

The differences between the 2 cases (presentation of CAH, the need for genital reconstructive surgery, the nature of puberty) did not impair the fertility potential of these 2 patients during adulthood.

CONCLUSION

Management of CAH during pregnancy is important to ensure successful term delivery with no added pregnancy complications like gestational diabetes or hypertension.

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VIRILISING OVARIAN TUMOUR: A TERTIARY CENTRE EXPERIENCE

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INTRODUCTION/BACKGROUND

To determine the clinical features, a spectrum of imaging characteristics and histopathologic findings of virilizing tumours of the ovary.

CASE

A 69-year-old female presented with a 1-year duration of increasing hair growth over both arms and androgenic and male pattern facial hirsutism which needed facial hair trimming once a week.

She attained menarche and menopause at the age of 12 and 55 respectively. She was diagnosed with hypertension and Graves' disease at 30 years of age. She was clinically obese with a BMI of 30 kg/m², blood pressure 149/84 mmHg, deepening of voice and hirsutism score of 16. There was no clitoromegaly, no proximal myopathy, no cutaneous bruising or abdominal striae. The total testosterone level was >52.05 nmol/L (NR: 0.1-1.6) with normal ACTH, cortisol and DHEA-S. An abdominal CT scan showed a left ovarian mass measuring 7.3 x 7.4 x 5.4 cm with solid components and signs of peritoneal carcinomatosis; however, no calcification within the mass was noted. She underwent primary debulking total abdominal hysterectomy with bilateral salpingo-oophorectomy (TAHBSO), omentectomy and pelvic node dissection.

Histopathological examination demonstrated steroid cell tumour of the ovary. Post-operatively, testosterone levels reduced to normal and showed improvement of alopecia and hirsutism on follow-up 6 months later.

CONCLUSION

In post-menopausal women the appearance of signs of virilization and high testosterone levels should be

investigated systematically for underlying malignancy and to determine if the high testosterone levels are of an adrenal or ovarian origin. Failure of recognition will lead to a poor prognosis. In this patient, hematological investigations ruled out an adrenal cause however radiological imaging identified an ovarian etiology.

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WHAT TESTOSTERONE CONCENTRATIONS SHOULD WE EXPECT IN HEALTHY MEN?

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INTRODUCTION/BACKGROUND

Older men generally have lower testosterone concentrations compared with younger to middle-aged men. In aging men, lower testosterone concentrations are associated with poorer health outcomes. Understanding the relationship between testosterone and men's health status has implications for defining appropriate testosterone reference ranges to apply in clinical practice.

METHODOLOGY

Studies defining reference ranges for testosterone in selected groups of healthy men and meta-analyses of prospective cohort studies which analysed associations of testosterone with key health outcomes in community-dwelling men were identified. These studies used mass spectrometry to assay testosterone concentrations.

RESULTS

In 124 men aged 21-35 years with normal reproductive function, 95% confidence limits for testosterone were 10.4-30.1 nmol/L. In 1185 non-obese men aged 19-39 years, the range was 9.2-31.8 nmol/L. In 394 healthy men aged 70-89 years, the range was 6.4-25.7 nmol/L. Individual participant data (IPD) meta-analyses of 21,074 men from nine studies showed lower testosterone concentrations in men older than 70 years (with higher luteinising hormone), and in those with higher BMI, or with diabetes or cancer. Extension of these IPD meta-analyses showed non-linear associations of testosterone with all-cause and cardiovascular mortality risk. Men with low testosterone concentrations (<7.4 nmol/L) had higher all-cause mortality.

CONCLUSION

Reference ranges for testosterone in healthy younger to middle-aged men are higher than for healthy older men.