

WHY DOCTORS FEARED TESTOSTERONE



FOR 70 YEARS, AND WHAT FINALLY CHANGED.

EVEN FOR MEN WHO ALREADY HAVE IT.

For anyone who wants the complete arc, from the single 1941 case that started the fear to real clinical experience treating testosterone-deficient men who already have prostate cancer.



TESTOSTERONE INTELLIGENCE · THE PAPERS
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A paper is the evidence: peer-reviewed, rigorous, the record of what is actually known.

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TESTOSTERONE INTELLIGENCE · THE PAPERS

WHY DOCTORS FEARED TESTOSTERONE FOR 70 YEARS

The 1941 Study That Started It, and the Evidence That Ended It

Rebellion Health's Testosterone and the Prostate Paper covered the saturation model and TRAVERSE. This companion Paper goes further, into the original 1941 source, a second historical myth about testosterone flare, and real clinical data on giving testosterone to men who already have, or have had, prostate cancer.

An 80-year taboo that shaped how millions of men were treated was built on one case.

ABRAHAM MORGENTALER, MD

PART ONE

THE ORIGIN, AND WHY IT LASTED SEVENTY YEARS

In 1941, Charles Huggins and Clarence Hodges published findings that castration or estrogen caused metastatic prostate cancer to regress, a discovery of genuine importance that later won Huggins the Nobel Prize and established androgen deprivation as the foundation of advanced prostate cancer treatment, a role it still holds today.

The same paper reported that testosterone caused a cancer marker to rise, and concluded that cancer of the prostate is activated by androgen injections, a conclusion resting on remarkably thin evidence, essentially a single patient. That second claim shaped medical practice for seven decades, hardening into the phrase every urologist of that era learned: giving testosterone was like pouring gasoline on a fire.

PART TWO

THE SATURATION MODEL, IN THE AUTHORS' OWN TERMS

In 2009, Morgentaler and Traish published the saturation model in *European Urology*, resolving the paradox directly. Prostate androgen receptors become fully occupied, saturated, at relatively low testosterone concentrations. Below that point, prostate tissue is highly sensitive to changes in testosterone, exactly why castration so dramatically shrinks the cancer. Above it, additional testosterone adds little to no further effect, because the receptors are already full.

A Second Historical Myth, Also Debunked

- Doctors long believed a temporary testosterone spike from LHRH agonist therapy, called T flare, could dangerously accelerate prostate cancer, prompting routine co-prescription of blocking drugs
- A 2019 review of the 1980-2016 literature found 5 of 6 studies showed no significant PSA rise during flare, and 3 separate randomized trials found no disease flare at all, even in men with widely metastatic disease

PART THREE

TESTING THE MODEL DIRECTLY, IN MEN WHO ALREADY HAVE THE DISEASE

Beyond theory, several groups have directly studied what happens when testosterone-deficient men who already have, or have had, prostate cancer receive testosterone therapy, a population the old paradigm would never have allowed near it.

- Active surveillance. Among men on active surveillance for low-grade prostate cancer, biopsy progression rates were similar whether or not they received testosterone therapy, and similar to historical controls.
- After radical prostatectomy. Among 850 men who had their prostate removed, those placed on testosterone replacement had a 54 percent lower estimated likelihood of biochemical recurrence, and recurrence, when it happened, was delayed by an average of 1.5 years, compared with matched untreated men.
- Biochemical recurrence and metastatic disease. In a case series of 22 men, including 13 with metastatic prostate cancer, mean testosterone rose from 210 to 1,111 ng/dL with no cases of rapid-onset complications, vertebral collapse, or pathological fracture, and 7 of 10 men with follow-up imaging showed no disease progression within 12 months. All patients reported improved vigor and well-being.

Read This Correctly

- These are smaller, non-randomized, hypothesis-generating studies, not definitive proof
- But they consistently point the same direction as the far larger, definitive TRAVERSE trial below, and represent a genuine test of the saturation model's predictions in the population with the most to lose if the old fear had been correct

PART FOUR

TRAVERSE SETTLES IT AT TRIAL SCALE

TRAVERSE's dedicated prostate-safety substudy followed 5,246 men for a combined 14,304 person-years. Incidences of high-grade prostate cancer, any prostate cancer, acute urinary retention, invasive prostate procedures, and new treatment for urinary symptoms were all low and did not differ significantly between testosterone and placebo groups: 12 total cases in the testosterone group versus 11 in placebo, with no meaningful signal in either direction.

In a 2025 personal reflection, Morgentaler calls this the most powerful piece of evidence to date, tracing his own career from insisting on biopsies before any testosterone prescription in 1988 to eventually treating a 94-year-old man with extensive bone and nodal metastases who could no longer tolerate standard androgen deprivation therapy.

These results provide conclusive evidence that testosterone therapy is not associated with increased prostate cancer risk.

PART FIVE

WHAT STILL MATTERS, EVEN WITH THIS EVIDENCE

- The saturation model applies to restoring deficient testosterone to a normal physiologic range, not to supraphysiologic dosing.
- Standard prostate monitoring, PSA and an exam before starting therapy, and ongoing monitoring during it, still matters. Testosterone can unmask a pre-existing, previously undetected cancer, which is exactly why screening remains part of responsible care.
- Men with active, high-risk, or rapidly progressing prostate cancer remain a specialized clinical situation requiring individualized urologic or oncologic judgment, not a blanket recommendation.

This resource is an educational overview drawing on the original 1941 Huggins and Hodges study, the saturation model literature, real-world clinical case data, and the TRAVERSE trial, with balancing caveats. It does not replace standard prostate screening or an individualized evaluation. Always consult your provider before starting, adjusting, or stopping any hormone therapy.