International Journal of Endocrinology

Hindawi

Special Issue on

Male Hypogonadism and DHEA Deficiency: A Focus on Controversies in Replacement Therapy

CALL FOR PAPERS

Male hypogonadism is a condition related to low total testosterone (T) levels and its free fractions (FT); according to gonadotropin levels it can be classified as primary (i.e., testicular failure) or secondary (due to alterations of the hypothalamic-pituitary axis). Clinical manifestations strictly depend on the age of onset. If symptoms begin at a very early age, at birth, or before puberty, it can easily be diagnosed as most of its symptoms are typical (female or intersexual internal and external genitalia, hypospadias, absent or incomplete pubertal development, eunuchoid body proportions, persistence of prepubertal external genitalia, cryptorchidism, etc.). By contrast, the late-onset form is characterized by symptoms and signs that are often unspecific and mimic natural male ageing (weakness, obesity, fatigue, low libido, depression, mild anaemia, sleep disturbances and osteoporosis, type 2 diabetes mellitus, etc.) and cannot be easily diagnosed. Due to the very important role of testosterone, beyond sexual differentiation, secondary sexual characteristics, and reproductive activity, many organs and systems can be affected, including bone, cardiovascular systems, adipose tissue, and the nervous system.

A number of questions are still open in this field, starting from the definition of "low T" itself; both the extremes of reproductive life (i.e., delayed puberty and ageing) raise questions to clinicians about diagnosis and treatment. Moreover, testosterone deficiency is related to a constellation of metabolic symptoms and increased cardiovascular risk. Oxidative stress can underlie both complications. Heart failure is accompanied by anabolic deficiency, but many controversies are present in literature about advantages or risk of replacement therapy.

Hypogonadism induced by androgen deprivation therapy in patients affected by carcinoma of the prostate is another field with unsolved questions.

On the other hand, another important anabolic hormone is DHEA, produced in a great amount by the adrenal gland and testes. The low levels of this hormone are also difficult to be defined; therefore "DHEA deficiency" has no precise borders. Trials with DHEA administration have been performed, especially in the field of heart failure, chronic obstructive pulmonary disease, and cognitive disorders, but its employment in common approach to bedside patients is still underestimated.

The aim of the present issue is to explore new ideas about the physiopathological and clinical aspects of hypogonadism and DHEA deficiency, with a focus on controversies in replacement therapy. Review articles are accepted, but we would also encourage original papers.

Potential topics include but are not limited to the following:

- Controversies about the definition of hypogonadism and indication to replacement therapy
- Oxidative stress in hypogonadism and effects of testosterone administration
- Metabolic effects of androgen administration
- Bone turnover in hypogonadism
- Hypogonadism and prostate cancer; effects of androgen deprivation therapy
- Functional hypogonadism: medical alternatives to testosterone replacement therapy?
- Hypogonadism and cardiovascular disease: to treat or not to treat?
- DHEAS deficiency in males and its clinical application

Authors can submit their manuscripts through the Manuscript Tracking System at https://mts.hindawi.com/submit/journals/ije/astcnl/.

Papers are published upon acceptance, regardless of the Special Issue publication date.

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Submission Deadline
Friday, 13 September 2019

Publication Date
January 2020