

7. Testosterone supplementation as part of HRT

Dear [Dr _____],

Advice and guidance response pertaining to [Patient name].

(select as required)

Are there any related symptoms?

Prior to consideration of testosterone replacement assess other areas that may impact on libido

Adequate HRT replacement – testosterone therapy would not usually be considered without first trying HRT

- Assessment of vulvovaginal atrophy and use of vaginal oestrogens and lubricants to support sexual function
- Assessment of the pelvic floor where appropriate and onward referral to physiotherapists where pelvic floor dysfunction is interfering with intimacy
- Review of other medications that may negatively impact on sexual desire (e.g. SSRI /antihypertensives/B blockers)
- Relationship and psychological factors (this may include historic events and trauma)

The evidence has shown improvement in hyposexual desire in post-menopausal women only.

Considerations prior to testosterone therapy

- Women on oral oestrogens – especially conjugated equine oestrogen should be assessed for alteration of HRT regime to transdermal oestrogen – this switch can increase the proportion of circulating free testosterone and improve symptoms without the need for exogenous testosterone. Oral oestrogen can increase SHBG and thus reduce the efficacy of circulating testosterone in the body.
- Women would not usually be considered for testosterone therapy without being on HRT – testosterone alone can result in higher side effects.

Investigations

- Other causes of low libido as outlined above
- Blood tests to check **total testosterone levels** and liver function tests prior to commencing treatment
- Testosterone levels before treatment to establish a baseline and to ensure that levels are not in the upper range before treatment is commenced.
- Further levels are required within 3 months of commencing treatment at time of clinical review, again to ensure levels sit within normal female physiological range (lab reference ranges will vary across different laboratories)

Monitoring

- Total testosterone levels and clinical review are required every 6-12months – to ensure levels are within female physiological range and to assess response to treatment.
- Keeping levels within the female range reduces the risk of unwanted side effects.
- counselling for women

Common side effects are:

- Dark hair growth at the site of application is very common
- Acne, oily skin and increase in dark facial hair

- Male pattern hair loss (alopecia) – frontal (uncommon)
- Irritability/mood changes/aggression
- Deepening of the voice (v rare)
- Enlarged clitoris (v rare)

Treatment

No testosterone therapy is licenced for use in women in the UK - commonly used products:

- **Testim gel** 1% testosterone gel in 5ml tubes: Starting dose 0.5ml (5mg) per day; each tube lasts for 10 days
- **Tostran** (2% testosterone gel in a canister containing 60g): Starting dose 1 metered pump of 0.5g = 10mg on alternate days – each canister should last 240 days
- **Testogel** (2.5g sachets containing 40.5mg testosterone): Starting dose 1/8 of a sachet/day = approx. 5mg/day i.e. each sachet should last 8 days (*new formulation*)
- **AndroFeme cream** (1% testosterone cream in 50ml tubes with screw cap): Starting dose 0.5ml/day = 5mg /day i.e. each tube lasts 100 days (private prescription only)

Oral testosterone is not recommended

Duration

- A treatment trial is usually recommended for 3-6 months a clinical improvement
- If there is no improvement by 12 months it is usually recommended therapy be stopped.
- There is no recommendation to increase the dose above standard dose
- There are no trials looking at safety beyond 2 years but the use should be reassessed every 12 months as part of a holistic HRT review.

Contraindications to testosterone therapy

- Pregnancy and breastfeeding
- Active liver disease
- Hx of breast cancer (these women should be referred to secondary care if wishing to explore options)
- Competitive athletes
- Women who have upper limit of normal testosterone levels prior to consideration of treatment

Patients in whom the use of testosterone should be cautious:

- Testosterone may cause a rise in BP – women with either severe cardiac, renal, or ischemic heart disease.
- Patients on warfarin – INR monitoring around initiation requires close review because anticoagulant effect can increase.

Routine referral:

- Treatment trial in primary care is not supported by the ICB prescribing policy
- Failure to respond to treatment in women who would like a second opinion
- Women who have CI to HRT due to PMHx, who have tried alternative treatments and wish to discuss options e.g. Hx breast cancer.

Links to relevant national guidance, local guidelines and pathways:

BMS Testosterone replacement in menopause prescribing fact sheet:

[08-BMS-TfC-Testosterone-replacement-in-menopause-DEC2022-A.pdf](#)

BMS statement on Testosterone 26.7.24

[BMS Statement on Testosterone - British Menopause Society](#)

CKS HRT Prescribing:

[Hormone replacement therapy \(HRT\) | Prescribing information | Menopause | CKS | NICE](#)

Resources for patients

Information for patients: WHS factsheet – testosterone

[22-NEW-WHC-FACTSHEET-Testosterone-for-women-JAN2026-C.pdf](#)

If referring back, please state that the referral has already been through Advice and Guidance and include previous correspondence so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]