The “climacterium virile”: from Lagueur’s hesitations to our legitimate hedging in 2003

R.R. Tremblay

Oncology and Molecular Research Center, Laval University, Quebec, Canada.

The promotion of male sexual hormones in early 1930 was not characterized by high expectations. Hombreol (crystalline testosterone) was suggested for three indications: 1. the climacterium virile; 2. the treatment of prostate hypertrophy (PH); 3. the relief of depression, melancholy and schizophrenia. What is the state of the art 70 years later? Urologists have forgotten that PH could be decreased by a better ratio between androgens and estrogens; psychiatrists have lost their beliefs that schizophrenia could be treated with testosterone. Andrologists and endocrinologists are optimistic people who claim that the best treatment for frank hypogonadism in young adults remains testosterone for life (they have no fears about prostate hypertrophy or cancer!), but when you put the focus on the climacterium virile, you frequently experience the feeling that they are yet coasting along with Ernst Lagueur in Amsterdam, with his hesitations dated 1930.

Practically speaking, the climacterium virile is a multifactorial clinical entity designated by the misnomer andropause, in Canada as well as in Korea, a condition generally ascribed to a progressive decline in active androgen levels with advancing aging. This vision will be eventually considered as a simplistic explanation of an imbalance between anabolic and catabolic forces that characterizes the aging phenomenon. As published by Tremblay (The Aging Male 4: 23-29, 2001), andropause has two levels of constituent structure; a level of “deep-structure” that requires long term research involvement and an actual level of “surface structure” that becomes progressively accessible to physicians. A short-term issue should be dealing with the enrichment of this “surface structure” around the world while awaiting for the definition of an unambiguous center embedding entity.

Thus, in function of the conceptual definition of andropause and depending on the emphasis that is ascribed to male hypogonadism as a major determinant of andropause, the biological testing to assess the physiological changes that occur with advancing age such as those implying cognitive and sexual functions, the decrease in muscle mass, the development of osteopenia and the increase in fat mass shall be mainly oriented to detect testosterone deficiencies. Notwithstanding this reductionist vision, andropause is not anymore an illegitimate subject in medical sciences. Physicians do their best to associate clinical symptoms of andropause with a low bioactive level of testosterone. They realize too that in no more than 20% of their andropausic patients there exists a useful questionnaire to guide them in their diagnosis; they criticize our inability to propose a bioactive testosterone threshold below which aged men are at risk for cardio-vascular disease and osteoporosis; on the contrary, they are excited by the benefits of testosterone therapy in half of their well selected patients, but still afraid by prostate cancer. Overall, we perceive a positive attitude in the medical profession and in the general public to support our efforts to improve our knowledge of the “deep-structure” of andropause.