MAGNOLIA FUNCTIONAL WELLNESS

Testosterone Replacement Therapy in DFW

What Men Over 30 Need to Know Before Starting

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TL;DR A significant portion of DFW hormone therapy clinics are NP-run operations with a physician on paper but not in your care. Texas law requires a collaborative agreement — it doesn't require the physician to see a single patient. At Magnolia, Dr. Farhan Abdullah, DO sees the vast majority of patients personally; every NP-managed case is reviewed with him directly. Beyond oversight: he requires two morning draws before diagnosis, evaluates LH/FSH on every initial panel, manages estradiol by labs at every follow-up, and assesses reversible suppressors before defaulting to replacement. The TRAVERSE trial (2023) confirmed properly monitored TRT doesn't increase cardiovascular risk. The question is whether your provider — and an actual physician — is managing it correctly.

What I See as a Hospitalist That Most TRT Doctors Never Will

I work inpatient medicine at Methodist Dallas and Methodist Southlake alongside running Magnolia. That means I see the long game — the 58-year-old admitted for his second cardiovascular event who's been metabolically dysregulated for fifteen years, the 62-year-old with accelerating cognitive decline and a testosterone that's been in the low 200s since his mid-40s, the man whose visceral adiposity and insulin resistance compounded quietly for a decade while his PCP told him his labs were 'basically normal.'

Most physicians prescribing TRT in DFW — certainly the telehealth platforms — never see what happens downstream when hormonal dysfunction goes unmanaged or undertreated. I do. It's a different clinical lens, and it shapes how I approach every TRT evaluation at Magnolia.

When I say TRT done correctly is preventive medicine, I'm not using marketing language. I'm describing what the evidence shows and what I've watched play out on both sides — in patients whose metabolic and hormonal health was optimized early, and in patients who spent a decade being dismissed.

The Specific Ways DFW TRT Clinics Are Failing Patients Right Now

These are the specific clinical failures I see in patients who come to Magnolia after being managed elsewhere — and the concrete reasons each one matters.

Failure 1: Diagnosing on a single afternoon testosterone level

Testosterone follows a strict diurnal rhythm — levels peak between 7 and 10 AM and can drop 20 to 30 percent by mid-afternoon in the same individual on the same day.[3] A man with a 3 PM total testosterone of 320 ng/dL may have an 8 AM value of 410 — a completely different clinical picture. At Magnolia, we require morning draws before 10 AM, and confirm borderline results with a second draw before initiating treatment. This is what the Endocrine Society guidelines actually recommend.[2] Most DFW clinics don't do it.

Failure 2: Skipping LH and FSH

LH and FSH distinguish primary hypogonadism (testicular failure — high LH/FSH, low T) from secondary hypogonadism (brain-signaling failure — low/normal LH/FSH, low T). The distinction changes treatment approach, fertility counseling, and whether a reversible upstream cause exists. The Endocrine Society explicitly recommends LH and FSH in every hypogonadism workup.[2] When I ask new patients whether their previous provider checked these, the answer is no more often than it should be.

Failure 3: No estradiol management protocol

Testosterone aromatizes to estradiol. Unmanaged estradiol elevation causes water retention, mood instability, gynecomastia, and erectile dysfunction — symptoms routinely blamed on TRT itself when estradiol was never checked. At Magnolia, estradiol is measured at baseline and every follow-up. Anastrozole is prescribed when lab-confirmed elevation is producing symptoms — not preemptively in every patient, because some men don't aromatize significantly.

Failure 4: Pellet-first protocols that eliminate dose flexibility

Pellets deliver sustained testosterone over three to six months with no dose adjustment possible once inserted. For a newly initiated patient whose estradiol climbs at week four or whose hematocrit rises faster than expected, that inflexibility is a clinical liability. Pellets have a role for stable, established patients with known hormone response. They're not the right starting protocol for most new patients.

Failure 5: Treating testosterone in isolation from the metabolic picture

Low testosterone and metabolic dysfunction are bidirectionally related — each worsens the other. Central obesity increases aromatase activity, converting testosterone to estradiol, which suppresses the HPG axis further. Starting TRT without addressing the metabolic picture produces suboptimal results and misses the opportunity to change the trajectory. Evaluating insulin, thyroid, cortisol, and sleep alongside testosterone isn't a premium service. It's internal medicine.

Failure 6: No physician actually involved in your care

This one doesn't get said out loud in DFW, but it's the most important failure to understand.

Texas is a restricted practice state — NPs cannot prescribe or manage patients independently. They're required by law to have a collaborating physician with a signed prescriptive authority agreement on file. That sounds like meaningful oversight. In practice, it often isn't.

The law requires that the agreement exist and that it specify how chart review will be handled. It does not require the physician to see any specific percentage of patients. It does not require real-time review. It does not require the physician to ever set foot in the clinic. A physician can satisfy the legal requirement by signing an agreement that mandates quarterly review of a random chart sample — while an NP sees hundreds of patients independently between those reviews. There's an active marketplace of physicians who sign these agreements for a monthly fee, with minimal involvement beyond the paperwork.

> **What this means practically:** A significant portion of DFW hormone therapy clinics are NP-run operations with a physician medical director who may never interact with your care. The 'physician-led' language on the website reflects a legal compliance structure, not a clinical involvement standard. You won't know the difference from the outside unless you ask directly.

NPs are skilled clinicians within their training and scope. The problem isn't the NP. The problem is that hormone optimization — managing estradiol, hematocrit, thyroid interactions, cardiovascular risk, medication conflicts, primary vs. secondary hypogonadism — requires clinical judgment that goes beyond protocol-based care. When a case gets complicated, a protocol doesn't adapt. A physician does.

At Magnolia, Dr. Abdullah sees the vast majority of patients personally. For cases handled by our NP, every case is reviewed directly with Dr. Abdullah — not sampled, not retrospectively audited months later. Reviewed. The physician oversight at Magnolia is a clinical standard, not a compliance checkbox.

What the TRAVERSE Trial Actually Settled — and What It Didn't

For nearly two decades, cardiovascular risk was the primary reason physicians hesitated on TRT. That concern was based largely on two methodologically weak studies from the early 2010s. The TRAVERSE trial — 5,246 men, randomized, placebo-controlled, powered specifically for cardiovascular outcomes — resolved the question in 2023.[5]

> **The finding:** Testosterone replacement therapy in hypogonadal men with established cardiovascular disease or high cardiovascular risk does not increase the rate of major adverse cardiovascular events compared to placebo. Heart attack, stroke, cardiovascular death — no significant difference. That's Level 1 evidence. The cardiovascular hesitancy that kept appropriately indicated TRT from symptomatic men for years is no longer scientifically defensible.

What TRAVERSE did confirm: modestly higher rates of hematocrit elevation and atrial fibrillation in the testosterone group. This is the monitored risk — not a reason to withhold treatment, but a reason to monitor it properly. At Magnolia, CBC is checked at six weeks, three months, and every six months on a stable protocol. Hematocrit above 52 to 54 percent triggers dose adjustment or therapeutic phlebotomy before it becomes a clinical problem.

The cardiovascular argument against TRT has been settled by Level 1 evidence. The argument for structured monitoring has been strengthened. Both conclusions point to the same place: physician-managed TRT with fixed follow-up is the standard. Everything else is a workaround.

The Magnolia Protocol: Specifically What We Do Differently

These are hard, attributable standards — not descriptions of good care in general, but the specific protocols Dr. Abdullah applies at Magnolia Functional Wellness.

Two morning draws before diagnosis. Borderline testosterone values are confirmed with a second morning draw before any prescription is written. A single afternoon value is not a diagnosis.

LH and FSH on every initial panel. We distinguish primary from secondary hypogonadism on every evaluation. The clinical picture and treatment approach differ depending on the answer.

Full thyroid panel including reverse T3. TSH alone misses patients who convert T4 to reverse T3 instead of active T3. We check TSH, free T3, free T4, and reverse T3. I've had patients whose primary problem was thyroid, not testosterone — and they'd been told their thyroid was fine for years.

Estradiol at every follow-up, anastrozole by labs not protocol. Estradiol is checked at baseline, six weeks, three months, and every six-month visit. Anastrozole is prescribed when lab-confirmed elevation is producing symptoms — not automatically added to every protocol.

Fertility discussed before the protocol starts. Men with fertility goals in the next one to three years are counseled on hCG monotherapy or clomiphene before a suppressive protocol is initiated. This conversation happens at the first visit.

Hematocrit surveillance on a fixed schedule. CBC at six weeks, three months, and every six months. Hematocrit above 52 to 54 percent triggers dose reduction or therapeutic phlebotomy. Non-negotiable.

Six-week follow-up timed to trough. The first follow-up draw is timed to the morning before the next injection dose — the lowest point of the dosing cycle. This is the clinically relevant measurement for dose management. Random-draw follow-up levels are not meaningful for titration.

Metabolic and cardiovascular context built into baseline. Cardiovascular history, insulin, HbA1c, lipid panel, blood pressure, sleep history — part of the baseline evaluation, not a separate service tier. This is how I think about every patient from internal medicine training.

Who Should and Shouldn't Be on TRT — The Honest Version

Most TRT marketing glosses over contraindications. Here's the honest clinical picture.

Strong candidates: Men with total testosterone consistently below 300–350 ng/dL on two separate morning draws, or free testosterone in the lower quartile with a significant SHBG-adjusted deficit, and a meaningful symptom burden after reversible causes have been evaluated.

Men who need a different approach first: Untreated obstructive sleep apnea, significant obesity (BMI above 35), severe hypothyroidism, hyperprolactinemia, or active opioid use can all produce a testosterone picture indistinguishable from primary hypogonadism. Treating the testosterone without addressing these is treating the symptom instead of the cause.

Men with active fertility goals: Standard TRT suppresses sperm production. hCG monotherapy or clomiphene citrate maintains endogenous testosterone while preserving spermatogenesis. This distinction doesn't get made in a ten-minute telehealth visit.

Men with active, untreated prostate cancer: Hard contraindication. History of treated, localized prostate cancer in remission is a case-by-case discussion requiring urologic input.

The Question I Get More Than Any Other

It's some version of: 'My doctor checked my testosterone and said it was normal. But I still feel terrible. What's going on?'

Here's what's usually going on. Population reference ranges for testosterone are derived from cross-sectional studies that include elderly and chronically ill men. 'Normal' by that standard means you're not in the bottom of a population that includes 80-year-olds with multiple comorbidities. It doesn't mean your levels are optimal for a 42-year-old trying to function at full capacity.

Additionally: a high SHBG makes a 'normal' total testosterone functionally deficient. A 42-year-old with total testosterone of 420 ng/dL and SHBG of 68 nmol/L has a free testosterone in the lower range of normal — potentially symptomatic, potentially worth treating. Evaluating total testosterone alone against a population reference range is one of the least complete ways to assess androgenic status. It's also the most common basis on which men get dismissed.

At Magnolia: The evaluation doesn't end at a single number. It ends when we have a complete clinical picture — free testosterone, SHBG, LH, FSH, estradiol, thyroid, metabolic markers, symptom burden, and contributing factors all accounted for.

Frequently Asked Questions

What does the full initial workup look like at Magnolia, specifically?

Total testosterone (morning draw, before 10 AM), free testosterone, SHBG, LH, FSH, estradiol, prolactin, CBC with differential, comprehensive metabolic panel, lipid panel, TSH, free T3, free T4, reverse T3, PSA (men over 40), HbA1c, and fasting insulin. Results reviewed directly with Dr. Abdullah. If a borderline testosterone value comes back, a second morning draw is ordered before any treatment decision is made.

How long before I notice results?

Energy and mood: typically two to four weeks. Libido: four to eight weeks. Body composition — lean mass up, visceral fat down — requires three to six months with consistent resistance training. Full protocol optimization: typically by months three to four. Anyone telling you significant body composition changes happen in six weeks is overselling it.

What happens if I stop TRT?

Exogenous testosterone suppresses your HPG axis. When you stop, recovery takes weeks to several months and levels don't always return to exactly where they were pre-treatment — particularly after years of suppression. Recovery protocols using hCG and/or clomiphene can help stimulate HPG axis recovery. This is a real consideration to discuss before starting, not discover as a surprise when you want to stop.

Is there a meaningful difference between injections and pellets?

Yes — and it matters most in newly initiated patients. Injections allow precise dose adjustment based on follow-up labs. If estradiol goes high or hematocrit climbs, the dose changes at the next injection. Pellets, once inserted, deliver a fixed dose for three to six months with no adjustment possible. Pellets have a role for stable, established patients with known hormone response. They're not the right starting protocol for most new patients.

Why does it matter that Dr. Abdullah is also a hospitalist?

Most TRT prescribers never see the downstream consequences of hormonal and metabolic dysfunction that goes undertreated for years. Working inpatient medicine means Dr. Abdullah sees those consequences directly — the cardiovascular admissions, metabolic crises, cognitive decline trajectories. That clinical context shapes how he thinks about preventive hormonal optimization in ways that a clinic seeing only the front end of the problem cannot replicate.

How do I know if a clinic actually has a physician involved in my care?

Ask directly: 'Will I see the physician at my initial evaluation, or an NP?' and 'If I'm managed by an NP, how frequently does the physician review my case?' A clinic with genuine physician oversight will answer both questions specifically. A clinic running a compliance structure will hedge. In Texas, the collaborative agreement required by law doesn't mandate any minimum patient contact by the physician — it just has to exist. The legal requirement and clinical involvement are two different things, and the gap between them is where most of the variability in DFW hormone therapy quality actually lives.

Do you see patients outside of Southlake?

Yes. Telehealth consultations are available for patients across Texas. Initial lab work is ordered to a draw site near you; ongoing management is handled remotely for established patients. The evaluation is identical regardless of in-person or telehealth — same panel, same protocol standards, same follow-up schedule.

References & Further Reading

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7. Magnolia Functional Wellness — Women's HRT: magnoliafunctionalwellness.com/services/womens-hormone-replacement-therapy-southlake

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