(p=0.87), medication changes (p=0.53) or CAC absolute score>0 (p=0.37) but was associated with score>100 (p=0.02).

CONCLUSIONS: A CVD screening and referral workflow can be easily implemented into the urology outpatient setting. In our cohort, a third of men evaluated by cardiology had medical management to reduce their CVD risk. Further efforts are needed to validate an ED-CVD questionnaire or other clinical markers to best identify men at the highest risk of future cardiac events.

Figure: Novel cardiovascular disease screening questionnaire for men presenting with erectile dysfunction (ED-CVD questionnaire)

If you have experienced the following symptom or have the listed condition, check the corresponding box:	Checkbox	Points
Chest pain in past 12 months (that has not been evaluated)	☐	4
High blood pressure	☐	1
High cholesterol	☐	1
Diabetes	☐	2
Active smoker (tobacco products) within past 3 years	☐	2
History of stroke or TIA (transient ischemic attack)	☐	2
Erectile dysfunction	☐ 49yo or less	4
	☐ 50yo or older	1
TOTAL POINTS (add the points next to each checkbox selected)		

Have you seen a cardiologist in the last three years?	☐ Yes	☐ No

Table: Baseline characteristics of low (<4) vs. high (≥4) scoring ED-CVD questionnaire groups of men

	Low score	High score	p value
Age (median, IQR)	66 (60,72)	55 (45,64)	<0.001
Race/ethnicity (n, %)			<0.001
White non-Latino	210 (77.5%)	98 (58.7%)	
Black non-Latino	22 (8.1%)	29 (17.4%)	
Latino	17 (6.3%)	29 (17.4%)	
Other	8 (3.0%)	9 (5.4%)	
Not reported	14 (5.2%)	2 (1.2%)	
Obesity by body mass index (n, %)			0.038
No (<30 kg/m^2)	184 (67.9%)	97 (58.1%)	
Yes (≥30 kg/m^2)	87 (32.1%)	70 (41.9%)	

Source of Funding: None

MP35-10

PREVALENCE OF HYPOGONADISM AND TESTOSTERONE SCREENING PRACTICES IN MEN WITH OSTEOPENIA AND OSTEOPOROSIS: A RETROSPECTIVE COHORT STUDY

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INTRODUCTION AND OBJECTIVE: Hypogonadism and osteoporosis are rising health concerns in aging men worldwide. Defined by testosterone levels below 300 ng/mL, hypogonadism is a major risk factor for low bone mineral density and accounts for 16−30% of secondary osteoporosis cases in men. Despite this, routine testosterone screening in men with osteopenia or osteoporosis remains uncommon. This study examined hypogonadism prevalence and testosterone screening and treatment practices in male patients with osteopenia and osteoporosis at a tertiary academic health center.

METHODS: Retrospective data were obtained from a single high-volume academic institution using ICD-10 codes from October 2015 to September 2024. The population for this cohort study consisted of 15,634 patients with hypogonadism, 10,159 with osteopenia, and 7,249 with osteoporosis. Demographic characteristics and clinical risk factors including sleep apnea, diabetes, anemia, obesity, and metabolic syndrome were also collected.

RESULTS: In this cohort (mean age 54, 64.4% white), hypogonadism was found in 8% of patients with osteopenia and 11% with osteoporosis. Patients with osteoporosis had 1.37 times higher odds of hypogonadism than those with osteopenia (OR 1.37, 95% CI: 1.24−1.51, p<0.001). Testosterone testing occurred in 23.9% of patients with osteopenia and 31.7% with osteoporosis, with osteoporosis patients being 47% more likely to be tested (OR 1.47, 95% CI: 1.37−1.57, p<0.00001). Low testosterone (<300 ng/mL) was present in about half of both groups. Testosterone replacement therapy was more common in patients with diagnoses of osteoporosis and hypogonadism (65.8%) than in osteopenia and hypogonadism (63.5%). Sleep apnea was the most common comorbidity (27%), followed by diabetes (20.6%) and anemia (13.1%).

CONCLUSIONS: This study highlights key links between hypogonadism, reduced bone density, and testosterone screening practices in men. Hypogonadism was more common in men with osteoporosis than with osteopenia, yet testosterone testing remains limited, with osteoporosis patients tested more frequently than those with osteopenia, suggesting a care gap. Of those tested, about half had low testosterone (<300 ng/mL) in both groups, and over 60% with hypogonadism received TRT. These findings underscore the need for routine testosterone screening in men with low bone density, especially in those with osteoporosis, to enhance hypogonadism diagnosis and management.

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MP35-11

EXPLORING THE HORMONE PROFILES OF MEN COMPLAINING OF LOW SEX DRIVE

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INTRODUCTION AND OBJECTIVE: Low Sex Drive (LSD) is a frequently reported but underestimated and misunderstood aspect of male sexual health. The prevalence of abnormal hormone profiles associated with LSD remains unclear. This study aims to evaluate the hormone profiles of men and their relationship with self-reported LSD

METHODS: This study evaluates men presenting to an academic sexual medicine clinic with self-reported LSD. Patients on androgen deprivation therapy and those with castrate TT levels (≤50 ng/dl) were excluded. Patients were asked to grade their sex drive using a 10-point scale, with LSD defined as ≤3. Demographics, comorbidity data, and hormone profiles were used to describe the patient cohort. Hormone profiles were assessed within 3 weeks of initial consultation. The endocrine panel included early morning total testosterone (TT, liquid chromatography-mass spectrometry) and free testosterone (FT, equilibrium dialysis). Prolactin, thyroid stimulating hormone (TSH), thyroxine (T4), and estradiol (E2) were also assessed using an immunoassay. Low TT was defined as ≤300 ng/dL, normal estradiol 10-40 pg/mL prolactin <20 ng/mL, TSH 0.4-4 mIU/L, T4 4-12 mcg/dL. A descriptive analysis and a comparative assessment were performed between patients reporting LSD and those without LSD.

RESULTS: 1147 men were evaluated with a median age of 60 (IQR 52, 68) years. The median sex drive score was 6 (4, 8). 25% reported LSD. Median TT was 297 (228, 397) ng/mL, FT 8 (6, 11) ng/mL, estradiol 17 (13, 24) pg/mL, prolactin 9 (7, 12) ng/mL, TSH 2 (1, 3) mIU/L, and T4 7 (6, 8) mcg/dL. Of those reporting LSD, 51% had low T, 14% had low E2, 7% had high prolactin levels, and 14% had abnormal TSH. No correlations were seen between TT (Pearson correlation -0.028, p-value 0.36) or E2 (Pearson correlation 0.017, p-value 0.59) and reported sex drive, and no differences in hormone profile or prevalence of abnormal levels were observed when comparing men with LSD to men without LSD (Table 1).

CONCLUSIONS: Hormone profiles of men complaining of LSD in this cohort did not significantly differ from those who did not self-report LSD. No correlation was observed between TT and sex drive.