

# The Endocrinologist

THE NEWSLETTER OF THE SOCIETY FOR ENDOCRINOLOGY • ISSUE 84

SUMMER 2007

## Retail Therapy?

### PLUS

Hormones  
at the heart  
of toxicology

**BSF promotes  
practical skills**

Defying the doubters:  
the origins of ICE





► Welcome to the summer issue of *The Endocrinologist*! Already the football season is just a distant memory and the cricket season is upon us. Ah, the sound of rain dripping onto covers. Now that's what summer is really about.

Summer is also the conference season. In his latest dip into the archives (page 13), Gavin Vinson reminds us of the early debate about the value of international conferences. He suggests that such a discussion would be unlikely today, but in this increasingly carbon-conscious age I suspect we may revisit it soon.

Endocrinologists get about a bit you know. On page 16 you will find an account by Ieuan Hughes of his work as an endocrinologist chairing the Food Standards Agency's Committee on Toxicity. I have the great pleasure of serving on this committee with Ieuan, and I can confirm that we get some funny stuff to consider. It's quite an eye-opener. I am sure that there are other members doing interesting work like this. Do drop me a line and let me know what you're up to.

On page 4 we congratulate the prize winners from BES 2007 in Birmingham. It was an excellent meeting: well done to the local organising committee! Judging the young endocrinologists' prizes was a tough job, and the standard was most impressive.

Have you ever sat in a meeting listening to a medal lecture thinking, 'I wonder why Professor Jolly Excellent from the Department of Superb Endocrinology has never won a medal?' It may be because nobody nominated her. Now's your chance. Turn to page 7 for the call for nominations for medallists. It is important that these awards reflect the views of Society members, so do have your say.

We need your help in assessing abstracts for future BES meetings, as we seem to be a bit short of assessors in the pituitary category. Details are on page 6. We are also looking for nominations to serve on some of the Society's committees. This is an excellent way to get involved in what goes on in your Society, so see page 4 to find out more. On page 6 we focus on the activities of the Secretariats team in the Bristol office, who provide important support to a wide range of learned societies.

Once again, Tom Parkhill reveals just how he spends his time. Now he's been trying to buy hormonal products online. Turn to page 15 to see what he found! Meanwhile, don't miss Hotspur, who is back on page 17.

Of course Summer is also the exam season. It seems to get longer each year. This year we seem to be running exams constantly from May to early August. We then get 2 weeks off before starting again with resit exams at the end of August. With medicine finals moved to February, it's starting to feel like an all-year exam season. It can be really discouraging to read what a student writes in an exam and think, 'What complete idiot taught these students their endocrinology?', only then to realise that it was you. I am only kept sane when I'm marking 70 essays in a weekend by laughing at the daft things they write. I'm sure that you have examples of silly or funny endocrinology exam answers. Email them to me and we'll publish a selection of the best in the next issue, which will be a special issue on education. There will be a small prize for the one that makes me laugh the most!

Have a good Summer.

JOY HINSON  
(j.p.hinson@qmul.ac.uk)



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#### 2007 Advertising Rates

Advertise your event in *The Endocrinologist*!  
Members: Mono - Half page £110  
Mono - Full page £170  
Others: Mono - Half page £325  
Mono - Full page £500  
Colour - Full page £1300

Deadline for news items for the Autumn  
2007 issue: **27 July 2007**. Please send  
contributions to the above address.

# Clinical Excellence Awards 2008

► The Clinical Excellence Awards scheme seeks to reward those who make the biggest contributions to delivering and improving healthcare. This can be either through clinical service or through teaching and research in academic medicine. Following the Society's success in supporting members' nominations in previous years, we are pleased to be able to offer this service again for the 2008 round.

We can provide bronze, silver, gold and platinum award support to consultants (including honorary consultants) who have been in post for more than 1 year. The Society can only support a limited number of applications, so please contact Rachel Evans at the Bristol office ([rachel.evans@endocrinology.org](mailto:rachel.evans@endocrinology.org)) as soon as possible if you wish the Society to support your nomination.

All applications for Society support must be submitted by Friday 14 September in order to start the support process for 2008, though we do realise the results of the 2007 round will not be known by then.

Further details for members in England can be found at [www.advisorybodies.doh.gov.uk/accea/index.htm](http://www.advisorybodies.doh.gov.uk/accea/index.htm), for those in Scotland at [www.sacda.scot.nhs.uk/guide%20&%20forms/main.htm](http://www.sacda.scot.nhs.uk/guide%20&%20forms/main.htm), for those in Wales at [www.wales.nhs.uk/page.cfm?pid=3928](http://www.wales.nhs.uk/page.cfm?pid=3928) and for those in Northern Ireland at [www.dhsspsni.gov.uk/index/hss/clinical\\_excellence\\_awards\\_scheme.htm](http://www.dhsspsni.gov.uk/index/hss/clinical_excellence_awards_scheme.htm).

## CLINICAL EXCELLENCE AWARD PANEL

### Call for members

► We have supported many Society members in the Clinical Excellence Awards over the past 2 years. This has been possible thanks to our panel of A or A+ award holders, who support Society members seeking awards at level 9 and above.

To continue our support, we must periodically rotate members off the panel. In readiness for the 2008 Clinical Excellence Awards, we therefore need two members to join this group.

If you currently hold a platinum award (A or A+ equivalent), and would like to contribute to this scheme to support nominations for Clinical Excellence Awards, please contact Rachel Evans ([rachel.evans@endocrinology.org](mailto:rachel.evans@endocrinology.org)) at the Bristol office by 3 September 2007.

## Clinical Endocrinology free to Junior Members

► Junior Members are now eligible for free online access to *Clinical Endocrinology*. If you have not received an email about this offer from Blackwell Publishing, please contact [christine.davis@endocrinology.org](mailto:christine.davis@endocrinology.org).

## DON'T LOSE TOUCH!

► Changes to how we manage our membership database will soon provide you with more streamlined services: for instance, the ability to renew your subscriptions online. We will increasingly use email as a means of contacting you. If you don't receive regular emails from the Society then it means we don't have your correct email address. To ensure continuity, please contact [christine.davis@endocrinology.org](mailto:christine.davis@endocrinology.org) with your most up to date email details.

**Congratulations...** to Wiebke Arlt from the University of Birmingham, who has been awarded a personal chair in medicine.

## Hosts needed for Clinical Cases Meetings

► Would your centre like to host a regional Clinical Cases Meeting? We are increasing the number of meetings from one to three per year, and are looking for suitable venues. These half-day meetings normally attract up to 100 delegates, and have a small commercial exhibition. They could be run in association with any planned regional endocrine club meeting. For further details, please contact [julie.cragg@endocrinology.org](mailto:julie.cragg@endocrinology.org).

## BES 2009: CALL FOR SCIENTIFIC SUGGESTIONS

► If you would like to suggest topics for the Society for Endocrinology BES meeting in 2009, look out for the form included with this mailing. All ideas will be considered by the Programme Committee when it meets to set the scientific sessions. The form must be returned by 29 February 2008. Additional copies of the form are available at [www.endocrinology.org/](http://www.endocrinology.org/).

## Voting rights

► In spring 2008, all Ordinary Members will be asked to vote for Officers and Council Members. You will only be eligible to vote if your membership is in good standing. Please ensure therefore that your subscriptions are paid promptly when you receive your renewal invoice in October this year.

### SOCIETY CALENDAR

4-6 September 2007  
**Endocrine Nurse Training Course**  
University of Glasgow

5-7 November 2007  
**Clinical Update**  
Renaissance Manchester Hotel

26 February 2008  
**Society for Endocrinology Clinical Cases Meeting**  
RSM, London

7-10 April 2008  
**Society for Endocrinology BES 2008 Meeting**  
Harrogate International Conference Centre



# PRIZE WINNERS AT BES 2007

► Our first annual Society for Endocrinology BES meeting in Birmingham was a great success! A total of 922 people attended over the 4 days of the meeting, and 27 companies had displays in the exhibition. Among the wide range of sessions, delegates enjoyed 8 excellent plenary lectures.

Many awards were presented for outstanding work, with 19 prizes awarded to young endocrinologists. Our congratulations go to all the winners.

The recipients of £500 prizes for oral communications were Owais Chaudhri (London) for the abstract 'Kisspeptin-54 potently stimulates luteinising hormone release during the preovulatory phase of the menstrual cycle in healthy human females', and Manuel Lemos (Oxford) for 'Mice deleted for a multiple endocrine neoplasia type 1 (MEN1) allele develop pancreatic, pituitary and parathyroid tumours in association with hypercalcaemia'.

The overall winners in the poster section, who also each received a prize of £500, were Irina Grigorieva (Oxford), for her poster 'Mechanisms of DNA binding by the transcription factor GATA3 revealed by mutations causing the hypoparathyroidism-deafness-renal dysplasia (HDR) syndrome', and Elaine Murphy (London), for 'T3 rather than TSH mediates the effects of altered thyroid status on bone turnover in man'.

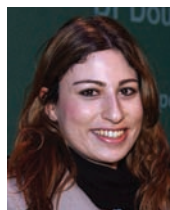
The other winners for individual categories within the poster section each received £100. The winner in the 'Bone' category was Patrick O'Shea (London), while in 'Clinical practice/governance and case reports' the recipients were Teng-Teng Chung (London) and David Carty (Glasgow), and the 'Comparative' section was won by Fadi Hannan (Oxford). 'Diabetes, metabolism and cardiovascular' winners were Daniel Morganstein (London) and Kylie Hewitt (Birmingham), while Vicki Smith (Birmingham) and Gelsy Arianna Lupoli (Naples, Italy) received the prizes in the 'Endocrine tumours and neoplasia' category. The 'Growth and development' category was won by Michael Bowl (Oxford) and Su-Ping Chang (Edinburgh), 'Neuroendocrinology and behaviour' by Alexandra Sinclair (Birmingham), and 'Reproduction' by Sharron Stubbs (London). Roland Stimson (Edinburgh) and Andrew Berry (Manchester) led the 'Steroid' section, while Elizabeth Kemp (Sheffield) wrote the winning 'Thyroid' poster.

Congratulations are also due to Pat Pickett from Shrewsbury, who was randomly selected to receive £100 for completing a conference evaluation form.

We're already looking forward to 2008 in Harrogate!



From left to right:  
Elaine Murphy  
(overall poster winner)  
Manuel Lemos  
(oral communication winner)  
Scott MacKenzie  
(Novartis award winner)



From left to right:  
Robert Semple  
(oral communication winner)  
Irina Grigorieva  
(overall poster winner)  
Chrisanthia Leontiou  
(AMEND winner)



From left to right:  
Owais Chaudhri  
(oral communication and  
Novartis award winner)  
Sally James (British Thyroid  
Association award winner)  
Gareth Lavery (oral  
communication winner)

## COMMITTEES CALL FOR NOMINATIONS

► Here's your chance to have a say in the running of your Society! We are seeking new members for the following committees. Unless otherwise stated, terms of office start on 1 January 2008 and most run for 4 years. Full committee remits and nomination forms can be found at [www.endocrinology.org/about/committee.html](http://www.endocrinology.org/about/committee.html). Forms should be returned to the Bristol office by 31 July 2007.

**Clinical** - 1 vacancy which we particularly hope will be filled by a member representing the therapeutic area of 'bone', plus 1 vacancy for a specialist registrar. As well as attending meetings of the Clinical Committee, the elected specialist registrar will also represent the Society at certain committee meetings of the Royal College of Physicians.

**Finance** - 1 vacancy (commencing 1 December 2007). Nominees must have experience of operating a large budget and a sound knowledge of investments and management accounts. They should have a good understanding of the Society's activities and ethos. If you would like to be considered for election, and would like further details, please contact Pat Barter, Finance and Administration Director, at the Bristol office ([pat.barter@endocrinology.org](mailto:pat.barter@endocrinology.org)).

**Nurse** - 4 vacancies. Note that all Society members can nominate members for the Nurse Committee.

**Programme** - 4 vacancies. We are particularly interested in receiving nominations to represent the areas of pituitary, diabetes, paediatric/growth/puberty and adrenal/ovary/intersex. This committee sets the scientific programme for the Society BES meetings. As it meets only once per year, it is essential that you attend this meeting if you are elected. The committee will meet next on Wednesday 23 April and Thursday 24 April 2008, and this will involve an overnight stay.

**Science** - 3 vacancies. We would like to recruit members to represent the areas of diabetes, neuroendocrinology and androgens.

# The injection device has just grown up



**Prescribing Information - UK and Ireland** (Please refer to the Summary of Product Characteristics for further information) **SAIZEN® 8 mg click.easy™ powder and solvent for solution for injection Somatropin (recombinant human growth hormone)**  
**Presentation** Each multi-dose vial of SAIZEN® contains Somatropin 8 mg as a powder, accompanied by a cartridge of solvent containing 1.37 ml of 0.3% w/v metacresol in water for injections. **Indications** The treatment of growth failure in children caused by decreased or absent secretion of endogenous growth hormone; Growth failure in girls with gonadal dysgenesis (Turner Syndrome); Growth failure in prepubertal children due to chronic renal failure; Growth disturbance (current height SDS < -2.5 and parental adjusted height SDS < -1) in short children born small for gestational age (SGA) with a birth weight and/or length below -2 SD, who failed to show catch-up growth (HV SDS < 0 during the last year) by 4 years of age or later; Replacement therapy in adults with pronounced growth hormone deficiency who must also fulfil the following criteria: **Childhood onset:** Patients diagnosed as growth hormone deficient during childhood must be re-tested and deficiency confirmed before start of replacement therapy with Saizen. **Adult onset:** Patient must be growth hormone deficient as a result of hypothalamic or pituitary disease and have at least one other hormone deficiency diagnosed (except for prolactin) and adequate replacement therapy instituted before treatment with growth hormone. **Dosage and Administration**

Saizen 8mg click.easy with the appropriate auto-injector is for multiple dose use. The dose is given by subcutaneous administration. It is recommended that Saizen is administered at bedtime. **Growth failure due to inadequate secretion of endogenous growth hormone:** 0.7-1.0 mg/m<sup>2</sup> body surface area per day or 0.025-0.035 mg/kg body weight per day. **Growth failure due to Turner Syndrome:** 1.4 mg/m<sup>2</sup> body surface area per day or 0.045-0.050 mg/kg body weight per day. Concomitant therapy with non-androgenic anabolic steroids can enhance growth response. **Growth failure in prepubertal children due to chronic renal failure:** 1.4 mg/m<sup>2</sup> body surface area per day, approximately equal to 0.045-0.050 mg/kg body weight per day. **Growth failure in short children born small for gestational age (SGA):** The recommended daily dose is 0.035 mg/kg body weight (or 1 mg/m<sup>2</sup>/day, equal to 0.1 IU/kg/day or 3 IU/m<sup>2</sup>/day). Treatment should be discontinued when the patient reaches a satisfactory adult height or the epiphyses are fused. For growth disturbance in short children born SGA treatment is usually recommended until final height is reached. **Growth Hormone Deficiency in adults:** Low daily doses of 0.15-0.3mg are recommended initially. Dosage should be adjusted stepwise, controlled by Insulin-like Growth Factor 1 (IGF-1) values. The recommended final growth hormone dose seldom exceeds 1.0mg/day. The lowest efficacious dose should be administered. In older or overweight patients, lower doses may be necessary. **Contraindications** Epiphyseal fusion in children; recurrence or progression of an underlying intracranial lesion; active neoplasia (any anti-tumour therapy must be completed prior to starting Somatropin treatment); known hypersensitivity to any ingredients in the powder for solution or solvent; critically ill patients. **Precautions** Treatment should be carried out under regular specialist medical supervision. Patients with intra or extracranial neoplasia in remission or those with growth hormone deficiency secondary to an intracranial tumour should be examined frequently whilst receiving growth hormone. Cases of leukaemia have been reported, but a causal relationship to growth hormone therapy has not been established. Growth hormone administration is followed by a transient phase of hypoglycaemia of approximately 2 hours then from 2 to 4 hours onward by an increase in blood glucose levels despite high insulin concentrations. Somatropin may induce a state of insulin resistance which can result in hyperinsulinism and in some patients hyperglycaemia. Use with caution in patients with or a family history of diabetes mellitus. In case of development of preproliferative changes and the presence of proliferative retinopathy Somatropin treatment should be discontinued. **Pregnancy:** Discontinue if pregnancy occurs. Thyroid function tests should be performed after starting treatment with Saizen and after dose adjustments. In case of severe or recurrent headache, visual problems, nausea and/or vomiting, a funduscopy for papilloedema is recommended. If papilloedema is confirmed a diagnosis of benign intracranial hypertension should be considered and growth hormone discontinued. If growth hormone treatment is restarted following resolution of intracranial hypertension, treatment should be discontinued following any recurrence. In children with chronic renal failure, renal function should have decreased to below 50% of normal before treatment. Conservative treatment for renal insufficiency should have been established and maintained during treatment. During treatment patients should be examined for progression of renal osteodystrophy. Treatment should be discontinued at the time of renal transplantation. Growth spurts may increase risk of joint related problems. Physicians and parents should be alert to the development of a limp and knee or hip pain in children treated with Saizen. In short children born SGA, other medical reasons or treatments that could explain growth disturbance should be ruled out before starting treatment. For SGA patients it is recommended to measure fasting insulin and blood glucose before start of treatment and annually thereafter. In patients with increased risk for diabetes mellitus oral glucose tolerance testing should not be administered. For SGA patients it is recommended to measure IGF-1 level before start of treatment and twice a year thereafter. If on repeated measurements IGF-1 levels exceed +2 SD compared to references for age and pubertal status, the IGF-1/IGFBP-3 ratio could be taken into account to consider dose adjustment. Experience in initiating treatment in SGA patients near onset of puberty is limited and therefore not recommended. Experience with SGA patients with Silver-Russell syndrome is limited. Some of the height gain obtained with treating short children born SGA with Somatropin may be lost if treatment is stopped before final height is reached. Cases of sleep apnoea and sudden death in patients with Prader-Willi-Syndrome under treatment with Somatropin have been reported. Saizen is not indicated for treatment of patients with Prader-Willi-Syndrome. Varying injection site can prevent lipatrophy. In persistent oedema or severe paraesthesia, decrease the dosage in order to prevent carpal tunnel syndrome. Adult growth hormone deficiency should be treated as a lifelong condition. Experience is limited in patients over 60 or with prolonged treatment. Concomitant corticosteroid therapy may inhibit the response to Saizen. **Side-effects** Antibodies to Somatropin can form in some patients, the clinical significance is unknown. Common side effects: Injection site reactions, localized lipatrophy, fluid retention in adults (peripheral oedema, stiffness, arthralgia, myalgia, paresthesia). Serious: Hyperglycaemia, hypothyroidism, avascular necrosis of the femoral head, idiopathic intracranial hypertension. *Please consult the Summary of Product Characteristics for more information in relation to other side effects.* Additional information is available on request. **Pharmaceutical Precautions** Store in the original package. Do not store above 25°C. Store the reconstituted product at 2°C to 8°C. Do not freeze. Use the reconstituted product within 28 days. **Legal Category** (POM) Basic NHS cost Prices in Ireland may differ, consult distributors Allphar Services Limited. Each carton contains 1 vial of SAIZEN® 8mg and 1 solvent cartridge. Cost: £175.68 **Product Licence/Authorisation Number** SAIZEN® 8mg click.easy™ PL 03400/0079 PA 285/5/4 Bacteriostatic solvent cartridge PL03400/0076 **Name and Address of Licence Holder** Serono Limited, Bedford Cross, Stanwell Road, Feltham, Middlesex, TW14 8NX, United Kingdom **Name and Address of Distributor in Ireland** Allphar Services Limited, Pharmaceutical Agents and Distributors, Belgard Road, Tallaght, Dublin 24, Ireland **Date of Preparation** January 2007. **Job Number** 4303P.

Information about adverse event reporting in the UK can be found at [www.yellowcard.gov.uk](http://www.yellowcard.gov.uk). In the Republic of Ireland information can be found at [www.imb.ie](http://www.imb.ie). Adverse events should also be reported to Serono Limited – Tel: +44 (0)20 8818 7373 or email: [medinfo.uk@serono.com](mailto:medinfo.uk@serono.com)

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Innovation for the growing generation

Date of Preparation February 2007  
Code SA107-0004



# Supporting other societies

► We at the Society's Bristol office pride ourselves at looking after our members, and we hope you think we do a good job. So it was, based on our lengthy experience, that we began to offer membership services to other learned societies a few years ago.

These services are provided by our Secretariats Team, and our impressive client list currently includes the Bone Research Society, the British Fertility Society, the British Society for Paediatric Endocrinology and Diabetes, the European Society of Endocrinology and the European Society for Paediatric Endocrinology.

The very wide range of cost-effective services and advice we can offer to learned society clients includes:

## **Membership applications, renewals and reminders**

Keeping track of members and their requirements is key to the success of a society. We ensure that membership records are kept up to date in a specialist database, and produce accurate reports for client societies. We oversee the processing of direct debit, cheque and online payments.

## **Keeping members up to date and answering queries**

Members need timely responses to their day-to-day questions. We handle enquiries by telephone, email and post. We also draft and send email alerts to ensure that members are kept updated.

## **Organising certification courses**

We can work with client societies to develop courses and a charging structure to ensure that members return funds to their societies for further investment in education. Our role includes producing application forms and log books. We develop systems to streamline the certification process and to ensure that applicants adhere to requirements.

## **Assisting with governance**

Our services include assistance with setting up sub-committees, editorial boards and the like. We will organise and attend committee and council meetings, and produce agendas and minutes. We will also organise and attend AGMs, producing agendas and minutes. We can organise ballots, from the production of nomination and ballot forms to providing final lists of nominees and successful candidates. We can help ensure that each client society adheres to its constitution.

## **Promotion of client societies**

We work with our clients to raise the profiles of their societies. This includes a wide range of potential activities, such as organising and managing client society's stands at their own and other congresses, and designing flyers and promotional material. We can redesign and develop new sections of web sites to incorporate features that are relevant to society members as well as being user-friendly and up-to-date. We can ensure that newsletters are produced to schedule and contain interesting content, as well as providing press and media services and developing client profiles in the media.



From left to right: Helena Marciano, Andrea Davis, Pauline Bertrand and Sharon Phillips

## **Administration of sponsorship arrangements**

Sponsorship can be an important source of revenue for clients. We produce agreements for sponsor companies and maintain records of sponsorship amounts for each year, occasionally renegotiating on behalf of the client. Our role includes managing and implementing the invoice process to ensure sponsor companies pay the agreed amounts into clients' bank accounts.

## **Financial and legal services**

We can assist client societies in setting up bank accounts, perform the administration for grants and awards, and assist with tender processes, including the submission of tender notices. Our services also include assistance with incorporation of limited companies and acting as a standing office for client societies.

Our team currently consists of four very experienced members of staff: Pauline Bertrand, Secretariats Manager; Andrea Davis, Secretariats Organiser; Sharon Phillips, Secretariats Organiser; and Helena Marciano, Secretariats Assistant. We work closely with other teams within the Society, such as Publications, Web Development, Events and Finance.

We always look forward to adding to our list of clients, and have recently submitted proposals to other European and UK societies. If you have a society that could benefit from our services, please contact [pauline.bertrand@endocrinology.org](mailto:pauline.bertrand@endocrinology.org).

## **Call for abstract markers**

► The Society is looking for members to mark abstracts in the pituitary category for the next two or three BES meetings. The deadline for submission of abstracts for the 2008 meeting is 15 November 2007, with abstracts passing to markers on 22 November in order to be marked and returned to the Bristol office by 30 November. If you would like to be involved and are able to commit to this timetable, please contact [shirine.borbor@endocrinology.org](mailto:shirine.borbor@endocrinology.org).

# Call for medal nominations

► The Society awards several medals annually, in recognition of outstanding contributions to endocrinology. All members are invited to make nominations for the 2009 awards. Nomination forms can be found at [www.endocrinology.org/about/medals.html](http://www.endocrinology.org/about/medals.html) or requested from Christine Davis in the Bristol office (Email: [christine.davis@endocrinology.org](mailto:christine.davis@endocrinology.org)). Please return them by 13 July 2007.

The Dale Medal is the highest accolade bestowed by the Society and is awarded to an individual whose studies have changed our understanding of endocrinology in a fundamental way. Previous recipients include AS McNeilly, S Lamberts, JK Findlay, R Kahn, W Vale, SR Bloom, D Baird and B McEwen.

The Society Medal is awarded to an endocrinologist working in the UK, in recognition of outstanding studies. It has previously been awarded to HOD Critchley,

BR Walker, VKK Chatterjee, JMC Connell, R Eastell, PJ Lowry, ICAF Robinson and PM Stewart.

The other medals are intended to promote links between the UK and other areas of the globe. The European Medal, presented to an endocrinologist in mainland Europe, has been awarded in the past to N Skakkebaek, AM Colao, C Strasburger, A Maggi, K Oberg, E Ghigo, I Huhtaneimi and B Vennström. The International Medal (formerly known as the Asia & Oceania Medal) is awarded to an endocrinologist from outside the UK, to promote international collaboration. Recipients of which include K Ho, K Morohashi, G Risbridger, K Kangawa, P Leedman, MJ Waters, ER Simpson and IJ Clarke. The Transatlantic Medal is awarded to an endocrinologist working in North America, and has previously been received by R Rosenfeld, B Spiegelman, DJ Mangelsdorf, K Korach, JS Flier, K Parker, JRG Challis and B O'Malley.

## Women in science, engineering and technology

► Networks are important sources of information and support, as well as a means of giving their members a joint voice. However, the UK currently lacks a national network for women covering all the areas of science, engineering and technology (SET) across academia, industry and enterprise.

Would such a national network be useful? If so, what should its main aims and functions be? We are keen to canvass the opinions of women working in SET in the UK. Let us know what you think by completing our short survey at [www.surveymonkey.com/s.asp?u=95853383191](http://www.surveymonkey.com/s.asp?u=95853383191). Please circulate this web address to your contacts, so we have the widest possible feedback.

We suggest that the network would be for all women working in academia, industry, enterprise and the public sector, as well as those on a career break. Its main aims might include:

- ▷ giving women a voice to express their opinions and so inform public policymakers, employers and public perceptions, achieved perhaps by holding regional meetings on specific topics or by providing online discussion forums
- ▷ organising local meetings so that women can share ideas, and inspire and learn from each other
- ▷ pointing women towards sources of training and advice, for example about job sharing or part time working, as well as publishing inspiring articles, podcast interviews and case studies of women in SET.

You can learn more about our proposals at [www.setwomen.co.uk](http://www.setwomen.co.uk) and also find out about comparable organisations through their web sites: Canadian Society for Women in Science and Technology ([www.scwist.ca](http://www.scwist.ca)), Association for Women in Science (USA) ([www.awis.org](http://www.awis.org)) and WISE-NET Australia ([www.wisenet-australia.org](http://www.wisenet-australia.org)).

JENNY KOENIG

## ASK A BIOLOGIST

► Concerned with accuracy of material on the web, and keen to encourage budding scientists, a number of active researchers and science enthusiasts have recently set up [www.askabiologist.org.uk](http://www.askabiologist.org.uk).

The site is aimed at school children, but anyone interested in biology can put a question on any topic direct to scientists. Behind the scenes, 70 professional researchers try to make sure that everyone gets an answer to their enquiry.

The questions are organised into themes and the most recent are documented, so the site is good for posing queries you have been pondering as well as just having a browse. I guarantee you will find answers to questions you would never have thought of asking! To give a feel for what it's like to do science, there are also profiles of the researchers and essays on areas of biological interest.

Please have a browse or ask a question, but also consider ways in which you could promote this to young people or their teachers, or whether you know any researchers who would be interested in contributing to the scheme.

Please contact me direct if you have any questions about the site, at [d.hone@lrz.uni-muenchen.de](mailto:d.hone@lrz.uni-muenchen.de).

DAVID HONE

► The National Osteoporosis Society will be announcing a call for proposals for the 2007 research grants round during the first week of June. Applications are invited for a Linda Edwards Memorial Ph.D. studentship (up to £100K over 4 years), Project Grants (up to £150K over 3 years) or Innovative Awards (up to £20K over 1 year) that clearly demonstrate how they will provide benefits to the general population with osteoporosis. The deadline for initial applications is 20th July 2007. For more information and to download an application form, please see [www.nos.org.uk/nos-research-grants-programme.htm](http://www.nos.org.uk/nos-research-grants-programme.htm)





Low testosterone

# The body of evidence

- Approximately 1 in 10 men aged 40 to 79 years have low testosterone with signs AND symptoms<sup>1</sup>
- 42% prevalence in men with Type 2 Diabetes<sup>2</sup> and 10-20% prevalence with Erectile Dysfunction<sup>3</sup>
- Tostran<sup>®</sup> is the only 2% testosterone gel:
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- With Tostran<sup>®</sup>, 92% of patients are within normal range after only one dose adjustment<sup>5</sup>

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**Tostran<sup>®</sup> Abbreviated Prescribing Information** Please refer to Summary of Product Characteristics before prescribing. **Presentation** Tostran 2% gel, contains testosterone, 20 mg/g. **Indications** Replacement therapy with testosterone for male hypogonadism when testosterone deficiency has been confirmed by clinical symptoms and laboratory analyses. **Posology** The recommended starting dose is 3 g gel (60 mg testosterone) applied once daily at approximately the same time each morning to clean, dry, intact skin, alternately on the abdomen or to both inner thighs. Application elsewhere should be avoided. The dose should be adjusted to the clinical or laboratory response. The daily dose should not exceed 4 g of gel (80 mg testosterone). The gel must not be applied to the genitals. Not for use in women, or children under the age of 18 years. **Contraindications** Androgens are contraindicated in known or suspected carcinoma of the breast or the prostate, known hypersensitivity to testosterone or any of the excipients, and in women. **Warnings and Precautions** Tostran should not be used to treat non-specific symptoms suggestive of hypogonadism if testosterone deficiency has not been demonstrated and if other aetiologies responsible for the symptoms have not been excluded. Tostran is not indicated for treatment of male sterility or sexual impotence. Prior to initiation of therapy, all patients must be examined to exclude a risk of pre-existing prostatic cancer. Careful and regular monitoring of breast and prostate must be performed. Testosterone may accelerate the development of subclinical prostatic carcinoma and benign prostatic hypertrophy.

Oedema with or without congestive heart failure may be a serious complication in patients with pre-existing cardiac, renal or hepatic disease. The treatment must be discontinued immediately if such complications occur. Testosterone may cause a rise in blood pressure and Tostran should be used with caution in men with hypertension. Tostran should be used with caution in patients with ischemic heart disease, epilepsy, migraine and sleep apnoea as these conditions may be aggravated. Care should be taken in patients with skeletal metastases due to risk of hypercalcaemia/hypercalcaemia. In diabetic patients, the metabolic effects of androgens may decrease blood glucose and therefore insulin requirements. Patients who wash in the morning should apply Tostran after washing, bathing or showering. Avoid the potential for transfer of testosterone from the patient to another person by careful hand washing and the wearing of loose clothing after the gel has been applied and has thoroughly dried. Bathe or shower before any close contact with another person. Particular care must be taken to prevent transfer of testosterone to pregnant women or children via skin contact. **Interactions** When androgens are given simultaneously with anticoagulants, the anticoagulant effect can increase and patients receiving anticoagulants require close monitoring of their INR. Concurrent administration of testosterone with ACTH or corticosteroids may increase the likelihood of oedema and caution should be exercised. **Undesirable effects** Very common (>1/10): application site reactions (including paresthesia, xerosis, pruritis, rash or erythema);

common (>1/100, <1/10): peripheral oedema, hypertension, polycythemia, increased prostate specific antigen, hirsutism, gynaecomastia. Certain excipients may cause irritation and dry skin. **Pack Size and Price** Packs containing one, two or three 60 g metered-dose canisters per pack. Price £26.67 per canister. **Legal Category** Prescription Only Medicine. Further information is available from the Marketing Authorisation Holder ProStrakan Limited, Galabank Business Park, Galashiels, TD1 1QH, United Kingdom. Marketing Authorisation Number PL16508/0025. ©ProStrakan. ®Registered Trade Mark. Date of PI Preparation April 2007.

Adverse events should be reported to ProStrakan Limited on 01896 664000. Information about adverse event reporting can also be found at [www.yellowcard.gov.uk](http://www.yellowcard.gov.uk)

**References** 1. Araujo A et al. *J Clin Endocrinol Metab* 2004; 89(12): 5920-5926. 2. Kapoor D et al. *Diabetes Care* 2007; 30: 911-917. 3. Roumeguere T. *European Urology* 2006; 50: 898-900. 4. Tostran<sup>®</sup> Summary of Product Characteristics. 5. Dumas C. Poster presented at the 25th Scandinavian Meeting of Urology, Göteborg, June 2005.

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M015/025

 **ProStrakan**  
[www.prostrakan.com](http://www.prostrakan.com)



We are pleased to highlight the activities of some of our corporate members in this special section. Companies wishing to join the Society should contact Tom Parkhill in the Bristol office ([tom.parkhill@endocrinology.org](mailto:tom.parkhill@endocrinology.org)).

### ARDANA BIOSCIENCE LTD



Ardana is a pharmaceutical company focused on improving human reproductive health. The company listed on the London Stock Exchange in March 2005.

The company was founded in 2000 to commercialise the pioneering research undertaken by the Medical Research Council's Human Reproductive Science Unit (HRSU) in Edinburgh, Scotland. Since its foundation, Edinburgh-based Ardana has built a broad portfolio of products and actively pursues products and technology to maintain a robust pipeline.

Ardana currently has two products available: a testosterone replacement therapy for the treatment of male hypogonadism and a muscarinic M3 selective receptor antagonist for overactive bladder. Products in clinical development cover a range of conditions including a further compound for male hypogonadism, growth hormone deficiency, prostate cancer, BPH, erectile dysfunction and endometriosis.

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### ASTRAZENECA



AstraZeneca is a major international healthcare business engaged in the research, development, manufacture and marketing of ethical (prescription) pharmaceuticals and the supply of healthcare services. It is one of the top five pharmaceutical companies in the world and has leading positions in sales of gastrointestinal, oncology, anaesthesia (including pain management), cardiovascular, central nervous system (CNS) and respiratory products. With the acquisition of Arrow, Cambridge Antibody Technology and Medimmune, AstraZeneca now has a significant position in antivirals, antibody therapeutics and vaccines.

AstraZeneca is listed in the Dow Jones Sustainability Index (Global) as well as the FTSE400 Index. With approximately 60 000 employees, AstraZeneca's headquarters are in London while R&D management is based in Sweden. Worldwide, AstraZeneca has six major research and development sites, four discovery facilities and a clinical research site. In total, AstraZeneca's R&D organisation employs approximately 12 000 people located in seven countries: Canada, France, India, Japan, Sweden, the UK and the USA. AstraZeneca has manufacturing activities in more than 20 countries.

Scientists at AstraZeneca have discovered and developed many of today's leading prescription medicines. AstraZeneca, a global leader in the development of cancer therapies, is committed to continuing the fight against cancer, through early detection and awareness programmes and through fundamental medical advances. AstraZeneca scientists are focused on developing a broad portfolio of anticancer products to extend and improve the quality of patients' lives. Over the past 30 years, AstraZeneca has developed effective cancer medicines for patients with breast and prostate cancer. AstraZeneca produces Casodex (bicalutamide), the world's leading antiandrogen, Zoladex (goserelin acetate), the second largest-selling LHRH agonist in the world,

Nolvadex, the first antioestrogen used in breast cancer, and the pure antioestrogen, Faslodex. We have also introduced a highly effective and well tolerated third generation aromatase inhibitor, Arimidex, that has shown superior efficacy to the previous gold standard hormonal treatment for breast cancer, Tamoxifen. Current R&D focuses on developing treatment options across the prostate and breast cancer continuum, and specifically on novel biologically targeted approaches such as EGFR-TK inhibition, VEGFR-TK inhibition and vascular targeting.

AstraZeneca has a major interest in two other areas where there is a major endocrine component: diabetes and obesity, and stress-related disorders. In these conditions AstraZeneca is looking for novel therapies that are a significant improvement on current treatments.

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- ▷ *European Journal of Endocrinology*, published in print and online with HighWire Press for the European Society of Endocrinology
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Eli Lilly and Company was founded in 1876 in Indianapolis, USA, and has had a long history of producing endocrine products, dating all the way back to the collaboration with Banting and Best and the introduction of the world's first insulin product in 1922.

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Ipsen Limited is the UK subsidiary of Ipsen, a European pharmaceutical group with over 20 products on the market and a total worldwide staff of nearly 4,000.

Ipsen's development strategy is based on a combination of products in targeted therapeutic areas: oncology, endocrinology and neuromuscular disorders, which are growth drivers, and primary care products which contribute significantly to its research financing. This strategy is also supported by an active policy of partnerships.

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Novo Nordisk Ltd is a focused healthcare company with a leading position in areas such as diabetes, growth hormone therapy, haemostasis management and hormone replacement therapy. With the broadest diabetes product portfolio in the industry, including advanced products within the area of insulin delivery systems, Novo Nordisk is the world leader in diabetes care.

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## OUT OF THE ARCHIVES...

# 'That international congresses are a waste of time and money'

► As you'll recall from my article in the last *Endocrinologist*, the endocrine archives provide a rich harvest. This time, I should draw your attention to probably the only debate that *Journal of Endocrinology* has ever published (1961 22 xxxvii). It's not citeable, of course, but hugely entertaining.

The first ever International Congress of Endocrinology had been held in 1960, in Copenhagen. It was a bit of an experiment, and no-one was sure whether these things were here to stay (CME accreditation was a very long way off). The Society for Endocrinology was clearly in several minds, particularly about whether to put in a bid to host the second. So the committee decided to ask the membership.

It's obvious that congresses were very different affairs in the early '60s. There was some corporate support, but any commercial exhibits were so discreet as to be invisible. And posters hadn't been invented. They came along in the '70s, from Europe, interestingly, not America.

So the standard form in the early 1960s was a plenary lecture to start the day, followed by oral sessions. Some of these were organised as symposia, but all accepted submitted abstracts were also delivered as oral communications. Consequently there was a rather constraining formality about the whole thing, and not nearly the opportunity for informal discussions that we all now value.

R D Bulbrook proposed the motion 'that international congresses are a waste of time and money', and his speech is hilarious. In picking out bits to quote, there's a danger of reproducing the whole lot, but try this: 'Giving a 10-minute paper may be even worse than listening to one. The audience will rarely exceed seven in number, six of whom will be deaf mutes, and the seventh a joint author. For this delightful experience the delegate may well have travelled 1000 miles in a couchette with five fellow passengers with highly contagious skin diseases'. (Don't gather from this last bit that travelling may have been more fun than it seems, even the fabled '60s were an age of innocence compared with today.)

F C Greenwood opposed the motion, and let's be clear, he didn't like the formal organisation of international congresses any more than Bulbrook did, even though he was speaking in their support. He states that the debaters 'are attacking the quickest and most efficient method of communication in science - talking to someone with the same interests and the same high level of blood alcohol as oneself ... one can meet the author of some effluent one has read in the library, and judge by 'fruitful discussion' whether the smokescreen over the results section was there by accident or design. These critical judgements are personal, usually slanderous, and do not arise from formal discussion of formal papers'. Finally he adds, 'International Congresses will be open to criticism until they are held without formal papers'. An odd sort of support, you might think.

However, none of the remaining seven speakers presented a more positive view. Everyone felt there were too

many delegates, who were presenting papers because that was the only way to get travel support, so turning the proceedings into something stultifyingly boring. Take P C Williams: 'Of course such conferences are a waste of time and money, but you won't stop them for that reason ... Then there is the question of papers. Are they necessary at all?'

So several speakers suggested ways to improve things, ruthlessly rejecting dull stuff (no-one asked who would judge it), or limiting the size in other ways. This part of the debate reveals a surprisingly dictatorial trait in many speakers. But the suggestion I really like came from N F Maclagan. In his institution, for a while, 'would-be attendants who were reading papers were not granted expenses, as their visit was held to involve a personal interest. If on the other hand they were attending without reading papers, it was assumed they had a genuine thirst for knowledge, and expenses were paid without question'.

It seems incongruous that, after all that, the silent majority had its day, and the motion was rejected with 9 for, 30 against. The Society for Endocrinology won its bid, and the 2nd International Congress of Endocrinology was held in London in 1964, with a format largely unchanged, by my

recollection. I do recall that *THE AUDIENCE WILL RARELY EXCEED SEVEN IN NUMBER, SIX OF WHOM WILL BE DEAF MUTES, AND THE SEVENTH A JOINT AUTHOR.*

and this has not been tried again. But other ways of improving the conferences have been much more successful, in my view. It's difficult to believe we'll ever see such a debate again.

Finally, here's a curiosity. Greenwood drew attention to *Annual Review of Physiology* 1961 23 v para 1. He asked, 'Do you possess an administration with the vision and finances to initiate the electronic televised literature bank envisaged there? By definition, administration is without vision, and this method of [literature] control must remain a dream'. Well, about 40 years later, the dream came true. Can this mean that administration has vision after all?

GAVIN VINSON

Gavin Vinson delves into the archives once more to reveal that international meetings originally met with much scepticism.

## Organising an event?

► Our online Calendar of World Events is a comprehensive listing of everything that's happening in endocrinology. If you would like us to include your meeting, remember you can submit the details yourself by entering them at [www.bioscievents.com](http://www.bioscievents.com).

# The practical challenge for bioscience

Richard Dyer,  
Chief Executive  
of the  
Biosciences  
Federation,  
aims to  
increase  
opportunities  
for practical  
training.

► From ecology to *in vivo* pharmacology and from taxonomy to biochemistry, the biosciences are practical subjects. Yet, in our schools and universities, the amount of practical experience that students acquire continues to diminish. This loss is of serious concern to the Biosciences Federation. Worse still, the decline is set to continue, because we are losing teachers with practical skills.

At A-level, my peers and I went out into the fields and threw metre squares 'randomly' on patches of grass, before counting the plants and insects that fell within their boundaries. Many of you will have had a similar experience, and will probably remember the enjoyment of these outings - and not just for getting your square around someone's neck! But this is now a rare educational activity. And the loss of training in field work is important because, for example, the subtle change in the distribution of lichens is an indicator of climate change. We have lost many lichenologists, and many that remain are close to retirement. To embark on a field project in this area now requires greater attention to the competence of your supervisor: you could find yourself working on wrongly identified lichens.

The same is true for scientists with *in vivo* skills. Once again, I have fond memories of tracing dogfish cranial nerves - well, perhaps not so fond, because I was not addicted to formaldehyde! However, it was an introduction to animal work and developed a real awareness of how nerves pass through tissue and bone. The experience brought a three-dimensional understanding of line drawings and excited interests that I suspect would not have been ignited otherwise. Some will argue that a prosected dogfish can provide nearly all these educational elements: it is a debate that those involved in medical education know well. Nonetheless, some practice on cadavers seems preferable to the alternative for veterinarians, doctors and those using animals for research. Today, the pharmaceutical industry has

great difficulty in recruiting in this area because few are qualified for the work.

Of course, not all bioscientists need to throw metre squares and cut up dogfish in order to make a research or teaching career in one of our disciplines. However, they probably will need to make up reagents correctly, and this is not a skill that one can anticipate today in all graduate students. The point is, the decline in practical skills threatens the strength of the biosciences.

How has the present situation arisen? There is no single answer to this question, but the expansion of university bioscience courses forms an important component of the answer. With doubling, trebling and quadrupling of student numbers in the biosciences, it has often proved too difficult to find and pay for the space and staff to enable practical work of a high standard. Indeed, as you will know, many courses are structured to minimise the need for practical training. It is possible to do an honours degree in pharmacology where, if you are predicted to obtain a lower second class degree, your honours project will be in the library. Graduates lacking practical skills will not usually attempt to find the time for more practical work when teaching in secondary schools.

What can be done to reverse this deteriorating situation? Clearly, motivation and money are needed. Motivation comes from need and leads to money. I chose the ecological and *in vivo* examples above because they are in areas where the need is real, and so is the possibility of extra resource. We do not think that we can usefully argue for an all-embracing single step solution to this problem, but we do think that we can target areas and work with others to achieve change. Indeed, we are quietly achieving significant success. The loss of practical skills is now part of the national agenda, and Government is discussing the resolution of particular needs in a positive way.

RICHARD DYER

► One of Richard Dyer's first tasks as Chief Executive of the Biosciences Federation (BSF) was to produce a new business plan. This plan emphasised that the Federation needed to work more closely with member organisations, to increase membership and income, and to become more effective at contributing to national debates on high level issues relevant to the biosciences. Good progress has followed in all areas.

In 2006, the BSF responded to 14 calls for input on UK and European science policy (see [www.bsf.ac.uk](http://www.bsf.ac.uk)). Caroline Wallace gave verbal evidence on behalf of the BSF to the House of Commons Science and Technology Committee relating to 'Scientific advice, risk and evidence: how governments handle them'. Rebecca Rowe, from the British Ecological Society, gave evidence on bioenergy to Defra. Sue Assinder, Chair of the Education Committee, also gave verbal evidence to the House of Lords Science and Technology Select Committee on science teaching in schools. Richard Dyer, with former Chair Keith Elliot, spoke extensively on the same subject with staff at the DfES.

Dr Dyer has also established ad hoc task forces, comprising individuals from member organisations, to respond to government and other consultations. The Society for Endocrinology has worked increasingly closely with the BSF on issues of policy, and contributed to responses on the efficiency and effectiveness of peer review, the competitiveness spending review, RAE 2008: reform of higher education research assessment and funding, and the Cooksey review of UK health research.

The BSF is increasingly quoted in the press and by parliamentarians for its position statements and consultation responses. This is encouraging both for the Federation and for its 43 member organisations, who view the BSF as a voice for all biosciences in the UK.



# Hormones for sale

► The word 'hormone' can have a magical quality. In a sales pitch to a woman, it's shorthand for 'makes you feminine'. To men, it means 'makes you more masculine'. To older people, it implies 'makes you feel younger'. Basically it's shorthand for 'a new, improved you'.

It's a seductive pitch. Of course, sometimes there is a basis in reality for some of the claims, though often in marketing you can write any old tosh and get away with it, because all you are doing is setting a mood. But where our science is pulled in you can feel critical hackles rise.

As usual, the web seems to corner the market in dubious sales pitches. Here, the hormonal elephant in the room is anabolics. Web sites suggest that their products will give you a body like Big Arnie's or Sylvester Stallone's. There's no doubt that sometimes the drugs do work but, even so, web sites are often tempted to weave a little pseudoscience around the h-word.

A mystery ingredient is always useful. For example, '*Urtica dioica* ... a new western herb that has been proven to down-regulate sex hormone-binding globulin, and therefore known to support increased free testosterone levels from within the body'. New? I don't think so! *Urtica dioica* is the common stinging nettle. I have been trying (unsuccessfully) to avoid it in my garden, but now I know what it does, perhaps I should be tempted to roll naked in the damn stuff. Or maybe not.

Internet anabolics also have a softer side. Homeopathic growth hormone is something of a boom area. In many ways it's a perfect homeopathic product: a highly valuable initial product, which is diluted to near infinity, but magically retains both its original potency and its original price. But doesn't it have side effects? Well, as one manufacturer of homeopathic growth hormone says '... because the GHG is homeopathic, you know that it is as safe as it is effective'. Couldn't have put it better myself, and I'm genuinely very reassured by this.

It's not only the internet where hormones weave their effect. John Lewis sells Dr Sebagh Crème Natural Hormone-Like Effect, 50ml for £62. I suspect that Dr Sebagh's Crème doesn't produce a testosterone- or cortisol-like effect, but who knows? Maybe you can choose which hormonal effect your body will undergo, and of course, in the world of hormarketing, there are no side effects. At least it doesn't offer to 'balance your hormones', which is my particular bête noir in the hormonal shopping mall.

But selling hormones is not just about drugs. You may well have missed the 'Louisiana Bayou Hattie Hormone Mood voodoo doll', for sale on eBay a few months ago. Part of a 'menopause collection' of dolls, she has 'a black eyed pea in her Mojo pouch for good luck' (don't ask). I guess she's a voodoo form of HRT (and I know some endocrinologists who have a similar attitude to HRT itself). Meanwhile, playing Ken to Hattie Hormone's Barbie, the soldier doll GI Joe has been criticised for building unrealistic body images in young boys, as the only way a boy can get anywhere near that 'idealised' physique is by taking to body-building drugs.

Perhaps this is the serious point to this article. I've described a fantasy world, but already for many people that's what hormones are. In 25 years' time, will the man/woman in the street view clinical endocrinology largely as a lifestyle choice? Will the science we are doing now lead us to an understanding of how to ward off times' winged arrow? Will endocrinology go the way of plastic surgery, where the minority deals with body reconstruction after accidents, but the money is to be made with botox and breast implants?

Endocrinology has some origins in 19th and early 20th century attempts to keep us young. Perhaps the good science we are doing now will lead us down that route in the future? Comments please!

Tom Parkhill takes a sideways look at the global marketing machine's latest miracle: the hormone.

TOM PARKHILL

## Scientist at the Seat of Power

### Zuckerman: Scientist extraordinary

By Bernard Donovan

*An enthralling biography of an immensely influential scientist.*

Solly Zuckerman was an authority in anthropological research, anatomy, animal behaviour and the physiology of sexual cycles, an expert advisor to government on blast injury and explosive damage in WW2 and advisor to successive governments.

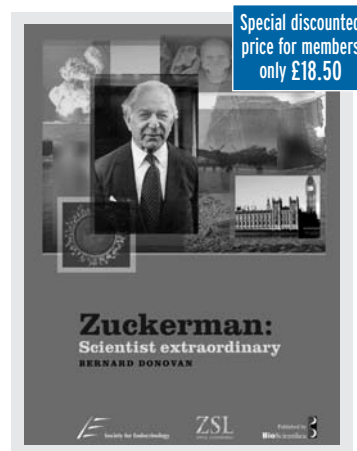
Prosecutor at the Zoological Society of London, Professor of Anatomy at Birmingham University, Scientific Advisor to the Royal Air Force and Chief Scientific Advisor to HM Government, Solly Zuckerman associated with the best in artistic, social and military fields, and was friendly with George Gershwin, A J Ayer and Lord Mountbatten.

This book asks, "Did he use or abuse his power? Should he have done more to encourage the input of scientific advances in British industry? Was he frustrated by an unreceptive establishment? How could he deny a fundamental scientific concept - the portal vessel theory?"

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# Dabbling in toxicology...

Endocrinologists have an important role in what might seem to be the most unlikely places, as Ieuan Hughes has discovered.

► **Why would a paediatric endocrinologist chair a committee on toxicology? You may well ask - just as I did, when I was approached to lead the Committee on Toxicity of Chemicals in Food, Consumer Products and the Environment (COT), some 5 years ago.**

As one of the Food Standards Agency's science advisory committees, COT provides advice to enable the Agency to fulfil its statutory aim to 'protect public health from risks which may arise in connection with the consumption of food'. I was a member of the COT Working Group that had reported on phytoestrogens and health in 2003 ([www.food.gov.uk/multimedia/pdfs/phyto-report0503](http://www.food.gov.uk/multimedia/pdfs/phyto-report0503)), the best review I have seen of the chemistry and physiology of oestrogens. We covered all aspects: dietary sources, the risks and benefits of consuming phytoestrogens, and the evidence for positive effects against cancer, the menopause and osteoporosis.

As Chair, I had to learn the whole new language of toxicology! Acronyms flow in abundance: NOAEL and LOAEL (respectively no and lowest observed adverse effect level), BMD and BMDL (benchmark dose and its lower 95% confidence interval of the benchmark dose), TDI and ADI (tolerable and acceptable daily intake) and MOE (margins of exposure), to name but a few.

Risk analysis is central to COT's work, but confined primarily to the first stage of risk assessment, rather than subsequent risk communication and management. Risk assessment includes hazard identification and characterisation, and sometimes exposure assessment and risk characterisation. Chemical risk assessment is characterised by 'variability' and 'uncertainty'. The former is defined as observable diversity and biological sensitivity or response. Uncertainty is more specific to chemical toxicology, where we must apply uncertainty factors to extrapolate data from animals to humans. Thus, it is customary to apply a 100-fold uncertainty factor for interspecies extrapolation (10-fold) and human variability (10-fold). That seems reassuringly generous when applied to a NOAEL, for example, and may be extended further when considering fetuses, infants, children and the elderly, for example.

So what recent work is relevant to endocrinology? The phytoestrogen assessment has led to several projects, including the epidemiology of hypospadias and undescended testes, and ongoing studies on breast cancer. We have considered potential effects of chlorinated drinking water and coffee consumption on reproductive outcomes, and the developmental effects of dioxins in rats. Other chemicals, like perfluoro-octanoic acid (found in fire-fighting foams) and perfluoro-octane sulphonate (used in the leather and upholstery industries) have been reviewed in this context and for their carcinogenicity and mutagenicity. A full multigeneration reproductive toxicity study by BP Chemicals Ltd enabled COT to allay concerns that terephthalic acid, used in cans and bottles, might migrate into food and possess endocrine disrupter activity.

A more mainstream endocrine study examined the effects of food supplements containing phosphate on the calcium-parathyroid hormone (PTH) axis and bone health. Evidence of elevated PTH reflected a short term adjustment to maintain plasma calcium levels in the normal range, and COT did not regard this as an adverse effect on bone health. However, the longer term effects of such elevated PTH levels are unknown.

Our report 'Development and function in adulthood of the male reproductive system: potential chemical-induced effects' looks at the role of endocrine disrupters in man. It combines experts' input with critical reviews of the abundant literature. Evidence of effects in humans relies on epidemiological studies of end-points like changing sperm counts and quality, and apparent increases in the incidence of testicular cancer, hypospadias and cryptorchidism, together described as testicular dysgenesis syndrome (TDS). Providing direct evidence to link the components of TDS with human exposure to endocrine disrupters is not currently possible. An animal model for TDS has been replicated in male rodents by exposure *in utero* to high doses of dibutylphthalate.

Data on anogenital distance in human infants now confirm, as in rodents, a greater distance in males versus females. One study reported reduced anogenital distance and impaired testis descent in boys whose mothers had elevated levels of prenatal phthalate exposure. The Cambridge Birth Cohort Project is an epidemiological pregnancy-related study of environmental factors that affect growth and development in offspring. It includes a detailed anthropometric analysis of the external genitalia and anogenital distance for males. In due course, we should be able to determine whether anogenital distance can be replicated in humans as a marker of prenatal androgen exposure.

COT comprises more than 25 experts across biomedicine and statistics, and the Chair can also call on individuals representing the public interest. Our scientific secretariat is made up of numerous post-docs at the forefront of their subjects. Though much of our work is in response to requests from the Department of Health or Defra, we also proactively identify issues and keep up to date with emerging areas. For example, a potential new issue arose recently in *New England Journal of Medicine* (2007 356 479-485), which reported a possible link between prepubertal gynecomastia and the use of lavender and tea tree oils. Products containing such oestrogenic compounds are a huge consumer industry, suggesting that more cases of gynecomastia from this cause may become apparent. That would spark a formal risk assessment by COT to analyse the extent of the problem with respect to exposure of the population.

So there is plenty of scope for endocrinologists to participate in this well-resourced committee, with its challenging agendas. Vacancies frequently arise for Society members who would like to explore further.

IEUAN A HUGHES

Learn more about the work of COT at [www.food.gov.uk/science/ouradvisors/toxicity](http://www.food.gov.uk/science/ouradvisors/toxicity).

# Perceptions, academia and misunderstandings

► Writers spend much of their day inside someone else's head, searching for the authentic voice of a stream of people. Paul Abbott, the writer of the TV programme *Shameless*, observed on *Desert Island Discs* recently that he may occupy up to 300 skulls in a day!

His life story was extremely moving. As one of eight children, he was abandoned by his mother and 'bone-idle' father, raped in mid-childhood, and then made two suicide attempts, all before he had reached the age of 16 years. The programme, *Shameless*, which I have not seen, is based loosely on his own life experiences.

His real father said he was very upset that viewers might think the father in *Shameless* was modelled on him, the TV father being a drug addict, alcoholic and sponger of money from the rest of the family. When Paul Abbott challenged his real father about what troubled him most about the TV portrayal, it wasn't the drugs, alcohol or sponging, but that the TV father had long hair! It is in moments like these that an individual's previously unknown thoughts, fantasies and concerns are revealed.

I experienced a similar revelation myself recently. In my last piece for this newsletter, entitled 'Retirement', I spent some time focusing on a former senior colleague and his wife, with whom I have maintained a friendly relationship.

In the article, I raised the possibility that he might have Alzheimer's disease, that he was agonisingly slow at choosing his meal in a restaurant, and that he never listened seriously to the words of wisdom I offered. I also suggested that, even after 9 years, I was not sure that his wife realised he had retired. I had changed their real names in the story to Douglas and Evelyn. I knew he read *The Endocrinologist* regularly. Clearly I had provided plenty of material from which offence might be taken.

Well, as luck would have it, we three were due to meet up for our 6-monthly social catch-up evening at a local pub. I took the opportunity to email a draft of the story to them before we met and, of course, before it was published.

I arrived late but got straight to the point, questioning him first.

'How did you like the story?'

'I liked it but I do have one quibble.'

'Was it about the suggestion of Alzheimer's?'

'No, I forgot that in an instant.'

I moved on quickly, looking for (and finding) another hole to dig myself into.

'Was it the reference to the extraordinary length of time you took to choose your meal?'

As the words left my mouth, I noticed that the menu card he was holding in his left hand had fallen asleep!

'No, it was none of your observations about my personal characteristics. In the last sentence of your draft, you have chosen the wrong tense of the verb to lie. I insist that it be changed.'

It was the response of a real academic: no hint of any emotional reaction to perceived personal insults, just cold critical analysis of the grammar used in the process of story-telling.

I then turned my attention to his lovely wife, a gentle, intelligent and compassionate woman, representing all that's best in middle England.

'How did you like the story?'

'I liked it but I did feel a little insulted.'

I waited for it, I knew what was coming - how silly a joke to suggest she had not known of his retirement after 9 years.

'Do you really see me as an Evelyn? Do you think that I look like an Evelyn?'

I couldn't believe it! I don't even know any Evelyns. What's wrong with all the Evelyns in the UK? I had to conclude that, in 2007, the name Evelyn was simply not compatible with celebrity status!

Well, we had a pleasant meal and then I negotiated with them over the possibility of further stories. They agreed, so long as more suitable names could be chosen. I relented and went to the bar to buy Rocky and Posh their drinks.

But little could prepare me for my next run-in with the English language. It occurred on a recent visit to the Caledonian Endocrine Society. I had reached the head of the taxi hire queue at Edinburgh airport when a cab drew up and the driver asked me, 'Do you want sex?'

I considered the offer for a moment or two, but it was a cold dark Friday afternoon in December, and a cup of tea was foremost on my mind. I took a step backwards, but the driver was persistent and he beckoned me again with his index finger, 'Psst, do you want sex?'

This embarrassing exchange was being conducted in front of an audience. To curtail it quickly, I advanced towards him and told him I wanted a taxi to Peebles Hydro, to which he replied, 'Aye, but are those five with you, because this is a sex-seater?'

'HOTSPUR'



**Society for Endocrinology** **CU 07**  
**Clinical Update**

**5-7 November 2007**  
 Renaissance Manchester Hotel

First of a new series of clinical training events providing essential training for all trainees and new consultants and an excellent forum for networking opportunities with peers and established endocrinologists.

Over a 3 year period, the programme will cover the new national curriculum in endocrinology and diabetes and is set to become the UK's premier clinical training event.

**CU 07**



## Adrenal ECM proteins, integrins and ACTH

ACTH is the most potent stimulus for both corticosterone and aldosterone secretion. It acts not only on the immediate, transcription-independent stimulation of adrenal steroid synthesis and release, but also increases gene expression.

Otis and colleagues now report their research into the expression of the main extracellular matrix (ECM) components and their receptor integrins in the adult rat adrenal gland. They also investigated whether components of the ECM can differentially modulate cell function and possibly interact with ACTH functions.

They found that ECM components and integrins may determine specific cell functions like proliferation and steroid secretion. The results also indicate that ECM modulates basal and ACTH-induced cell functions. The authors have shown, for the first time, that ECM components enhance the expression of 3 $\beta$ -HSD, so conferring upon adrenocortical cells the ability to respond intensively and with high efficiency to ACTH stimulation.

The authors also illustrate striking and specific distribution of integrins between cortex and medulla. This supports the presence of medullary rays, extending from the medulla to the cortex facilitating cross-talk relationships between the two. **JM**  
(See the full article in *Journal of Endocrinology* 193(3), June 2007)

## Primary aldosteronism

In this review, Young examines our current understanding of primary aldosteronism, a condition when one or both adrenal glands produce excess aldosterone.

Previously thought to be a rare form of hypertension, this condition's status as a cause of secondary hypertension is now properly established, accounting for 5-13% of hypertensive patients. Treatment aims to reduce the mortality and morbidity associated with hypertension and cardiovascular damage.

The diagnostic and therapeutic approaches have evolved and been simplified over time. Originally, primary aldosteronism was not suspected unless a patient presented

# HOT TOPICS

The latest from the Society's journals, brought to you by Jayanthi Mondi, Gabrielle Cowcill, Simon Laurensen and Andrew Lowe

with hypertension and spontaneous hypokalaemia. It is now recognised that most patients with primary aldosteronism are not hypokalaemic. Identification of cases is based on the measurement of paired plasma aldosterone concentration and plasma renin activity. A positive test must be confirmed with sodium suppression testing for aldosterone autonomy. Differentiation between the seven subtypes remains the final step in the diagnostic approach.

Treatments vary by subtype. Where appropriate, adrenalectomy remains a cost-effective treatment. The drug of choice is spironolactone, but eplerenone, a more receptor-specific successor, is also now available, dependent upon circumstances. **GC**  
(See the full article in *Clinical Endocrinology* 66(5), 2007)

## WT1 may regulate AR in male genital development

The Wilms' tumour suppressor (WT1) is one of the key regulators of early development of the male genitalia, while the androgen receptor (AR) is the major local factor responsible for their development.

A subset of patients with WT1 mutations and virilization defects were found to have normal testosterone-producing testes after birth, suggesting androgen resistance. This led to the hypothesis that WT1 and the AR might functionally interact during development of the external genitalia. Köhler and colleagues found that WT1 and the AR were coexpressed in the mesenchyme surrounding the urogenital sinus, mesonephros and Müllerian duct at 7 weeks p.c. and in the epididymis, vas deferens and

gubernaculum testes from 13 to 27 weeks p.c. in human male embryos. They saw modification of AR expression by WT1 (WT1 +/+, WT1 +/- and WT1 +/- R394W) in CV1, Hela, LNCaP and T293 cells.

LNCaP and T293 cells were considered to be the most physiological cell systems, as both originate from the human urogenital tract. In these cell lines, repression of AR expression (0.5-fold) by the mutant WT1 +/- R394W could be demonstrated in comparison with the wild-type WT1 +/--. The authors conclude that a functional interaction of WT1 and the AR might play a role during development of the male external genitalia, but, as the regulatory effects were moderate, this is most likely to be in concert with other local cofactors. **SL**  
(See the full article in *Journal of Molecular Endocrinology* 38(5), May 2007)

## New risk factors for breast cancer

Most candidates for breast cancer prevention have not accepted tamoxifen because of the perception of an unfavourable risk/benefit ratio. One way to improve the ratio of risk to benefit is to identify women whose risk of breast cancer is very high.

The main parameters used to determine risk are family history, age, atypia in a benign biopsy and reproductive factors. Mammographic density, the most powerful risk factor, is not routinely employed. Plasma oestrogen and androgen levels, bone density, weight gain, age of menopause and fracture history are also potentially important. They are not used in a comprehensive risk prediction model because of lack of prospective validation.

The Breast Cancer Prevention Collaborative Group have met to critically examine and prioritise risk factors that might be selected for further testing by multivariate analysis using existing clinical material. They have agreed that quantitative breast density, state of the art plasma oestrogen and androgen measurements, a history of fracture and height loss, BMI and waist/hip ratio have sufficient priority for further testing. **AL**  
(See the full article in *Endocrine-Related Cancer* 14(2), June 2007)

### **Pitfalls in Endocrine Testing**

London, UK, 3 July 2007.

Contact: Samantha Tagg, Royal Society of Medicine, 1 Wimpole Street, London W1G 0AE, UK (Tel: +44-20-72903859; Fax: +44-20-72902989; Email: endocrinology@rsm.ac.uk; Web: www.rsm.ac.uk/endocrinology).

### **Bone Research Society Annual Meeting**

Aberdeen, UK, 3-5 July 2007.

Contact: Janet Crompton, The Old White Hart, North Nibley, Dursley GL11 6DS, UK (Tel: +44-1453-549929; Fax: +44-1453-548919; Email: janet@janet-crompton.com; Web: www.brsoc.org.uk).

### **31st British International Congress of Obstetrics and Gynaecology**

London, UK, 4-6 July 2007.

Contact: Michelle Kane, 4B, 50 Speirs Wharf, Port Dundas, Glasgow G4 9TB, UK (Tel: +44-141-3310123; Fax: +44-141-3310234; Email: info@bcog2007.co.uk; Web: www.bcog2007.co.uk).

### **Genomics of Common Diseases**

Cambridge, UK, 7-10 July 2007.

Contact: Patricia van der Valk, Wellcome Trust Conference Centre, Wellcome Trust Genome Campus, Hinxton, Cambridge CB10 1RQ, UK (Tel: +44-1223-495000; Fax: +44-1223-495023; Email: p.vandervalk@wtconference.org.uk; Web: www.wellcome.ac.uk/conferences).

### **Life Sciences 2007: 1st Joint Meeting of the Biochemical Society, the British Pharmacological Society and the Physiological Society**

Glasgow, UK, 8-12 July 2007.

Contact: Life Sciences 2007 (Email: info2007@lifesci.org; Web: www.lifesciences2007.org).

### **Advances in the Molecular Pharmacology and Therapeutics of Bone Disease**

Oxford, UK, 10-11 July 2007.

Contact: Janet Crompton, The Old White Hart, North Nibley, Dursley GL11 6DS, UK (Tel: +44-1453-549929; Fax: +44-1453-548919; Email: janet@janet-crompton.com; Web: www.paget.org.uk).

### **International Symposium on Paget's Disease**

Oxford, UK, 12-13 July 2007.

Contact: Janet Crompton, The Old White Hart, North Nibley, Dursley GL11 6DS, UK (Tel: +44-1453-549929; Fax: +44-1453-548919; Email: janet@janet-crompton.com; Web: www.paget.org.uk).

### **40th Annual Meeting of the Society for the Study of Reproduction**

San Antonio, TX, USA, 21-25 July 2007.

Contact: Gwen Abramson, SSR, 1619 Monroe Street, Madison, WI 53711-2063, USA (Tel: +1-608-2562777; Fax: +1-608-2564610; Email: sssr-am@ssr.org; Web: www.ssr.org).

### **13th International Conference on Second Messengers and Phosphoproteins**

San Diego, CA, USA, 1-4 August 2007.

Contact: Laurence Brunton (Web: www.smp-2007.com).

### **63rd Harden Conference: Protein Folding and Assembly *In Vitro* and *In Vivo***

Ambleside, UK, 18-23 August 2007.

Contact: Biochemical Society (Tel: +44-20-72804150; Fax: +44-20-72804167; Email: meetings@biochemistry.org; Web: www.biochemistry.org/meetings/programme.cfm?Meeting\_No=63HDN).

### **2nd Annual International Meeting of Urology**

Porto Alegre, Brazil, 23-25 August 2007.

Contact: Claudio Teloken, Fundacao Faculdade de Ciencias Medicas de Porto Alegre, RS, Brazil (Tel: +55-51-33282328; Fax: +55-51-33424316; Email: secretaria@ccmeventos.com.br; Web: www.ccmeventos.com.br).

### **25th International Congress of Paediatrics**

Athens, Greece, 25-30 August 2007.

Contact: ICP 2007 Organiser, 16 Paradissou St, 5125 Athens, Greece (Tel: +30-210-6889100; Fax: +30-210-6844777; Email: icp2007@acnc.gr; Web: www.icp2007.gr).

### **Congress of the European Association for Clinical Pharmacology and Therapeutics**

Amsterdam, The Netherlands, 29 August-1 September 2007.

Contact: Rene Grouls, Catharina Hospital, Michelangelolaan 2, Eindhoven, 5602 ZA The Netherlands (Tel: +31-40-2398795; Email: kaprgs@cze.nl; Web: www.eacpt2007.nl).

### **Endocrine Nurse Training Course**

Glasgow, UK, 4-6 September 2007.

Contact: Lizy Jones, Society for Endocrinology, 22 Apex Court, Woodlands, Bradley Stoke, Bristol BS32 4JT, UK (Tel: +44-1454-642210; Fax: +44-1454-642222; Email: conferences@endocrinology.org; Web: www.endocrinology.org/meetings).

### **Mouse Molecular Genetics**

Cambridge, UK, 5-9 September 2007.

Contact: Pam Garland, Wellcome Trust Conference Centre, Hinxton, Cambridge CB10 1RQ, UK (Tel: +44-1223-495000; Email: p.garland@wtconference.org.uk; Web: http://firstcontact.hinxton.wellcome.ac.uk).

### **1st World Congress on Controversies in Neurology (CONy)**

Berlin, Germany, 6-9 September 2007.

Contact: Ruthi Yahav (Tel: +49-972-35666166; Fax: +49-972-35666177; Email: cony@comtecmed.com; Web: www.comtecmed.com/cony).

### **Acute Diabetes and Endocrinology for the General Physician**

London, UK, 10 September 2007.

Contact: Jennifer Lake, Academic Department, Royal Society of Medicine, 1 Wimpole Street, London W1G 0AE, UK (Tel: +44-20-72903919; Fax: +44-20-72902989; Email: jennifer.lake@rsm.ac.uk; Web: www.rsm.ac.uk/academ/c10-diabetes.htm).

### **4th Regional Postgraduate Course in Clinical Endocrinology**

Krakow, Poland, 13-15 September 2007.

Contact: Prof Bohdan Huszno (Web: www.euro-endo.org/meetings/meetings\_courses.htm).

### **29th Annual Meeting of the American Society for Bone and Mineral Research**

Honolulu, HI, USA, 16-19 September 2007.

Contact: ASBMR, 2025 M Street NW, Suite 800, Washington, DC 20036-3309, USA (Tel: +1-202-3671161; Fax: +1-202-3672161; Email: asbmr@asbmr.org; Web: www.asbmr.org/meeting/index.cfm).

### **43rd Annual Meeting of the European Association for the Study of Diabetes**

Amsterdam, The Netherlands, 17-21 September 2007.

Contact: EASD (Tel: +49-211-75846920; Fax: +49-211-75846925; Email: registrations@easd.org; Web: www.easd.org).

### **7th World Congress on Neurohypophysial Hormones**

Regensburg, Germany, 18-22 September 2007.

Contact: Dr Oliver Bosch, Institute of Zoology, University of Regensburg, 93053 Regensburg, Germany (Email: wcnh2007@biologie.uni-regensburg.de; Web: www.uni-r.de/wcnh2007).

### **2nd International Congress IVI**

Barcelona, Spain, 19-21 September 2007.

Contact: Noemi de Villasanté, Joan Guell 144, 08028 Barcelona, Spain (Tel: +34-93-3633951; Fax: +34-93-4393594; Email: ivicongress@tecnicviajes.com).

### **9th Seminar of the European Society of Contraception: from Abortion to Contraception**

Bucharest, Romania, 21-22 September 2007.

Contact: Nancy Habils, European Society of Contraception, Opalfeneweg 3, 1740 Ternat, Belgium (Tel: +32-2-5820852; Fax: +32-2-5825515; Email: esccentraloffice@contraception-esc.com; Web: www.contraception-esc.com).

### **5th Biennial World Congress on Men's Health and Gender: Men's Health in Transition**

Vienna, Austria, 21-23 September 2007.

Contact: Simone Viertler, Lazarettgasse 9/5, 1090 Vienna, Austria (Tel: +43-1-4096010; Fax: +43-1-4096011; Email: office@wcmh.info; Web: www.wcmh.info).

### **50es Journées Internationales d'Endocrinologie Clinique**

Paris, France, 27-28 September 2007.

Contact: G Copinschi, Laboratory of Experimental Medicine, Brussels Free University, CP 618, 808 Route de Lennik, B-1070 Brussels, Belgium (Email: klotz@ulb.ac.be; Web: www.endocrino.net).

### **3rd EUGOGO International Teaching Course on Graves' Orbitopathy**

Mainz, Germany, 28-30 September 2007.

Contact: Susanne Pitz, Department of Ophthalmology, Gutenberg-University Hospital, Langenbeckstrasse 1, 55131 Mainz, Germany (Tel: +49-6131-176762; Fax: +49-6131-173455; Email: pitz@augen.klinik.uni-mainz.de; Web: www.eurothyroid.com).



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