW ENGLAND JOURNAL OF MEDICINE

After publication of my article on prostate biopsies in men with low testosterone, I published a number of additional articles looking at the relationship between testosterone and the prostate. In one provocative study, a colleague and I looked at whether testosterone therapy posed special dangers for men who were already at high risk for developing prostate cancer.

In this study, we compared the results of testosterone therapy given for twelve months in two groups of men with low testosterone. The first group consisted of twenty men considered to be at high risk for prostate cancer based on biopsy results showing an allegedly precancerous condition called prostatic intraepithelial neoplasia (PIN). The second group consisted of fifty-five men with normal biopsy results. At the end of one year of treatment, both groups had a similar, modest increase in PSA. One man in the study, who was in the high-risk group, developed cancer.

So, overall testosterone therapy resulted in a one-year cancer rate of 1.3 percent (one of seventy-five men). More importantly, the one-year cancer rate among the high-risk men with PIN was 5 percent. This compared to the known cancer rate of 25 percent over three years in this population. While the two figures are not directly comparable, these results certainly did not seem to suggest that testosterone therapy had increased the cancer rate in this high-risk group. And the overall cancer rate was not very high at all.

Here was another piece of evidence that the old assumptions about testosterone and prostate cancer were incorrect, specifically the notion that testosterone therapy was like pouring gasoline on a fire. First, we had found that men with low testosterone did not seem to be protected against developing cancer. Now, at the other extreme, we found that men at high risk for prostate cancer did not seem to suffer any dramatic “explosion” of cancer when treated for a year with testosterone therapy. And when I looked back at my extensive experience of treating men with testosterone therapy, many for ten years or longer, precious few cases of cancer had developed.

It was heresy, but I couldn't help thinking that the old stories linking testosterone levels to risk of prostate cancer might well be wrong. After all, if one looks at the natural progression of prostate cancer, it never occurs in men in their twenties when testosterone levels are at their lifetime peak, even though autopsy studies have shown that a significant percentage of these young men already harbor microscopic prostate cancers. Instead, prostate cancer becomes increasingly common as men age, when testosterone levels have declined.

I was coming to the conclusion that the average physician might be unduly fearful of the risk of prostate cancer with testosterone therapy. From my lectures to physicians around the country, it became clear to me that many physicians withheld testosterone therapy from their patients because they feared stimulating a sleeping cancer. I thought it might be time to write a review article that put the risks of testosterone in perspective, particularly the risk of prostate cancer. Fortunately for me, the *New England Journal of Medicine* was receptive to my proposal to consider such a publication.



Prostate tumor confined to prostate gland.

The *New England Journal of Medicine* is arguably the most prestigious medical journal in the world, and its reputation stems in part from publishing only the best-researched articles. Together with Dr. Ernani Rhoden, a urology professor from Brazil who came to Boston to do a year-long research fellowship with me, we spent a year reviewing all the available scientific and medical literature on the risks of testosterone treatment to be able to provide a manuscript that lived up to such standards. Once we had written up the manuscript, our paper was subjected to multiple waves of reviews by physicians from various specialties—urology, oncology, endocrinology—to make sure that we had not left out any key studies or misrepresented any of the data.

The first thing we looked at was the rate of prostate cancer in men undergoing treatment with testosterone. Although many of the studies were small, the cumulative cancer rate in these trials was only slightly higher than 1 percent. This cancer rate was actually less than the cancer detection rate in men undergoing screening for prostate cancer. However, there was no large, long-term study looking at cancer rates in men receiving testosterone therapy and comparing them to men who did not receive testosterone therapy; thus, by themselves, these studies could not provide a definitive conclusion regarding risk.

There also were some large, sophisticated studies that indirectly addressed the risk of testosterone and prostate cancer. Unlike the studies I just mentioned, in which men given T treatment were monitored for the development of prostate cancer, these large studies simply looked to see if there was a connection between a man's own natural level of testosterone and his risk of developing prostate cancer. In these observational studies, blood samples were taken and frozen at the beginning of the study, and then the large study group was followed for long periods of time. At the end of the study period, often ten to twenty years later, a group of men would have developed prostate cancer. The blood samples obtained from these men at the beginning of the study would then be tested for testosterone and other hormones and compared to a similar group of men who were matched for age and other characteristics but who did not develop prostate cancer. What did they find?

In 2004, when my article in the *New England Journal of Medicine* was published, there were fifteen of these longitudinal studies examining the relationship of hormones and prostate cancer. Since 2004, there have been approximately a half-dozen more. Not one has shown any direct relationship between the level of total testosterone in a man's blood and the subsequent likelihood that he will develop prostate cancer. Specifically, average total testosterone levels were not higher in the cancer group compared to men without cancer, and men with the highest T values were at no greater risk for later developing prostate cancer than men with the lowest T values.

Among the dozens of additional calculations in each of these studies, an occasional minor correlation did show up, such as a connection with the minor androgen DHEA in one, a ratio of testosterone to SHBG in another, or a calculated free T in a third. But in all cases so far, attempts to confirm these minor connections have failed.



At the end of immersing ourselves into this literature for a full year, Rhoden and I were stunned by the fact that there was not a single study in human patients to suggest that raising testosterone increased the risk of prostate cancer. Although I was fairly convinced at this point that testosterone therapy was not a risk for prostate cancer, I had to admit that the evidence was not absolutely conclusive. And there was still a widespread belief that testosterone therapy was risky. And so our relatively sanitized conclusion appeared as follows:

“Thus, there appears to be no compelling evidence at present to suggest that men with higher testosterone levels are at greater risk of prostate cancer or that treating men who have hypogonadism with exogenous androgens increases this risk.”

Our article appeared in the *New England Journal of Medicine* in 2004. Whatever the truth may turn out to be regarding testosterone and prostate cancer, it was clear that raising testosterone did not appear to be like “food for a hungry tumor.” Physicians who had been interested in offering testosterone therapy to their patients but were worried about the cancer risk now had a reference article that gave them some degree of comfort.

Later that same year, the Institute of Medicine, a branch of the National Academy of Sciences, published its recommendations regarding testosterone research in aging men, with an eye toward ensuring the safety of men participating in testosterone studies. Recognizing the disparity between the concern that testosterone stimulates prostate cancer and the lack of any strong supporting evidence, the report concluded: “In summary, the influence of testosterone on prostate carcinogenesis and other prostate outcomes remains poorly defined . . .” The unwillingness of the report’s authors to identify testosterone as a definite risk for prostate cancer was a major departure from the standard story line that had colored earlier discussions of testosterone therapy and served as a nice bookend to our article on testosterone risks in the *New England Journal of Medicine*.

## DISCOVERIES IN THE BASEMENT OF THE COUNTWAY MEDICAL LIBRARY

As much as my year-long review of the scientific literature had given me confidence that testosterone therapy did not increase the risk of developing prostate cancer, there were still a few issues that disturbed me.

The first was the original observation by Huggins himself that administration of testosterone to men caused “enhanced growth” of prostate cancer in men with metastatic disease. A second was a well-known 1981 article from the Memorial Sloan Kettering Cancer Institute in New York, authored by the most prominent prostate cancer expert of his era, Dr. Willet Whitmore, that reported near-universal poor outcomes when men with metastatic prostate cancer received testosterone injections. And the third was the phenomenon known as testosterone flare. Testosterone flare refers to the temporary increase in testosterone caused by the use of medications called LHRH agonists in men with advanced prostate cancer. Testosterone flare has been associated with a variety of complications attributed to the sudden growth of prostate cancer.



All three of these issues applied only to men with known metastatic disease, and because no one was suggesting that testosterone therapy be offered to men with advanced prostate cancer, the existence of this literature wasn’t terribly troubling. What was of concern to those of us prescribing testosterone therapy was the possibility that we might be putting our otherwise healthy patients at risk for prostate cancer, but so far all the data looked reassuring on this point. Metastatic disease was something quite different, and it would not have been shocking to learn that it responded differently to high levels of testosterone than localized disease within the prostate.

But I was still bothered. I had read all the relevant articles years ago during my training, but not with a critical eye toward the relationship of testosterone and prostate cancer. One day, I found myself with an unexpectedly free afternoon and decided to investigate. Everything changed for me the day I descended into the basement of the Countway Library, Harvard Medical School’s incredible archive of medical literature. It was the most exciting day of my professional career, a day that changed my views on testosterone, prostate cancer, and, even more, on medicine itself.

## THE ORIGINAL HUGGINS ARTICLE

The basement of Countway Library is where the old volumes of medical journals are kept. Some of these, from august journals such as *The Lancet*, go back to the 1800s. It is an amazing collection, open to any member of the Harvard community.

I found the original article by Huggins from 1941. It was in the very first published volume of what is now a highly respected journal called *Cancer Research*. I read how Dr. Huggins and his coinvestigator, Clarence Hodges, used the new blood test called acid phosphatase to show that lowering testosterone by castration or estrogen treatment caused prostate cancer to regress, and how T injections had caused “enhanced growth” of prostate cancer in these men. And then I noticed something that made my heart race.

Huggins and Hodges had written that three men had received T injections. But results were given for only two men. And one of these men had already been castrated. This meant that there were results for only a single man who had received T injections without prior hormonal manipulation. Dr. Huggins had based his “enhanced growth” conclusion on a single patient, using a test—acid phosphatase—that has since been abandoned because it provides such erratic results!

I sat there in the basement of the library, reading the same lines over and over to make sure I hadn't misread it. Later, I asked several colleagues to read it as well. Dr. Huggins's assertion that higher testosterone caused greater growth of prostate cancer, repeated for so long and accepted as gospel, was based on almost nothing at all!

# REPORT

## Destroying the Myth About Testosterone Replacement and Prostate Cancer

By Abraham Morgentaler, MD, FACS Introduction By William Faloon

### THE MEMORIAL SLOAN KETTERING EXPERIENCE

I was still giddy when I decided to look up the article detailing the experience of testosterone administration to men with metastatic disease from the Memorial Sloan Kettering Cancer Institute, published in 1981 by the urologic giant of his day, Willet Whitmore, and his colleague, Jackson Fowler. The short summary of the paper was quite damning. Over a course of eighteen years, fifty-two men with metastatic disease had undergone treatment with daily T injections, usually as a last-gasp treatment for their cancer. Of these fifty-two men, forty-five had experienced an “unfavorable response,” most within the first month of treatment.



This seemed pretty grim. Maybe Huggins had been right after all, despite basing his conclusions on a solitary patient. But then I discovered something equally shocking in the fine print of this article. Of the fifty-two men studied, all but four had already been treated with castration or estrogen treatment to lower testosterone. And of these four previously untreated men, one had an early, unspecified unfavorable response, while the remaining three men continued to receive daily T injections for 52, 55, and 310 days without apparent negative effects. In fact, one of these men was reported to have had a “favorable response” to T administration.

Drs. Fowler and Whitmore were impressed by the difference in outcomes for the untreated group of four men compared with the men who had already undergone hormonal treatment to lower testosterone. To explain the lack of negative effects on the untreated men, the authors postulated the following: “Normal endogenous testosterone levels may be sufficient to cause near maximal stimulation of prostatic tumors.” In other words, raising testosterone levels beyond the normal range did not seem to cause any increased cancer growth, even in men with metastatic disease!

This important concept was lost in the headline of the study, which clearly indicated that giving testosterone to men with prostate cancer was associated with rapid onset of negative consequences in most men. One had to read the article closely to learn that the headline applied only to men who had been previously castrated. Although this article has been cited for many years as evidence that T administration causes rapid and near-universal growth of prostate cancer (PCa), the authors in fact clearly made the point that the worrisome effects of T administration did not appear to occur in their small group of men without prior hormonal treatment.

### TESTOSTERONE FLARE

It had been an amazing day in the library, which had long since turned to night. My head was spinning, but I wanted to tackle the last hurdle, the problem of testosterone flare. In the early 1980s, medications were developed to replace the need for surgical removal of the testicles for men with advanced prostate cancer. These medications are called LHRH agonists, and they continue to be used to this day. LHRH injections cause T concentrations to increase by 50 percent or more for seven to ten days, after which testosterone levels fall rapidly to castrate levels. This transient rise in testosterone is called testosterone flare.



Not long after LHRH agonists began to be used, there were reports of complications occurring after men began these treatments, and these complications were attributed to testosterone flare causing rapid growth of prostate cancer. These complications included the inability to urinate, worsening of bone pain, or, in the most tragic cases, paralysis due to collapse of a vertebra in which the cancer had eaten away the bone. As a result, for the last twenty years, it has been routine to add medications to block testosterone flare when starting a patient on treatment with LHRH agonists.

That night in the basement of Countway Library, I pulled all the original studies I could find of LHRH agonists, as well as reports of bad outcomes due to the flare. As I read, two things became apparent. First, many of the bad outcomes attributed to testosterone flare occurred a month or more after initiation of treatment. This meant that these complications occurred not when testosterone levels were high, but when testosterone levels had already dropped for some time to castrate levels.

Second, out of the substantial literature on LHRH agonists and prostate cancer, I could find only two articles that actually measured and reported PSA levels during the time of the testosterone flare. And here was the kicker: both articles showed

absolutely no change in mean PSA values during the time of the testosterone flare! Curiously, neither article so much as mentioned this result.

PSA is an excellent indicator of prostate cancer growth. The fact that PSA did not rise in these men during the testosterone flare strongly suggested that the cancers did not grow during this time. Perhaps the complications attributed to testosterone flare were nothing more than the cancer progression that would have happened without any treatment at all.

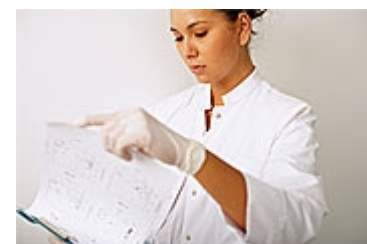
It had been quite a day and night in the Countway Library. I left with my head spinning and a feeling that I had stumbled onto something very important. It was like the children's story *The Emperor's New Clothes*—we see what we want to see. And for two-thirds of a century, it had been assumed that raising testosterone increased prostate cancer growth. But maybe the emperor was naked.

Even in men with metastatic disease, there was no evidence I could find that raising testosterone made prostate cancer grow more than it would have anyway. Shockingly, the very publications cited so regularly to demonstrate a dangerous relationship between testosterone and prostate cancer contained evidence that this was not true.

## THE PARADOX RESOLVED

Still, I was worried, because there was a bothersome unresolved paradox to explain. For decades, the storyline was that lowering testosterone levels caused prostate cancer to shrink away and raising testosterone levels caused it grow. The second part of this story was now seriously in doubt, yet the first part was obviously correct. In my own practice, I had seen the beneficial effects of lowering testosterone levels many times over in men with advanced prostate cancer. This part of Dr. Huggins's work was indisputable. But if lowering testosterone levels caused these cancers to shrink, how was it possible that raising testosterone levels did not cause the cancers to grow? This was a paradox that needed to be solved if physicians were to accept the possibility that testosterone therapy may not increase the risk of prostate cancer.

The answer turns out to be not all that complicated. All the reports of testosterone causing rapid growth of prostate cancer occurred in men who already had extremely low testosterone levels, due to castration or estrogen treatment. Once we get beyond the near-castrate range, it is hard to find any evidence that changes in T concentrations matter at all to prostate cancer. This is essentially what Drs. Fowler and Whitmore described in their 1981 article when they suggested that "near maximal" growth of prostate cancer is provided by naturally occurring T concentrations.



The experimental proof of this concept was provided by a landmark article published in 2006 using much more sophisticated means. In this study by Leonard Marks and colleagues, men with low testosterone received injections of testosterone or a placebo every two weeks for a total of six months. At the beginning and end of the study, measurements of testosterone and DHT (the more active form of testosterone within prostate tissue) were obtained from the blood and also from the prostate itself. The results showed that although blood concentrations of testosterone and DHT rose substantially in the T injection group, as expected, the concentration of testosterone and DHT within the prostate itself did not change at all and was similar to the group that received placebo injections. In addition, biochemical markers of prostate cell growth also did not change with T injections.

This study showed in elegant fashion that raising testosterone levels in the blood did not raise testosterone levels within the prostate. It is as if once the prostate has been exposed to enough testosterone, any additional testosterone is treated as excess and does not accumulate in the prostate. In technical terms, we say the prostate has been saturated with regard to testosterone. And it is this saturation that resolves the paradox of testosterone and prostate cancer.

Saturation explains the paradox in this way. At very low levels of T, near the castrate range, prostate growth is very sensitive to changes in T concentration. Thus, severely lowering testosterone will definitely cause prostate cancer to shrink; adding testosterone back will cause the cancer to regrow. However, once we get above the point where the prostate is saturated with testosterone, adding more testosterone will have little, if any, further impact on prostate cancer growth. Experimental studies suggest the concentration at which this saturation occurs is quite low.

In other words, the old analogy I learned in training was false. Testosterone is not like food for a hungry tumor. Instead, a much better analogy is, "Testosterone is like water for a thirsty tumor." Once the thirst has been satisfied, prostate tumors have no use for additional testosterone. And the vast majority of men with low testosterone appear to have prostates that are not particularly thirsty.

## A NEW CONCERN: PROSTATE CANCER AND LOW TESTOSTERONE

I no longer fear that giving a man testosterone therapy will make a hidden prostate cancer grow or put him at increased risk of developing prostate cancer down the road. My real concern now is that men with low testosterone are at an increased risk of

already having prostate cancer.

When my colleagues and I published our results in 1996 from prostate biopsies in men with low testosterone and PSA of 4.0 ng/mL or less, the 14 percent cancer rate was several times higher than any published series of men with normal PSA. In 2006, Dr. Rhoden and I published a larger study of prostate biopsies performed in 345 men. The cancer rate of 15 percent in this group was very similar to the first study. But whereas the cancer rate in 1996 was much higher than anything published to that date in men with PSA of 4.0 ng/mL or less, in 2006 the perspective had changed due to an important study called the Prostate Cancer Prevention Trial.



In that study, the cancer rate among men with a PSA of 4.0 ng/mL or less was also 15 percent. Because this value is identical to what we had found in our patients with low testosterone, it was suggested that the cancer rate in men with low testosterone is the same as the normal population—neither higher nor lower. However, the average age of men in our study was a decade younger than the men studied in the Prostate Cancer Prevention Trial (fifty-nine versus sixty-nine years). Almost half the men in the other study were seventy years or older, and age is the greatest risk factor we know for prostate cancer. The way I look at these numbers is that men with low testosterone have a cancer rate as high as men with normal T who are a decade older.

More importantly, in our study of 345 men, we found that the degree of testosterone deficiency correlated with the degree of cancer risk. Men whose testosterone levels were in the bottom third of the group were twice as likely to have cancer diagnosed on biopsy as men in the upper third. This finding adds to the concern that low testosterone is a risk factor for prostate cancer.

There is now additional data from around the world associating low testosterone and worrisome features of prostate cancer. For example, low testosterone is associated with more aggressive tumors. In addition, men with low testosterone appear to have a more advanced stage of disease at the time of surgical treatment.

Whereas I originally began to perform prostate biopsies in men with low testosterone because I was worried that treatment might cause a hidden cancer to grow, I now perform biopsies in these men because I am concerned they might have an increased risk of cancer. This risk is approximately one in seven for men with PSA values less than 4 ng/mL.

Because prostate cancer tends to be curable when caught early, I feel I've done these men a service by finding their cancers before they have an abnormal PSA or DRE. With today's ability to monitor men with prostate cancer, not all of these men will necessarily require treatment. But the ones who have evidence of more aggressive tumors should definitely have an advantage by having their diagnosis made early.

### **THE EVIDENCE AS IT NOW STANDS**

For over sixty-five years, there has been a fear that testosterone therapy will cause new prostate cancers to arise or hidden ones to grow. Although no large-scale studies have yet been performed to provide a definitive verdict on the safety of testosterone therapy, it is quite remarkable to discover that the long-standing fear about testosterone and prostate cancer has little scientific support. The old concepts, taken as gospel, do not stand up to critical examination. I believe the best summary about the risk of prostate cancer from testosterone therapy, based on published evidence at the time this book is written, is as follows:

Low blood levels of testosterone do not protect against prostate cancer and, indeed, may increase the risk.

High blood levels of testosterone do not increase the risk of prostate cancer.

Treatment with testosterone does not increase the risk of prostate cancer, even among men who are already at high risk for it.

In men who do have metastatic prostate cancer and who have been given treatment that drops their blood levels of testosterone to near zero, starting treatment with testosterone (or stopping treatment that has lowered their testosterone to near zero) might increase the risk that residual cancer will again start to grow.

One of the most important and reassuring studies regarding testosterone and prostate cancer was an article published in the *Journal of the National Cancer Institute* in 2008, in which the authors of eighteen separate studies from around the world pooled their data regarding the likelihood of developing prostate cancer based on concentrations of various hormones, including testosterone. This enormous study included more than 3,000 men with prostate cancer and more than 6,000 men without prostate cancer, who served as controls in the study. No relationship was found between prostate cancer and any of the hormones studied, including total testosterone, free testosterone, or other minor androgens. In an accompanying editorial, Dr. Carpenter and colleagues from the University of North Carolina School of Public Health suggest scientists finally move beyond the long-believed but unsupported view that high testosterone is a risk for prostate cancer.



Prostate cancer with infiltration into bladder, lymph nodes, and urethra.

More and more physicians are coming around to recognize that testosterone therapy is not a true risk for prostate cancer, but it can take many years to alter established beliefs. Don't be surprised if your own doctor still raises this issue with you if you are considering testosterone therapy. If he objects to treating you for that reason, you should refer him to the article above, or one of the other review articles listed in the References at the back of this book. Even better, have him read this chapter!

**Q.** I'm fifty-three years old and I've been on testosterone therapy for two years, with good results. However, my father was diagnosed with prostate cancer at age seventy-five. Does this mean I need to stop testosterone?

**A.** There is a familial form of prostate cancer, but only in families in which prostate cancer occurs at age sixty-five or younger. Even in those families where a family member develops cancer at a young age, this does not necessarily mean that every other male in the family will develop cancer. Men with a family history of prostate cancer should be sure to have a yearly PSA and prostate exam. There is no need to discontinue testosterone treatment.

**Q.** My physician started me on testosterone, but I never had a prostate biopsy. I am sixty-four years old. Was this a mistake?

**A.** Because there is no evidence that testosterone treatment increases the risk of prostate cancer, it is fine to begin therapy as long as your PSA and DRE are normal. My own practice is to recommend prostate biopsy in men with low testosterone because our published data indicate there is an increased risk that cancer is already present in men with low testosterone, but this is by no means a standard recommendation yet among physicians.

**Q.** Why do you perform prostate biopsies on men with low testosterone if you don't feel that testosterone treatment will make a hidden cancer grow?

**A.** Because so many men with prostate cancer will not die from it, even without treatment, there is a fair amount of controversy over how aggressive to be in making the diagnosis. My perspective is that it is worth knowing the diagnosis, whether or not one chooses to be treated immediately. And because low testosterone seems to represent a small but definite increased risk, I feel that biopsy in men over fifty with low testosterone is worthwhile.

**Q.** A man in my bowling league was started on testosterone treatment and then developed prostate cancer one year later. Doesn't that show that testosterone is risky for prostate cancer?

**A.** If the wife of this man had switched to a new type of laundry detergent before the cancer was diagnosed, would we assume the cancer was caused by the detergent? Of course not. But we are predisposed to believe that testosterone therapy causes prostate cancer, so it is easy to hear a story like this and assume that testosterone therapy caused the cancer. Prostate cancer and testosterone therapy are both common in the United States, and both tend to occur in the same age range, so there will always be stories of men developing cancer some time after beginning testosterone therapy. If testosterone really made prostate cancers grow, then we should see high rates of cancer among men who start testosterone therapy. But we don't. It's false logic.

**Q.** Isn't it true that all men would eventually get prostate cancer if they lived long enough? If so, why does it even matter if testosterone were to increase the risk of something that is inevitable anyway?

**A.** Men do get prostate cancer at an increasingly high rate as they age. And it is true that most men diagnosed with prostate cancer would never have a moment's trouble from it, even if it were left untreated, because most of these cancers grow so slowly that other medical conditions eventually become more troublesome. Yet for those with more aggressive forms of prostate cancer, the danger is very real. The challenge is to identify men at risk, because even high-grade prostate cancer is curable when caught early.

**Q.** It took more than thirty years for scientists to learn that hormones were dangerous for women and caused breast cancer. Isn't it possible we'll eventually find out the same is true for testosterone and prostate cancer?

**A.** The fear that hormone therapy is dangerous in women is currently being reevaluated, and it appears to not be as dangerous as was originally proclaimed. More to the point, it is critical to understand that men are not women and that testosterone is not estrogen. Anyone, particularly a scientist, must always allow for the possibility that new information will one day change current views. But after so much research over so many decades, there is little reason to believe that testosterone therapy poses a major risk for prostate cancer. As a medical student once said to me, "If testosterone is really so dangerous for prostate cancer, why is it so hard to show it?"



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## References

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- Agarwal PK, Oefelein MG. Testosterone replacement testosterone therapy after primary treatment for prostate cancer. *J Urol.* 2005 Feb;173(2):533-6.
- Araujo AB, Kupelian V, Page ST, et al. Sex steroids and all-cause and cause-specific mortality in men. *Arch Intern Med.* 2007;167:1252-60.
- Bhasin S, Singh AB, Mac RP, Carter B, Lee MI, Cunningham GR. Managing the risks of prostate disease during testosterone replacement therapy in older men: recommendations for a standardized monitoring plan. *J Androl.* 2003;24:299-311.
- Bhasin S, Storer TW, Berman N, et al. Testosterone replacement increases fat-free mass and muscle size in hypogonadal men. *J Clin Endocrinol Metab.* 1997;82:407-13.
- Bremner WJ, Vitiello MV, Prinz PN. Loss of circadian rhythmicity in blood testosterone levels with aging in normal men. *J Clin Endocrinol Metab.* 1983;56:1278-81.
- Carter HB, Pearson JD, Metter EJ, et al. Longitudinal evaluation of serum androgen levels in men with and without prostate cancer. *Prostate.* 1995;27(1):25-31.
- Cherrier MM, Craft S, Matsumoto AH. Cognitive changes associated with supplementation of testosterone or dihydrotestosterone in mildly hypogonadal men: a preliminary report. *J Androl.* 2003;24:568-76.
- Dobs AS, Meikle AW, Arver S, Sanders SW, Caramelli KE, Mazer NA. Pharmacokinetics, efficacy, and safety of a permeation-enhanced testosterone transdermal system in comparison with bi-weekly injections of testosterone enanthate for the treatment of hypogonadal men. *J Clin Endocrinol Metab.* 1999;84(10):3469-78.
- English KM, Steeds RP, Jones TH, Diver MJ, Channer KS. Low-dose transdermal testosterone therapy improves angina threshold in men with chronic stable angina. *Circulation.* 2000;102(16):1906-11.
- Gann PH, Hennekens CH, Ma J, et al. Prospective study of sex hormone levels and risk of prostate cancer. *J Natl Cancer Inst.* 1996;88(16): 1118-26.
- Greenstein A, Mobjeesh NJ, Sofer M, Kaver I, Matzkin H, Chen J. Does sildenafil combined with testosterone gel improve erectile dysfunction in hypogonadal men in whom testosterone supplement therapy alone failed? *J Urol.* 2005 Feb;173(2):341.
- Harman SM, Metter EJ, Tobin JD, et al. Longitudinal effects of aging on serum total and free testosterone levels in healthy men: Baltimore Longitudinal Study of Aging. *J Clin Endocrinol Metabol.* 2001;86(2):724-31.
- Hoffman MA, DeWolf WC, Morgentaler A. Is low serum free testosterone a marker for high grade prostate cancer? *J Urol.* 2000;163: 824-7.

Hsing AW. Hormones and prostate cancer: what's next? *Epidemiologic Rev.* 2001;23(1):42-58.

Huggins CB, Stevens RB, Hodges CV. The effects of castration on advanced carcinoma of the prostate gland. *Arch Surg.* 1941;43:209.

Hwang TI, Chen HE, Tsai TF, Lin YC. Combined use of androgen and sildenafil for hypogonadal patients unresponsive to sildenafil alone. *Int J Impot Res.* 2006;18:400-4.

Kaufman JM, Graydon RJ. Androgen replacement after curative radical prostatectomy for prostate cancer in hypogonadal men. *J Urol.* 2004 Sep;172(3):920-2.

Kupelian V, Page ST, Araujo AB, Travison TG, Bremner WJ, McKinlay JB. Low sex hormone binding globulin, total testosterone, and symptomatic androgen deficiency are associated with development of the metabolic syndrome in non-obese men. *J Clin Endocrinol Metab.* 2006;91:843-50.

Lazarou S, Morgentaler A. Hypogonadism in the man with erectile dysfunction: what to look for and when to treat. *Curr Urol Rep.* 2005;6:476-81.

Lazarou S, Reyes-Vallejo L, Morgentaler A. Wide Variability in Laboratory Reference Values for Serum Testosterone. *J Sex Med.* 2006;3:1085-9.

Marin R, Escrig A, Abreu P, Mas M. Androgen-dependent nitric oxide release in rat penis correlates with levels of constitutive nitric oxide synthase isoenzymes. *Biol Reprod.* 1999;61:1012-6.

Marks LS, Mazer NA, Mostaghel E, et al. Effect of testosterone replacement therapy on prostate tissue in men with late-onset hypogonadism: a randomized controlled trial. *JAMA.* 2006;296:2351-61.

McNicholas TA, Dean JD, Mulder H, Carnegie C, Jones NA. A novel testosterone gel formulation normalizes androgen levels in hypogonadal men, with improvements in body composition and sexual function. *Br J Urol.* 2003;91:69-74.

Morgentaler A. *The Viagra Myth: The Surprising Impact on Love and Relationships.* San Francisco, CA: Jossey-Bass/Wiley, 2003.

Morgentaler A, Crews D. Role of the anterior hypothalamus-preoptic area in the regulation of reproductive behavior in the lizard, *Anolis carolinensis*: Implantation studies. *Horm Behav.* 1978;11:61.

Morgentaler A, Bruning CO, III, DeWolf WC. Incidence of occult prostate cancer among men with low total or free serum testosterone. *JAMA.* 1996;276:1904-6.

Morgentaler A. Male Impotence. *Lancet.* 1999;354:1713-8.

Morgentaler A. Testosterone and the prostate: is there really a problem? *Contemporary Urol.* 2006;18:26-33.

Morgentaler A. Testosterone replacement therapy and prostate risks: where's the beef? *Can J Urol.* 2006;13:S40-3.

Morgentaler A. Testosterone therapy for men at risk for or with history of prostate cancer. *Curr Treatment Options Oncol.* 2006;7:363-9.

Morgentaler A. Testosterone and Prostate Cancer: An Historical Perspective On A Modern Myth. *Eur Urol.* 2006;50:935-9.

Morgentaler A, Rhoden EL. Prevalence of prostate cancer among hypogonadal men with prostate-specific antigen of 4.0 ng/ml or less. *Urology.* 2006;68:1263-7.

Morgentaler A. Testosterone and sexual function. *Med Clin N Am.* 2006;90:S32-4.

Morgentaler A. Cultural Biases and Scientific Squabbles: The Challenges to Acceptance of Testosterone Therapy As A Mainstream Medical Treatment. *Aging Male.* 2007;10:1-2.

Morgentaler A. Guideline for Male Testosterone Therapy: A Clinician's Perspective. *J Clin Endocrinol Metab.* 2007;92:416-7.

Morgentaler A. Testosterone Deficiency and Prostate Cancer: Emerging Recognition of an Important and Troubling Relationship. *Eur Urol.* 2007;52:623-5.

Morgentaler A. Testosterone replacement therapy and prostate cancer. *Urol Clin N Am.* 2007;34:555-63.

Morley JE, Kaiser FE, Perry HM, et al. Longitudinal changes in testosterone, LH and FSH in healthy older men. *Metabolism.* 1997;46(4):410-3.

Nieschlag E, Swerdloff R, Behre HM, et al. Investigation, treatment and monitoring of late-onset hypogonadism in males. ISA, ISSAM, and EAU recommendations. *Eur Urol.* 2005;48:1-4.

Oh JY, Barrett-Connor E, Wedick NM, Wingard DL. Endogenous sex hormones and the development of type 2 diabetes in older men and women: the Rancho Bernardo study. *Diabetes Care.* 2002;25:55-60.

Pope HG Jr, Cohane GH, Kanayama G, Siegel AJ, Hudson JI. Testosterone gel supplementation for men with refractory depression: a randomized, placebo-controlled trial. *Am J Psychiatry.* 2003;160:105-11.

Rhoden EL, Estrada C, Levine L, Morgentaler A. The value of pituitary magnetic resonance imaging in men with hypogonadism. *J Urol.* 2003;170:795-8.

Rhoden EL, Morgentaler A. Testosterone replacement therapy in hypogonadal men at high risk for prostate cancer: results of 1 year of treatment in men with prostatic intraepithelial neoplasia. *J Urol.* 2003;170:2348-51.

Rhoden EL, Morgentaler A. Treatment of testosterone-induced gynecomastia with the aromatase inhibitor, anastrozole. *Int J Impot Res.* 2004;16:95-7.

Rhoden EL, Morgentaler A. Influence of demographic factors and biochemical characteristics on the prostate-specific antigen (PSA) response to testosterone replacement therapy. *Int J Impot Res.* 2006;18:201-5. Shabsigh R. Testosterone therapy in erectile dysfunction. *Aging Male.* 2004;7:312-8.

Shores MM, Mocerri VM, Gruenwals DA, et al. low testosterone is associated with decreased function and increased mortality risk: a preliminary study of men in a geriatric rehabilitation unit. *J Am Geriatr Soc.* 2004;52:2077-81.

Shores MM, Matsumoto AM, Sloan KL, Kivlahan DR. Low serum testosterone and mortality in male veterans. *Arch Intern Med.* 2006;166:1660-5. Tenover JL. Testosterone replacement therapy in older adult men. *Int J Androl.* 1999 Oct;22(5):300-6.

Traish AM, Toselli P, Jeong SJ, Kim NN. Adipocyte accumulation in penile corpus cavernosum of the orchietomized rabbit: a potential mechanism for veno-occlusive dysfunction in androgen deficiency. *J Androl.* 2005;26:242-8.

Vermeulen A, Verdonck L, Kaufman JM. A critical evaluation of simple methods for the estimation of free testosterone in serum. *J Clin Endocrinol Metab.* 1999;84:3666-72.

The Institute of Medicine Report. Testosterone and Aging: Clinical Research Directions. Washington, DC: The National Academies Press, 2004.

Wang C, Swerdloff RS, Iranmanesh A, et al. Transdermal testosterone gel improves sexual function, mood, muscle strength, and body composition parameters in hypogonadal men. *J Endocrinol Metab.* 2000;85(8):2839-53.

Whitsel EA, Boyko EJ, Matsumoto AM, Anawalt BD, Siscovick DS. Intramuscular testosterone esters and plasma lipids in hypogonadal men: a meta-analysis. *Am J Med.* 2001;111(4): 261-8.

Zvara P, Sioufi R, Schipper HM, Begin LR, Brock GB. Nitric oxide mediated erectile activity is a testosterone dependent event: a rat erection model. *Int J Impot Res.* 1995;7:209-19.

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