INTRODUCTION AND THE AIM OF THE WORK

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Testosterone therapy for men with infertility or erectile dysfunction, even if they are not specifically hypogonadal, is not uncommon (wilson and Griffin, 1980). It may be more common in the primary care setting than in andrological practice.

Androgens may cause fluid and nitrogen retention, increase . Skeletal muscle mass and increase erythropoiesis by stimulating the kidney to produce erythropoietin (Erslev, 1990), Cardiomegaly and decreased cardiac output (Hall and Hungerford 1982), decreased renal blood flow and hypertension (Molteni et al.. 1969) and sensitization of ∞ and β adrenergic receptors resulting in enhanced vascular reactivity (Greenberg et al., 1974) are added to the list.

In a carefully documented study, normal individuals given 200 mg of testosterone enanthate weekly or bimonthly for up to 10 months showed mild but significant increases in white blood cells, red blood cells, haematocrite and

haemmoglobin concentrations (Palacios et al.. 1983) Krauss et al.. (1991) confirmed the previous findings of Palacios et al.., however the literature is free from a comparative study between oral and intramuscular androgen therapy regarding their effects on blood indices.

The aim of the present study is to evaluate the safety of oral mesterolone and intramuscular injection of testosterone enanthate when given either empirically or to hypogonadal men on the blood indices.