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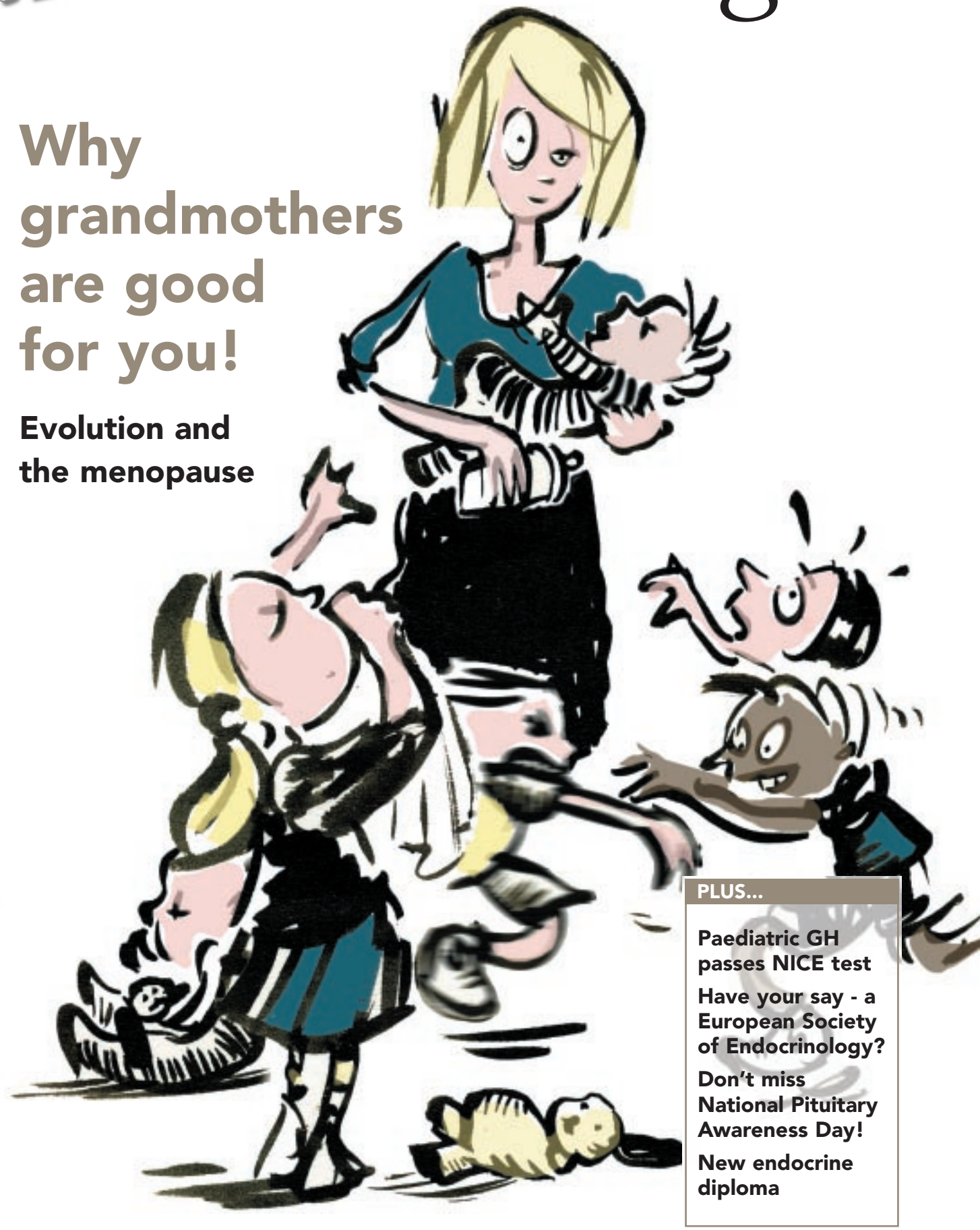
THE NEWSLETTER OF THE SOCIETY FOR ENDOCRINOLOGY NUMBER 72 • SUMMER 2004

THE Endocrinologist

Why grandmothers are good for you!

Evolution and the menopause



PLUS...

- Paediatric GH passes NICE test
- Have your say - a European Society of Endocrinology?
- Don't miss National Pituitary Awareness Day!
- New endocrine diploma

The Endocrinologist

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Deadline for news items for
the Autumn 2004 issue: **13 August 2004**.
Please send contributions to the above address.

It wasn't quite 'Brighton Rock' but the odds on for a good meeting (the 23rd Joint Meeting of the BES) proved correct and there were some excellent symposia, medal lectures and lively poster sessions. For the icing on the tote there was a night on the pier washed down with plenty of wine and fish and chips and an excellent banquet at Glyndebourne serenaded by an opera singer.

We may not be able to tell our grandmothers how to suck eggs but we could enlighten them about their role in reproductive success. In this issue Simon Aylwin explains the 'grandmother hypothesis' and suggests that the menopause and other age-related endocrine changes offer an evolutionary advantage. He touches on the raw facts that HRT is not the elixir of longevity and that perhaps "Menopause might occur at 50 to protect vitality at 70".

Stephen Shalet reflects on the outcome of the NICE Appraisal Committee that recommended the continued use of GH replacement therapy in all children who are GH deficient. Whilst he is happy with the outcome, he wonders whether this recommendation was based more on politics and fears of public outcry than evidence (or lack of it) that increased growth can improve the quality of life. Hotspur's anecdote about his impersonation of a John Wayne limp may bring a sympathetic tear to your eye.

Inspired by geotechnology, Andrew Hewitt, a civil engineer and now Chairman of the Trustees of the Pituitary Foundation, recalls the dark days after surgery to remove of a craniopharyngioma. He tells of the support he subsequently received from the Pituitary Foundation and the growth of the foundation since its inception in 1994. Sadly for Monty, the acromegalic cat, there is no feline pituitary support group, but, as Tom Parkhill explains, after successful radiotherapy he can now live out his remaining years snoring in comfort.

I cannot end this Editorial without congratulating Sue Thorn and her team for the successful outcome of the Charity Commission review of the Society. I am sure all members will be delighted to hear 'that the charity is governed to a high standard which meets the best practice…' - a flawless conclusion.

SAFFRON WHITEHEAD

Society gets top marks!

When a letter arrived from the Charity Commission in early 2003, we were hardly overjoyed to learn that they had selected the Society at random for a review! We really didn't need anything extra as we were already juggling our extremely busy work schedule around the office move.

Setting an October date for the review gave us until September to supply the Commission with a large selection of documents to aid their preparation. They were interested in assessing how well-informed the trustees are, the effectiveness of our systems regarding the legal governance of the Society, the recruitment and training of trustees (did you know that all new trustees have a day's training and receive a manual?), reporting and relationships, how we set and monitor standards in what we do, and our financial controls.

As luck would have it, at its April meeting last year, Council considered a major paper that looked at all our activities and assessed how closely they match our charitable objective, namely the advancement of public education (including research) in endocrinology. The Commission found this document particularly useful as it provided a list of all our activities, demonstrated that the trustees are aware that a rapidly developing society could inadvertently go outside the terms of its trust, and, importantly, confirmed that we had not done so.

The Charity Commission were also impressed that ten of the twelve trustees attended the review meeting on 22 October. Each was allocated a particular subject area and the Bristol staff prepared detailed personalised briefings, together with a copy of the file that had gone to the Commission. We held a briefing the previous evening, at which our solicitor and accountant were also present. Everyone was rather nervous when we gathered in the Bristol office, but we needn't have worried. The review went swimmingly, and took only half the allotted time, largely because the materials supplied in advance had dealt with many issues.

We were very pleased with the conclusions of the final report, which stated that 'The trustees demonstrated that the charity is governed to a high standard which meets the best practice... The charity operates in a fast-moving sphere of research which makes great demands on the trustees and staff. The trustees continually review all aspects of their governance including their adherence to the objectives of the charity.'

The only legal requirement resulting from the review was for the annual trustees' report (the text that you receive with the accounts) to include a section on plans and activities for the future. The Commission also recommended a more detailed declaration of eligibility for those nominated as trustees, and a written policy on whistle-blowing and complaints. These matters are being actioned.

All in all, it was time-consuming and nerve-racking preparing for the review, but has been a beneficial experience. It did force us to close a few gaps that we were aware of, and it is very reassuring to have the Commission's 'stamp of approval'.

SUE THORN

European Society proposed

Important proposals for the creation of a European Society of Endocrinology are enclosed with this issue and at www.euro-endo.org/news/news.htm. These originate from EFES (the European Federation of Endocrine Societies), which is considering conversion to provide a society with individual membership, an annual congress, and much greater activity at a pan-European level, in particular regarding professional liaison with the EC.

EFES are seeking the views of all national societies by 1 October 2004. The Society for Endocrinology's Council will formulate its response when it meets on 7 September. Feedback from members will be invaluable in compiling our comments. Please make sure to read the proposals, and send your feedback to rachel.evans@endocrinology.org by **1 August 2004**.

Fellowships reinstated

We are pleased to announce that a limited fellowship scheme is being reintroduced, funded jointly by the Society and the Clinical Endocrinology Trust, to whom we are very grateful. As a basic science fellowship is currently drawing to a close, a clinical research fellowship is being made available to enable a suitable candidate to advance their research career in the field of endocrinology.

The fellow's institution is responsible for setting the pay scale but the Society/Clinical Endocrinology Trust will only pay a maximum of an average of £40,000 pa (including oncosts such as national insurance and pension, and also including laboratory fees). No further funding will be available and extensions will not be considered.

Whilst not excluding applicants who might be funded through an NHS Trust, the Society would prefer the fellowship to be administered through a university.

The deadline for applications is **30 July 2004** and interviews will be held in October. Full details and an application form can be found at http://www.endocrinology.org/sfe/grants.htm or from Ann Lloyd in the Society's office (ann.lloyd@endocrinology.org). A basic science fellowship will commence at the end of this clinical fellowship.

SOCIETY CALENDAR

13-16 July 2004
Society for Endocrinology Summer School
St Anne's College, Oxford, UK

9-11 September 2004
Society for Endocrinology Endocrine Nurses Training Course
Wills' Hall, Bristol, UK

1-3 November 2004
195th Meeting of the Society for Endocrinology
Royal College of Physicians, London, UK

4-6 April 2005
24th Joint Meeting of the British Endocrine Societies
Harrogate International Centre, Harrogate, UK

Society for Endocrinology

Postgraduate Diploma in ENDOCRINOLOGY

PhD students!

Do you want to:

Win friends and influence people?

Understand plenary lectures?

Impress your PhD examiners with your broad knowledge base?

...then register for the Postgraduate Diploma in Endocrinology

Officially launched at BES 2004 in Brighton, the Society for Endocrinology Postgraduate Diploma in Endocrinology was initiated after a request from the Society's Young Endocrinologists Committee for an accredited training scheme in endocrinology.

While intended for PhD students, the Diploma will also be available to postdoctoral researchers. The concept is strongly supported by PhD supervisors who are keen that students obtain a broad education in endocrinology, to complement the more focused study of a PhD.

It is free of charge, but recipients must be fully paid-up members of the Society. Qualification for the Diploma requires the accumulation of 10 credits, which can be earned in three ways:

Conference attendance

Attend the Society's annual November meetings or BES meetings and earn 1 credit per meeting.

Conference presentations

Present a poster or make an oral presentation at the Society's annual November meeting or BES meeting, either as first author for 2 credits, or as co-author for 1 credit.

Assessed portfolio

Develop a portfolio of 3000-word essays, undertaking one per year. Tutorial support will be available. Essays will be marked by an assessment panel. Each essay will earn you 1 credit.

A minimum of 3 credits must be earned in each category, plus 1 additional credit from the category of your choice, to gain the 10 credits you need for your Diploma.

So, PhD students, take the plunge, sign up - it may even help at your viva!

Postdocs, don't delay! Supervisors, encourage your students to apply!

For an application form, contact Julie Cragg at the Society office (julie.cragg@endocrinology.org).

Basic Science Review Lecture: call for abstracts!

Basic scientists who are no more than 6 years post-PhD should apply now to present a 30-minute review lecture during this year's annual Society meeting. The lecture can be on any endocrine subject (probably a recent or current area of personal research). Applications will be judged by the Awards Committee of the Society using the standard criteria of originality, scientific quality and general relevance/impact. The Society is offering a £500 honorarium for this prestigious award.

Applicants must be members of the Society for Endocrinology. They should be under 35, although older applicants may be considered in extenuating circumstances (please give details if relevant). Abstracts should be submitted on a single A4 sheet, accompanied by a mini-CV on a second A4 sheet. This should include your date of birth and up to five publications of relevance to the lecture topic. Please also supply the name, address and telephone number/email address of your head of department to assist in the selection process.

Send applications to Julie Cragg, Society for Endocrinology, 22 Apex Court, Woodlands, Bradley Stoke, Bristol BS32 4JT no later than **28 June 2004**.

Clinical scientists are encouraged to apply for the Young Endocrinologists Clinical Review Lecture, held at the Clinical Cases Meeting each year in February. Details will be sent out in the August mailing.

Re-election of Officers

Constitutionally, the Society's officers are required to offer themselves for re-election on the second and subsequent years of their term of office.

Professor S Bloom (Chairman), Professor J Wass (General Secretary) and Professor A Logan (Programme Secretary) were elected at the 2002 AGM and will commence their third year of office in November 2004. Professor A White, who was elected as Treasurer in December 2001, will commence her fourth year of office. Should any Ordinary member wish to put forward an alternative name for any of the Officers, please contact Julie Cragg or Sue Thorn in the Bristol office by **30 July 2004**.

Endocrine nurse news

BES 2004 in Brighton was the setting for our 6th symposium. The topic 'Congenital adrenal hyperplasia' attracted a large audience of both nurses and clinicians. We would like to thank all our speakers and also Serono who kindly sponsored the Nurses tea. It was great to see so many of you at the BES and to see how many more posters had been submitted by nurses this year. Next year we hope to announce a poster prize - watch this space! We were pleased to welcome a nurse from New Zealand who had come to the UK specifically to attend the meeting.

Linda Smethurst (Manchester) and Ann Catteau (Southampton) are two welcome new faces on the committee following their election from a total of six nominations. We also welcome Professor Steve Shalet to the committee as Council representative.

Three nurses, Sue Cox, Jean Mundy and myself, have now completed and successfully submitted their portfolios/essays for the Society's Certificate of Adult Endocrine Nursing (see right for further details). They will receive their certificates at the next nurse training course in Bristol on 9-11 September. This year's topic is the thyroid gland. Registration forms and programmes are available with this mailing and from ann.lloyd@endocrinology.org.

MAGGIE CARSON

Certificate of Adult Endocrine Nursing

The Society's newly launched Certificate of Adult Endocrine Nursing:

- identifies and recognises nurses who have actively worked to develop their role as endocrine nurses
- promotes good practice in patient care and clinical management
- encourages clinicians to look for this certificate when promoting and appointing staff
- encourages nurses to participate as equal partners in the endocrine community
- improves opportunities for endocrine nurses to network.

Nurses can work at their own pace towards the certificate, which will be awarded on completion of four compulsory elements:

- attendance at the Society's annual endocrine nurse training course
- abstract submission to a November or BES meeting
- attendance at a November or BES meeting
- either a 1000-word essay on an aspect of your role in endocrine nursing (e.g. 'My contribution to good endocrine nursing practice') or a portfolio showing a record of practice.

In order to receive the certificate on completion of these elements, nurses must be members of the Society for Endocrinology, in good standing with their subscriptions.

For further details and an application form, please contact Ann Lloyd at the Society's Bristol office (ann.lloyd@endocrinology.org).

OBITUARY

Jim Grant

Dr James Kerr Grant - Jim or simply 'JKG' as he was known to his staff - died on 6 January 2004 at the age of 87, after a short illness.

Jim was born in Dundee, educated in Edinburgh and spent most of his working life in Glasgow. He graduated as a chemist and, after service in the Second World War, he started work in the Biochemistry Department at the University of Edinburgh with Professor Guy Marrian, who introduced him to steroid biochemistry. It was the 1950s and Jim played a significant role in working out the pathways of adrenal steroidogenesis and the enzymes that control the process. In 1956 he spent a year in Professor F Lynen's Laboratory in the Max Planck Institute for Cell Chemistry in Munich, honing his steroid expertise.

In 1960, Jim was recruited by the University of Glasgow as a Senior Lecturer to establish and run the Department of Steroid Biochemistry. This was based in Glasgow Royal Infirmary and it had the dual roles of research/teaching and NHS service provision. He remained in this post until he retired as Reader in Steroid Biochemistry in 1981. For 20 years Jim's department was one of five specialist steroid units in the UK, which together developed clinical steroid biochemistry. His expertise led him to be appointed as a WHO consultant to the Iranian Ministry of Health from 1970 to 1974.

His department had an impressive research output, and attracted research students and fellows from around the world. Jim continued his interest in adrenal steroids and also developed an internationally renowned team working on androgen metabolism and action in the prostate. At the time of his retirement, Jim had published more than 120 original papers and supervised or assisted 19 PhD students in steroid biochemistry. Several of Jim's team went on to have successful careers in research, clinical biochemistry or industry.

Jim's academic life was broad and included long periods on the Editorial Boards of the journals *Endocrinology* and *Steroid Biochemistry*. He was elected a Fellow of the Royal Society of Edinburgh in 1980 and an Honorary Member of the Society for Endocrinology in 1981. His NHS department developed a range of more than 20 steroid assays using the emerging techniques of chromatography, fluorimetry and immunoassay. These were validated in both analytical and clinical terms and subject to rigorous quality control and update.

Jim was a man of tremendous energy and vision. His enthusiasm and attention to detail encouraged all to attain the highest standards of professionalism, but he could be a hard task-master. He was a great communicator and a genius at teaching with no more than a piece of chalk and a blackboard.

With the death of Jim Grant, the Society has lost a great character, who will be remembered with affection by his former colleagues. His legacy, however, lives on in modern clinical and steroid biochemistry.

MIKE WALLACE
GRAHAM BEASTALL

With regret

We are sorry to announce the deaths of Professor D K O'Donovan and Dr J Ginsburg, two Senior members of the Society. Obituaries will follow.

Call for medal nominations

Nominations are now requested for recipients of the following medals, which are awarded annually by the Society, in recognition of outstanding contributions to endocrinology. Nominations should be sent to Julie Cragg in the Bristol office by **7 July 2004**. Nomination forms and a full list of previous medallists can be found under 'About the Society' at www.endocrinology.org, or from the Bristol office.

2005 Society Medal (previously R Eastell, P J Lowry, I C A F Robinson, P M Stewart, S O'Rahilly, S Franks, J R Seckl and A J L Clark)

2005 European Medal (previously K Oberg, E Ghigo, I Huhtaneimi, B Vennström, J-Å Gustafsson, B Groner, E R de Kloet and G Schutz)

2005 Asia & Oceania Medal (previously P Leedman, M J Waters, E R Simpson, I J Clarke, R Smith, J K Findlay, P D Gluckman and S Seino)

2005 Dale Medal (previously S R Bloom, W Vale, R Kahn, D Baird, B McEwen, J Folkman, S Moncada, R P Ekins and H G Burger)

2005 Transatlantic Medal (previously K Parker, J Flier, K Korach, J R G Challis, B O'Malley, J M Friedman, D M Stocco, J F Strauss III and J C Marshall)

Medal winners

Congratulations to **Wylie Vale** (San Diego) and **Jeffrey Flier** (Boston), who were awarded the 2004 Dale Medal and the 2004 Transatlantic Medal respectively at BES 2004.

Member on the move...

The only member who has changed address this issue is **M W Savage**, who is now at North Manchester General Hospital.

Webspinning

Melissa Westwood highlights the best on the web

Internet ex-Pore-at-Ion

www.pasteur.fr/recherche/banques/LGIC/LGIC.html

This database, hosted by the Pasteur Institute, deals with the three superfamilies of ligand-gated ion channels: glutamate cationic receptors, ATP-gated channels and the cys-loop superfamily. Each gene has one entry, which has been constructed (and checked) by an expert in the field to provide information on nucleic acid and protein sequence. There are also some sequence alignments, phylogenetic analysis and data on atomic co-ordinates where available.
SERVICES: D, L; STRONG POINTS: Research information;
WEAK POINTS: Some parts still under construction; RATING: Good.

Cancer: making it All Clear

www.cancersource.com

Where can cancer patients, doctors and nurses all go for timely information? Try CancerSource - a searchable, well-designed site that has everything from news on the latest cancer research to an extensive drug database. Information for each of the user groups is organised by a tabbed browsing interface, and articles, which are updated daily, appear to be tailored to their target audience. Full access requires online registration.
SERVICES: D, L, N, O (miscellaneous information); STRONG POINTS: Good design;
WEAK POINTS: Registration required; RATING: Excellent.

Thanks to Kevin Ahern and *Genetic Engineering News*. Don't forget to visit the Society for Endocrinology on the web: www.endocrinology.org; tell us about your favourite web site: melissa.westwood@man.ac.uk.

BSc, PhD ... MD?

www.nature.com/bioent

Here's one for all the budding entrepreneurs out there. Hosted by the Nature Publishing Group, this site aims to provide an 'interactive resource for scientists hoping to commercialise their research'. Topics include news on events/issues that impact on business development, hints, tips and practical advice from industry insiders, profiles of up-and-coming life science companies and an invaluable resource section.
SERVICES: L, N, O (job information, email alerts); STRONG POINTS: Content, organisation; WEAK POINTS: Registration required; RATING: Excellent.

KEY **Services** provided at web sites:

- **T** Tools - Analytical computing tools
- **D** Data - Searchable or downloadable database information
- **G** Goods - FTP delivery of useful items (e.g. full package, bug fix or demo software)
- **L** Links - Useful links to other sites
- **N** News - News of interest
- **S** Support - Feedback in response to users' enquiries
- **O** Others - e.g. Innovative use of web tools, appearance, editorial point of view

Ratings: Excellent, Very Good, Good
Nothing below good will be reported here.

Science and the media - calling young endos!

'The voice of young science: science in the British media' is the title of a forthcoming 1-day workshop looking at how leading UK journalists approach stories.

How do they balance the drive for news and entertainment with reporting the facts? Why have stories been handled the way they have? What effect does this have on the portrayal of science and scientists? Sessions will include:

- Science in the media: looking at problems, for instance when announcements 'go wrong'
- Realistic approaches to science reporting: including the best ways to get involved in a debate in the public forum

Delegates will learn about the interface between science and the media, how science reaches the news, and the mechanisms by which scientists can contribute to media/public discussion. The participating journalists are also keen to identify some younger faces in science and clinical research for future contact.

The event is organised by Sense About Science and will take place at the Science Media Centre in the Royal Institute, London, on 17 September 2004. It is aimed at postgraduate students, postdoctoral fellows, or equivalents in their first job. You should be passionate about science or clinical research and want to take on the challenge of communicating to a wider audience. Demand for a place on this fantastic course is expected to be high, but the Society has secured four places for suitable Young Endocrinologists. To apply, send a CV and covering letter to jane.shepley@endocrinology.org by **9 July 2004**.

ALISON MOSTYN
YOUNG ENDOCRINOLOGISTS STEERING GROUP

Winners at BES

The winner of the 2004 BES Award supported by Pfizer was I Gonzalez (London), who collected a £10,000 research grant. Travel grants of £500 were awarded to D Gonzalez (Cambridge), Paul Squires and Rosemary Bland (Coventry), Joanne Barnard (London), Claire Perks (Bristol) and Fiona Lovett (Cambridge). The Novartis Awards, each of £1000, were won by I Gonzalez (London) and Oliver Walker (Cambridge). Thanks to Pfizer and Novartis for their generous support, and congratulations to all the recipients!

Wimbledon wannabies at BES 2004: (left to right) Fred Wu, Jack Ham, Maggie Carson, Slobodan Vukicevic, Vijay Jayagapol and Steve Franks.

Stem cells in the spotlight

Just one of the many highlights of BES 2004 in Brighton...

A windswept seafront perhaps wasn't that surprising a welcome to Brighton in late March! BES 2004 opened in fine thought-provoking style with a public meeting entitled 'Stem cell research: what will it do for us?' Organised jointly with Sense about Science, this controversial topic was chosen for its public interest, and attracted an audience of over 120. About half were members of the public, including school groups, patient representatives and local hospital staff.

The main speaker, Professor Harry Moore, co-directs the Centre for Stem Cell Biology at the University of Sheffield. He began by outlining the current position of stem cell research and its long-term prospects, before explaining its importance, and the impact of legislation.

While many cell types in the body can keep regenerating, many cannot. Common degenerative diseases include type 1 diabetes mellitus, Parkinson's disease, Alzheimer's disease and heart disease. Unlike donor hearts and kidneys, cells cannot be donated in the 'conventional' way to overcome these diseases. Islet cells from cadavers have been successfully transplanted, but two or three donors are required, and so there aren't enough to treat the millions of diabetic patients.

The answer for diabetics could be stem cells that are induced to make insulin, while Parkinson's patients could receive brain implants containing stem cell-derived neurones that secrete dopamine. Stem cells are necessary because they are undifferentiated, pluripotent and will keep dividing. Furthermore, we can make them grow into specialised cells such as insulin-secreting cells, brain cells and heart cells.

They are obtained from the inner cell mass of a blastocyst. Controversially, human stem cell research requires the donation of human embryos, and this has meant revising the Human Fertility and Embryology Act (HFEA) 1990. The original act allowed research on embryos up to 14 days of culture to advance the treatment of fertility, and to investigate causes of congenital diseases and other problems associated with infertility and miscarriage.

In 2001 the law was amended to embrace investigation of other, serious diseases, including use of stem cell research. The guidelines are strict, requiring local ethical approval, an HFEA licence, counselling for donors of embryos and consent that, where stem cells are produced, they may be stored for future use. Retrospective consent may also be required from individuals who have had their embryos stored.

The establishment of a National Stem Cell Bank will allow research to progress, but Professor Moore thinks that it will be at least 20 years before stem cells are put to therapeutic use. As he explained, 'It's not simply the ability to make specialised cells, we also need to know that they are not genetically reprogrammed, that they are free of viruses and other potential contaminants, and that they will not keep dividing once implanted. There is still a long way to go.'

The associated social, moral, religious and political issues came under discussion by the invited panel: Dr Adam Hedgecoe, a sociologist from the University of Sussex, Rabbi David Myer from the Brighton and Hove Reform Synagogue and Dr Des Turner, retired endocrinologist and now MP for Brighton Kemptown.

Topics included the dangers of new scientific discoveries, setting legal frameworks without stopping progress, and the uncertainty of cutting-edge science. They raised the question of adult versus embryonic stem cells, and how the media had confused cloning with tightly regulated stem cell research, so raising public concern. Des Turner remarked that 'We in Parliament are quite satisfied that cloning will not happen in the UK for a very long time.'

Over a quarter of the audience have so far returned evaluation forms, and more than 80% of these have been extremely positive about the event - a great result for our first attempt at engaging the public. Researchers and members of the public alike have commented that the content was pitched at the right level, and that the event should have been longer! We hope to include public science events as regular features of BES or Society meetings from now on, whenever venue and programme allow.

SAFFRON WHITEHEAD & JANE SHEPLEY

An endocrinologist in politics...

Former endocrinologist Des Turner is now MP for Brighton Kemptown. Educated at Luton Grammar School, he graduated in botany from Imperial College. After a masters degree in biochemistry at University College he went to Guy's as a postgraduate student to study gut hormones. Quentin Letts once described Des as 'a Brylcreemed old leftie' - a leftie he may be, but there was no evidence of Brylcreem when I asked him a few questions at the BES!

How did you make the move from science to politics?

I spent nearly 20 years in science. My political career started when I became a borough councillor in 1985. In 1997, I was elected as Labour MP for Brighton Kemptown.

Have you carried your science background into politics?

My special political interests are in health, ageing, social services, science policy and poverty issues. I am a member of the Science and Technology Select Committee.

What issues are currently being scrutinised by the Select Committee?

At the moment we are looking at nanotechnology, the development of scientific technology and the expense of scientific publishing.

Were you always interested and active in politics?

I suppose I was always interested in politics but I didn't become active until I became a councillor. Then it's like a drug. One wants to make a difference in people's lives.

Finally - is being Chair of the House of Commons Yacht Club very onerous?!

Not exactly, but I love sailing!

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).

Abbott Diagnostics Ltd

Abbott House, Norden Road, Maidenhead SL6 4XE, UK
(Tel: 01628-773355; Fax: 01628-644305;
Web: www.abbottuk.com)

Ardana Bioscience Ltd

Ardana Bioscience Ltd is a specialty pharmaceutical company, which aims to discover, develop and market innovative products that promote better reproductive health.

The company was created in July 2000 to commercialise research developed by the Medical Research Council Human Reproductive Sciences Unit (HRSU) in Edinburgh, UK. The HRSU is one of only four academic centres of excellence in human and primate reproductive biology in the world. On inception, Ardana rapidly reviewed and prioritised the HRSU research programmes, and today it is aggressively progressing selected projects through early stage development.

In tandem with this activity, the company has undertaken a series of licensing agreements and strategic product and company acquisitions to rapidly build a later stage development portfolio.

Ardana's key therapeutic and commercial areas of interest are:

- Androgen replacement
- Endometriosis/menstrual disorders/infertility
- Male and female contraception
- Male and female sexual dysfunction
- Obstetrics

Within its chosen therapeutic areas, Ardana plans to market its own products to endocrinologists and reproductive health specialists. The launch of Ardana's first flagship product, a buccal testosterone replacement therapy indicated for male hypogonadism, is anticipated in 2004.

Ardana Bioscience Ltd, 58 Queen Street, Edinburgh EH2 3NS, UK (Tel: 0131-226 8550; Fax: 0131-226 8551;
Web: ardana.co.uk)

AstraZeneca

Mereside, Alderley Park,
Macclesfield
SK10 4TG, UK
(Web: www.astrazeneca.com)

BioScientifica Ltd

BioScientifica Ltd is the trading subsidiary of the Society for Endocrinology. All profits made by BioScientifica are returned to the Society.

Our staff have unrivalled experience in organising conferences and symposia, as well as all types of learned publishing, including the use of electronic media. Key subject areas include metabolism, endocrinology, fertility and many other fields. Our daily contact with both the pharmaceutical industry and prominent clinicians and scientists in the UK and abroad gives us a unique edge in working with these highly demanding communities. We work with some of the world's most prestigious societies and pharmaceutical companies.

Conference organisation
We run annual and one-off conferences ranging in size from 50 to 1500 delegates. We function as a complete professional conference organiser, arranging every aspect of the event, from choice of venue and booking speakers, through social events, to follow-up after the conference. We have experience of most of the UK's premier conference venues (such as Birmingham ICC, Glasgow SECC and Bournemouth ICC).

Product launches and symposia
We organise symposia and product launches for pharmaceutical and healthcare companies and medical organisations. We will work with your staff to select venues and organise events appropriate to your requirements. Our experienced publishing department can effectively extend the lifetime of any symposium by publishing conference proceedings.

Membership services
BioScientifica runs membership services for scientific and learned societies, including the British Fertility Society and the Bone and Tooth Society.

Publishing
BioScientifica has developed an enviable reputation for rapid and accurate publication of conference and symposium proceedings. We can publish the content from your meeting in the format of your choice, ranging from formal proceedings in a hardback book to a single-article newsletter-style summary. We offer a complete service, including liaison with your speakers (where appropriate), right through to delivery and distribution of the finished product.

A major part of our expertise is in publishing world-class research journals both online and in print, for example *European Journal of Endocrinology* and *Reproduction*. We also publish newsletters and academic books. Contact us for examples.

Electronic and internet publishing
BioScientifica can produce symposium proceedings on CD-ROM or on the internet. These can be fully searchable with links to journals, new research, manufacturers' home pages, patient support groups, etc.
For more information on any of these services contact:

Tom Parkhill, Business Development Officer
(Tel: 01454-642230; Email: tom.parkhill@endocrinology.org)
Liz Brookes, Events Manager
(Tel: 01454-642210; Email: liz.brookes@endocrinology.org)

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Eli Lilly and Company Ltd

Lilly has been at the forefront of many of the most significant breakthroughs in modern medicine, and, in the words of our former president Eli Lilly, grandson of the company founder, 'research is the heart of the business, the soul of the enterprise'. This commitment to discovering and developing innovative therapies for many of the world's unmet medical needs means that Lilly is now a leader in providing health information and medicines in a number of major therapy areas, including mental health, primary care, critical care, and diabetes and endocrinology.
Eli Lilly and Company Ltd, Lilly House, Priestley Road, Basingstoke RG24 9NL, UK (Tel: 01256-315000; Web: www.lilly.co.uk)

Genzyme Therapeutics

Genzyme Therapeutics is a major biotechnology company focusing on the research and development of products to address unmet medical needs. We are probably best known in the UK for the development of Cerezyme (imiglucerase), which is used in the management of the rare lysosomal storage disorder, Gaucher's disease.
Genzyme Therapeutics, c/o Kellie Higgins, 17 Hollands Road, Haverhill CB9 8PU, UK (Tel: 01440-716443; Fax: 01440-710985; Email: kellie.higgins@genzyme.com; Web: www.genzyme.com)

GlaxoSmithKline

GlaxoSmithKline is one of the world's leading research-based pharmaceutical and healthcare companies. We are committed to improving the quality of human life by enabling people to do more, feel better and live longer.

We are committed through an extensive research and development programme to the development of a number of PPAR agonists and other novel pharmaceutical agents for the treatment of type 2 diabetes. To date, GlaxoSmithKline has invested an unprecedented £160 million in landmark clinical outcome studies and other studies employing rosiglitazone alone or in combination with other agents to evaluate their impact on prevention or progression of type 2 diabetes and reducing the risk of cardiovascular disease. Since the approval of rosiglitazone in July 2000, more than 4 million patients have been treated worldwide.
GlaxoSmithKline, Stockley Park West, Uxbridge UB11 1BT, UK (Tel: 020-89909000; Fax: 020-89904321; Web: uk.gsk.com)

Ipsen Ltd

Ipsen Ltd is the UK subsidiary of a multinational pharmaceutical group, founded in 1929 by Dr Henri Beaufour. Ipsen has a history of successful discovery, with a continued commitment to research and development in four key therapeutic areas: endocrinology, oncology, neurology and haematology. The product portfolio comprises nearly 30 products and includes several that are therapeutic class leaders.

The ability to combine the therapeutic potential of peptides with sophisticated controlled-release delivery systems has been a major factor contributing to the company's growth and success in recent years. Ipsen is the only company in the world to supply prolonged release formulations of more than one peptide: Decapeptyl (triptorelin), Somatuline (lanreotide) LA and Autogel.

Our commitment to endocrinology and in particular to growth disorders is demonstrated by our continuing research and development programme into the role of somatostatin analogues, including the development of new receptor subtype specific compounds, and further by our recent partnership with Genentech. This partnership will allow us to develop our portfolio within endocrinology and has already allowed us to bring NutropinAq (somatropin, recombinant DNA origin, *Escherichia coli*), a liquid preparation of growth hormone, to the UK.
Ipsen Ltd, 190 Bath Road SL1 3XE, UK (Tel: 01753-627700; Fax: 01753-627701; Web: www.ipsen.ltd.uk)

Novartis Pharmaceuticals UK Ltd

Novartis AG is a world leader in healthcare, with core businesses in pharmaceuticals, consumer health, generics, eye care, and animal health. The Group has invested approximately $2.4 billion in research and development, employs about 70,000 people, and operates in over 140 countries around the world.

In the UK, Novartis has large research and production facilities, as well as a dedicated sales and marketing company. Novartis UK is organised into integrated business units, covering all aspects of customer relations from clinical development to sales and marketing.

Our endocrine/oncology business team has the leading UK product in the somatostatin analogue market, in the form of Sandostatin LAR. Radiolabelled sandostatin analogues and universal somatostatin receptor blockers are both in development. Other products that we currently market include Zometa, a highly potent bisphosphonate, Aredia, Femara, an aromatase inhibitor, and Glivec, the first signal transduction inhibitor to reach the market, representing a significant milestone in targeted anti-tumour therapy.

The Novartis endocrinology team is proud of its links with the Society for Endocrinology and is pleased to offer support where it can. The team can be contacted on 01276-698561.
Novartis Pharmaceuticals UK Ltd, Frimley Business Park, Frimley, Camberley GU16 7SR, UK (Tel: 01276-692255; Fax: 01276-698605; Web: www.novartis.com)

Novo Nordisk Pharmaceuticals Ltd

Novo Nordisk is a healthcare company with a leading position within areas such as diabetes care, growth hormone therapy, haemostasis management and hormone replacement therapy.

Within growth hormone therapy, Novo Nordisk launched its first growth hormone product in 1966, and has been involved in basic and clinical research in this area ever since. In 1988, Novo Nordisk introduced a biosynthetic growth hormone preparation, Norditropin®.

In 1999, Novo Nordisk launched the world's first - and still the only - ready-to-use liquid growth hormone, Norditropin® SimpleXx®. This is supplied in an advanced pen system that was developed by building on work with patients and utilising existing experience in diabetes research. This pen system was designed to ensure that people who use growth hormone could simply, comfortably and accurately administer their dose.

In June 2003, Norditropin® SimpleXx® was approved by the European Commission for the treatment of children who were born short for gestational age. Novo Nordisk is committed to manufacturing and marketing pharmaceutical products and services that will continue to make a significant difference to patients, the medical profession and society.

With headquarters in Denmark, Novo Nordisk employs approximately 18,700 people in 68 countries and markets its products in 179 countries.

Novo Nordisk Pharmaceuticals Ltd, Broadfield Park, Crawley RH11 9RT, UK (Tel: 0845-6005055; Web:www.novonordisk.co.uk)

Organon Laboratories Ltd

Organon is a renowned global pharmaceutical company with a strong commitment to healthcare. Organon makes products that contribute to the health of people and their quality of life. It is this that ultimately determines our existence and success. We are committed to innovation and have developed some of the most innovative prescription medicines for gynaecology, mental health, anaesthesia and cardiovascular disease.

Organon's commitment to innovation is apparent in the UK. Since 1996, a multimillion pound investment has transformed Organon's drug discovery complex into the largest research centre of its kind in Scotland.

Together with our other main research facility in Oss, The Netherlands, we are exploring the boundaries of pharmaceutical research, in the hope that generations to come will enjoy a more secure and healthier future.

Organon Laboratories Ltd, Cambridge Scientific Park, Milton Road, Cambridge CB4 4FL, UK (Tel: 01223-432700; Fax: 01223-424368; Web: www.organon.co.uk)

Pfizer Ltd

Pfizer, with its UK business headquarters in Surrey and global headquarters in New York, is a research-based global pharmaceutical company. Pfizer discovers, develops, manufactures and markets leading prescription medicines for humans and animals, and many of the world's best-known consumer products.

Since 1998 Pfizer has made a capital investment of more than £1 billion in the UK and, following its acquisition of Pharmacia in April 2003, is the largest supplier of medicines to the NHS. It is estimated that on any given day, 40 million people around the world are treated with a Pfizer medicine.

Pfizer is excited to add the Pharmacia endocrine care portfolio of Genotropin® (somatropin recombinant), and Somavert® (pegvisomant powder and solvent for solution for injection) to the organisation. Pfizer is highly committed to these important products and to continued investment in this key therapeutic category.

Pfizer wish to continue to help enhance patient care today while refining therapy for future generations. Pfizer will be using its resources and capabilities to help provide the greatest value to patients.

Pfizer Ltd, Walton Oaks, Dorking Road, Tadworth KT20 7NS, UK (Tel: 01304-616161; Web: www.pfizer.co.uk)

Randox Laboratories Ltd

Randox Laboratories Ltd has over 20 years' experience in the development, manufacturing and marketing of high quality diagnostic reagents and equipment for laboratory medicine. Randox supply about 35,000 laboratories in over 130 countries worldwide. All Randox reagents are manufactured under rigorous quality control procedures to achieve the high quality standards expected in clinical science. Approximately 28% of gross sales revenue is invested in research and development, to ensure that kits are developed to the highest specifications and conform to international standards. Commitment to quality is emphasised by ISO 13485 accreditation for the development and manufacturing of diagnostic test kits.

Randox's clinical products can be found in almost every country throughout the world. The Randox portfolio includes biochip array technology, clinical chemistry automation systems, external quality assurance schemes, internet driven quality assurance systems, quality control materials, clinical reagents and environmental diagnostics.

Randox Laboratories Ltd, 55 Diamond Road, Crumlin BT29 4QY, UK (Tel: 028-94422413; Fax: 028-94452912; Email: marketing@randox.com; Web: www.randox.com)

Sandoz Biopharmaceuticals

Sandoz, a Novartis company, is one of the leading manufacturers of biotechnological products. Long-standing experience and know-how make Sandoz a renowned partner in three business franchises: pharmaceuticals, biopharmaceuticals and industrial products. With headquarters in Vienna, Sandoz employs around 13,000 people and posted sales of $2.9 billion in 2003.

Based on extensive expertise in the field of recombinant products, Sandoz has cutting-edge experience in the production and processing of biopharmaceuticals, and as such constitutes the competence centre in the biopharmaceutical production field within Novartis. Drawing on the company's rich experience in biotechnology, Sandoz Biopharmaceuticals is expanding to meet growing demand.

Within Sandoz, the pharmaceuticals business produces high quality generic pharmaceuticals that are sold to pharmacies and hospitals. The industrial products business manufactures active pharmaceutical ingredients for industrial partners.

In 2003, numerous different company brands were rebranded under the single name Sandoz. Over the last few years, the company has grown dynamically and undertaken various strategic acquisitions. The establishment of a uniform brand has strengthened and harmonised its global position and identity.
Sandoz GmbH, Wagramer Str. 19, 1220 Vienna, Austria (Tel: +43-1-26068; Web: www.sandoz.com)

Schering Healthcare Ltd

The Brow, Burgess Hill RH15 9NE, UK (Tel: 01444-232323; Fax: 01444-246613; Web: www.schering.co.uk)

Serono Ltd

Serono Ltd is the UK subsidiary of Serono International S.A, the largest biotechnology company in Europe with a portfolio of endocrine products including recombinant gonadotrophins and the recombinant human growth hormone Saizen.

Serono's UK Growth Hormone team is committed to the highest level of support for clinicians, nurses and ultimately patients using Saizen. Through our products and services, we aim to provide a difference to the quality of life of patients on GH therapy in a full range of indications including Adult GH deficiency, paediatric GH deficiency, Turners Syndrome and chronic renal failure.

The Saizen device family provides a real choice of GH administration devices including One.Click, the only true multidose autoinjector for growth hormone and Cool.Click, a new generation needle-free device for the administration growth hormone. Both devices use the Saizen 8mg Clickeasy multidose formulation of growth hormone. Serono Homecare can also provide a tailored home delivery service for consumables and drugs where required as well as a nursing service to support successful use of Saizen in patients.

Serono Ltd is pleased to be a major benefactor of the BES.
Serono Ltd, Bedfont Cross, Stanwell Road, Feltham TW14 8NX, UK (Tel: 020-88187200; Fax: 020-88187222; Email: serono_uk@serono.com; Web: www.serono.com)

Menopause: design fault or design feature?

Simon Aylwin questions how the endocrinology of ageing should be interpreted in the light of developments in evolutionary biology.

Hormone replacement therapy (HRT), particularly oestrogen replacement, provides an ever-expanding source of literature for physicians to try and integrate into clinical practice. But while we have perhaps been distracted by HRT, a more seismic shift has taken place in the understanding of the evolutionary purpose of post-menopausal life.

A central early dogma of life-history theory held that there should be no selection pressure after the end of reproductive capacity. However, it has been increasingly accepted that the prolonged lifespan of human beings, beyond their reproductive years, is not merely a phenomenon of post-industrial societies. With notable exceptions, the increasing average life expectancy amongst such populations is predominantly a consequence of the falling infant and juvenile mortality rates, rather than improvements in social welfare and availability of medical care. So what is the advantage to the species of an extended post-reproductive lifespan - a feature unique to mankind?

Enter the 'grandmother hypothesis', which suggests that it is help from, rather than for, the ageing female that has contributed the selection pressure to embed this longevity into our species' hard-wiring. Fundamentally, the grandmother hypothesis holds that nutritional support for younger women (and families) from their mothers improves both their fecundity and their lifetime reproductive success in terms of rearing offspring to maturity.

Lahdenperä *et al*. (*Nature* 2004 **428** 178-181) have recently added weight to this interpretation by demonstrating precisely these effects in two contrasting populations over the 18th and 19th centuries. In both Canada and Finland, women with a live mother began reproducing earlier and had an average of 1.6 more offspring, more of whom survived to maturity. Each additional 10 years of grandmaternal life over the age of 50 led to two additional grandchildren. The advantage of having a live grandmother was largely lost where they were living outside the community (so what else has changed?).

If grandmothers are so important to our success, why burden women with the menopause, or for that matter any of the other endocrine phenomena of ageing? Female reproductive capacity drops markedly at 40 years although ovarian steroidogenesis continues unabated for a further 10 years or more. Perhaps the evidence base for HRT provides the answers.

One of the unsung findings of the Women's Health Initiative (WHI) study (*JAMA* 2002 **288** 321-333) was the spectacular lack of impact of HRT on overall mortality. A bit more of this, a bit less of that, and at the end a monumental zero effect - an odds ratio of 0.98. The WHI study was brought to a premature halt, but we know that oestrogen replacement poses a cumulative risk of breast cancer. One might speculate that the physiological fall in oestrogen occurs at a time when it ceases to confer long-term survival benefit up to and including grandparental age. Menopause might occur at 50 to protect vitality at 70.

> *'Each additional 10 years of grandmaternal life over the age of 50 led to two additional grandchildren'*

In addition to the menopause, an increasing number of pauses are now recognised as features of normal ageing, like the declines in IGF-I, DHEA and testosterone in males. As clinicians, we are at a loss as to whether these are 'normal', and have made attempts to 'correct' these levels to young adult ranges. One by one, however, interfering with these age-related changes has ended in tears. Amongst other conditions, ageing brings with it an increased risk of cancer: are the declines in IGF-I, oestrogen and androgen protective adaptive mechanisms to preserve the vigour of the vital grandparent?

So perhaps we should recognise the specific evolutionary contribution of post-reproductive females, and equally acknowledge that age-related endocrine changes might not be entirely accidental. We clearly need to treat the consequences of post-menopausal oestrogen status, and we might even treat the deficiency itself - we just need to be smart enough to treat the consequences.

SIMON AYLWIN

NICE and easy does it: paediatric GH therapy

All growth hormone-deficient (GHD) children, including those with Prader-Willi syndrome (PWS), girls with Turner's syndrome, and patients whose growth is adversely affected by chronic renal failure, can continue to be offered GH therapy as they were before. So concluded the NICE appraisal of paediatric GH therapy. (Intra-uterine growth retardation did not have a product licence at the time the therapy was appraised.)

NICE also provided guidance on the transitional care of the GHD teenager. Where retest GH status at the end of linear growth and completion of childhood GH therapy is consistent with severe GHD (as judged by criteria derived from middle-aged GHD adults), GH replacement should be continued seamlessly up until 25 years of age. At this age, completion of certain aspects of adult body composition and the acquisition of bone mass is expected. Older patients with severe childhood-onset GHD may be considered for GH replacement, based on exactly the same criteria that apply to cases of adult-onset severe GHD in the UK.

The appraisal committee reviewed evidence regarding both clinical and cost effectiveness of GH treatment for each condition under consideration. Evidence from randomised clinical studies, observational studies, and from children with these diseases, via their carers, patient/carer groups and clinical experts, was reviewed.

In total, 32 studies of clinical effectiveness were reviewed across the indications. The studies evaluated short-term growth and final height outcomes, together with some body composition outcome data. Treatment duration in the studies ranged from 6 months to 8 years. Analysis of the clinical efficacy data showed that the effect of GH on short-term growth velocity ranged from no improvement to approximately one standard deviation above the normal growth velocity for children of the same age. However, adult height was improved in each indication, with the height gain ranging from approximately 3cm to 16cm, depending on the underlying condition. The beneficial effects of GH on body composition in children with PWS amounted to 7-8% less body fat and approximately 4kg more lean body mass than untreated children.

Treatment with GH is expensive. In the appraisal committee's assessment of cost effectiveness for the various indications, it considered a number of analyses from GH manufacturers (Eli Lilly, Novo Nordisk and Pharmacia (now Pfizer)), as well as an independent assessment report by the Wessex Institute for Health Research and Development. Not surprisingly, the most important factors influencing the cost of therapy were considered to be its effectiveness, dose and length of treatment.

The Wessex report estimated that the lifetime incremental cost of treating one child with GH ranges from £43,100-£53,400 for GHD to £55,500-£83,000 for PWS. Cost/benefit analyses submitted by the manufacturers showed that the incremental cost effectiveness ratio (based on gain in height as the desired endpoint) per quality-adjusted life year gained was £5500-£9000 for GHD, £10,500-£18,000 for Turner's syndrome and £5000-£11,000 for chronic renal failure.

Based on all this information, the NICE appraisal committee decided that the cost effectiveness of the height gain resulting from GH treatment of GHD, Turner's syndrome and chronic renal failure was sufficient for them to approve its use for these conditions. In the guidelines, NICE states that the height gain is a worthwhile gain for the resource (GH treatment), given its lifelong value and the psychological importance to the child.

The appraisal was a breeze considering that the evidence base for the treatment of children with GH is so thin! Gain in height is assumed to be a surrogate for improvement in quality of life or achievement of potential. Absolutely no confirmatory data exist to support this assumption, although some evidence suggests that achievement of target genetic height following GH therapy in children with severe GHD is a surrogate for the acquisition of normal body composition and skeletal health.

Even without the requisite evidence, most of us can accept relatively easily the notion that a child with a genetic form of GHD who is destined to achieve a final height, if untreated, of just 4ft, or in the case of a girl with Turner's syndrome, 4ft 8.5ins, will benefit from GH treatment. Unfortunately, the most common aetiology of GHD in children is described as isolated idiopathic GHD, and it is more often partial than severe in terms of degree. Furthermore, on retesting at the end of linear growth, many but not all such children will be shown to have normal GH status. Under these circumstances it is much more difficult to be convinced that the child has gained significant benefit from childhood GH treatment.

'The appraisal was a breeze considering that the evidence base is so thin'

As a leading UK paediatric endocrinologist, Professor Chris Kelnar, recently wrote, 'if you cannot demonstrate effectiveness of GH therapy in terms of meaningful quality of life outcomes in short stature children, cost effectiveness is not even an issue that requires consideration'. It is curious, then, that NICE could draw such robust conclusions.

Make no mistake, I am happy with the outcome of the NICE paediatric GH appraisal. At face value, NICE made huge allowances for the lack of evidence and ostensibly listened to the experts. A cynic, however, might believe it was a political decision; perhaps those in high places within the Department of Health may perhaps have anticipated headlines like 'Government rationing stops children growing' in the wake of a negative appraisal.

It will be interesting to consider whether the generosity of the NICE appraisal committee extends similarly to adults with GHD. Read the next edition of *The Endocrinologist* to find out!

STEPHEN SHALET

'Foundation' engineering

Few articles in *The Endocrinologist* are inspired by geotechnology and written by a civil engineer - but please trust me and read on! My story started on a canal boat holiday, a marvellous opportunity to observe civil engineering in its purest and simplest terms: cuttings, embankments, locks, bridges and aqueducts. As you steer the boat, there is plenty of time to look around, stare into the distance and notice that, if you close one eye and then the other...

Are you getting the picture? I wasn't. My optician tested my visual fields and sent me to hospital with a note saying 'suspected pituitary tumour'. It was actually a craniopharyngioma but, as the neurosurgeon said, 'it was tangled up in the clockwork' and as a result 'the pituitary stalk became severed' during its removal.

Well, it could have been worse. If it hadn't been removed, I would have first become blind and then dead. But what was all this about replacement hormones? What was this diabetes that wasn't the same as ordinary diabetes? What do they mean when they say I have to increase my cortisone if I am poorly? Can my GP help? He is struggling. He tells me that, on average, he will see just one patient with my condition in the whole of his career.

All of this was 12 years ago. Somehow my wife and I muddled through. Then we heard of a new organisation that was trying to provide information to pituitary patients. It had brochures that described the various conditions that might result from pituitary disorders. It had a helpline that people could phone for support. It was proposing to have a regular newsletter and to start up local support groups, where pituitary patients and their carers could meet and share their experiences. This was brilliant. Recalling our dark days just after my operation, this support would have been marvellous back then. Furthermore, my own problems hadn't gone away. There was still a substantial difference between managing my own hormones and relying on a feedback loop that had evolved over millions of years.

Consequently, we helped to start a pituitary support group around Bristol. We were overwhelmed by the number of people who, like us, had been struggling to understand pituitary disease and how it was affecting them. People with acromegaly had the chance to meet others with the condition for the very first time. Sufferers of Cushing's described their desperation in trying to persuade anyone that they were seriously ill and not just overeating. We heard about people who were so thirsty that they drank out of puddles and were told that they urinated at lot because they drank so much. And while local groups started up around the country, the organisation went from strength to strength, building up its available literature, creating its own web site, winning lottery grants to start up more local groups, and battling with NICE on the national stage to try to secure replacement growth hormone for patients.

This was the Pituitary Foundation 18 months ago. At its inception in 1994, those who had initiated it, including Sue Thorn, John Wass and Stafford Lightman, had recognised the need and had had the vision, the determination and the contacts to forge an organisation that was able to support and inform people who were affected by pituitary conditions. They now felt that it was time for the Foundation to be led by the people it was created for and, as a patient, I was asked to become Chairman of the Trustees.

An engineer needs a plan. If he is going to make things happen - build a canal, build a bridge - he first needs to understand all the issues that will influence his design. Will the foundations be in sand or clay? How far can we stretch the aqueduct's spans to save the cost of extra pillars? Where will the raw materials and money come from? How long have we got to build the project? How long does it need to last? There are two watchwords that, for me, underlie all these considerations: quality and sustainability.

I have no doubt that the bedrock of quality that supports the Foundation is the information provided by our Medical Committee, on which key endocrinologists from around the country serve. Our ability to provide first class information adds tremendous strength to our ability to support patients and carers.

As for sustainability, another whole article is waiting to be written. The next step will mark the Foundation's 10th anniversary on 24 November 2004, with a National Pituitary Awareness Day to raise the profile of pituitary disease. But 10 years is not enough. We must find the right way to engineer the Foundation so that it is always there - so that, for as long as there are going to be pituitary patients, there will be a Pituitary Foundation.

ANDREW HEWITT BA CENG MISTRUCTE MICE

THE PITUITARY FOUNDATION

National Pituitary Awareness Day

Wednesday 24 November 2004

The Pituitary Foundation will mark its 10th anniversary in November 2004 with its first health awareness day. The aim is to promote public understanding of the importance of the pituitary gland, and to highlight how it can disrupt the whole body when things go wrong.

If you would like to support this event locally and can arrange a display or local press cover, or if you would like more information, contact Jan at the Pituitary Foundation (janpacker@pituitary.org.uk).

Thank you to all members of the Society for Endocrinology for your continued support.

Feedback seems to be the hardest word...

We live in a world in which our performance is constantly evaluated. At the close of every meeting, big or small, every participant is requested to complete an evaluation questionnaire. What were the talks like? Did they meet your educational needs? What about the venue? The arrangements? The lighting, the colour of the curtains, the quality of cake available during the tea break?

As a contributor to such events, I always dread receiving the analysis of the questionnaire results. It is always my failure that preoccupies me. Even if 60% of the audience 'strongly liked' my talk and 30% 'quite liked' my talk, the other 10% certainly did not! What's wrong with these people? Are they nuts or simply ignorant? Where did I go wrong? Not up to date enough, poor presentation skills, unattractive looks or one joke too many - which in a medical talk usually means one joke. Were the data under-interpreted, over-interpreted or was the presentation simply too dull?

How can I do better? I need to gain more sympathy; after all, we all need to be loved. If you prove to be technically inept with the Powerpoint presentation the audience laughs at you rather than with you. For years I had already tried to capture the sympathy vote by adopting the 'John Wayne' limp as I walked onto stage - but without any noticeable improvement in my evaluation scores.

I was given further food for thought when I recently participated in a workshop held in Houston, Texas, on the subject of fertility in cancer survivors. The quality of the presentations was high and at least three presentations, two oral and one poster, contained work about to appear in either *Nature* or *The Lancet* during the following 10 days. This success meant that the presenters of the two oral communications introduced their talk with 'This talk is embargoed, the data are due to be published in *The Lancet/Nature* during the next 10 days; I forbid any video recording of this material!'

Not only were many of the presentations at the cutting edge of the subject but also the speakers were intensely passionate about the need for cancer survivors to have a chance to reproduce. This emotional investment became easier to understand when several of the speakers announced that they themselves were cancer survivors.

Now I was due to present the following day and I had to face it, my cupboard was bare, both scientifically and emotionally. Nothing was about to appear in *Nature/The Lancet,* and thus far I have been fortunate enough not to have cancer.

I came clean on the scientific front: 'This talk is not embargoed, all the data to be shown have been published and anyone wishing to video the presentation can do so to their heart's content.' Then I sifted through my personal medical history but all I could come up with was a torn knee cartilage, some broken bones and a Dupuytren's contracture: clearly too lightweight to draw sympathy. No way could I pretend to be a cancer survivor, but I took the opportunity to exaggerate my 'John Wayne' limp.

'I was due to present the following day and I had to face it, my cupboard was bare, both scientifically and emotionally'

My worst fears were confirmed when I saw the results of the questionnaire analysis. The usual distribution of scores was in evidence, but complimented by one additional pithy comment that simply said: 'the real John Wayne had cancer'.

'HOTSPUR'

be SIGnificant!

Join your Special Interest Group today...

Society members are entitled to join any Special Interest Group (SIG) at no extra cost. Get involved now to play a full and active part in your area of research!

Enthusiastic volunteers are sought to run groups in:

- Steroids
- Pituitary
- Neuroendocrinology
- Any other areas that you suggest

Bone and mineral is the topic for a suggested SIG - would you join?

PCOS and the metabolic syndrome is the newest group, formed in response to our recent call for volunteers - get in touch if you would like to join!

Contact Rachel Evans in the Bristol office (rachel.evans@endocrinology.org) straightaway you are interested in any of the above.

SIGs aim to:

- Provide a focus for sub-specialties within endocrinology, to strengthen the discipline and form a community for promotion of interdisciplinary interests
- Organise small meetings for focused groups, either individually or as part of the annual November meeting
- Increase the profile of endocrinology as a speciality

Each group will:

- Set up an informal committee and constitution
- Initiate and manage communication between its members
- Organise any desired activities on a cost-neutral basis

To read more about SIGs see issues 67 and 70 of this newsletter at www.endocrinology.org/sfe/newslet.htm

Hot Topics

More of the most recent research highlights from the Society's journals brought to you by Jolene Guy, Paul Ashton, Mona Munonyara and Nathalie Gilmore.

LIF, PGE_2 and murine decidualisation

Embryo implantation requires a series of biochemical changes and differentiation in both the embryo and the uterus. Several factors are known to induce or be essential for decidualisation, including steroids, prostaglandins and leukaemia inhibitor factor (LIF). Maternal expression of both prostaglandins and LIF appears vital for successful implantation of the murine embryo. Although the action of prostaglandins, particularly prostaglandin E_2 (PGE_2) is well understood, the molecular mechanism by which LIF regulates the implantation process and interacts during decidualisation and implantation has remained unclear.

Fouladi Nashta and co-workers investigated the effect of LIF and PGE_2 and their inhibitors on murine stromal cells *in vitro*. An increase in alkaline phosphatase (ALP) is a recognised marker of decidualisation. The study found that PGE_2 increased ALP activity but was dose-dependently suppressed by a prostaglandin inhibitor. Unexpectedly, LIF had an inhibitory effect on decidualisation in 2% serum but did not affect PGE_2 secretion. In the absence of serum, no differences were observed between LIF-treated and untreated cells. This study presents a significant insight into the molecular events of early murine pregnancy. **JG**

(See the full article in Journal of Endocrinology ***181(3)****, June 2004)*

Cell-type specificity of retinoic acid

Retinoic acid is thought to regulate the growth of carcinoma cells through retinoic acid receptors (RARs). In this study, Wu and colleagues investigated the regulatory effects of all-trans retinoic acid (ATRA) on RARα-dependent signal transduction in gastric and breast cancer cell lines. The authors report that ATRA exerted different regulatory effects on ubiquitination and sumoylation of RARα, depending on cell type.

In MCF-7 breast cancer cells, ATRA enhanced the ubiquitination of RARα. This led to the accelerated degradation of RARα through the ubiquitin/proteasome pathway, causing the separation and translocation of its heterodimeric partner, retinoic X receptor α (RXRα), to the cytoplasm, and the loss of its DNA binding activity. However, in BGC-823 gastric cancer cells, DNA binding activity increased because ATRA augmented sumoylation of RARα, rather than ubiquitination, facilitating stability with its heterodimeric partner in the nucleus.

It appears that RARα in its sumoylated form is more efficient in mediating ATRA signals than ubiquitinated RARα in different cancer cell types. **PA**

(See the full article in Journal of Molecular Endocrinology ***33(3)****, June 2004)*

Leptin: cardiovascular friend and foe

Leptin regulates cardiac and vascular contractility through a local nitric oxide-dependent mechanism, in addition to its well-established metabolic effects. In this review, Ren examines leptin's potential associations with cardiovascular disease.

Hyperphagia and elevated levels of leptin (along with insulin) are common features of obesity, hyperlipidaemia and hypertension. This seems paradoxical, since leptin is a potent inhibitor of food intake and is expected to decrease insulin levels via improved insulin action and inhibition of insulin secretion. The 'selective leptin resistance' theory might explain why hyperleptinaemia contributes to increased sympathetic activity and arterial pressure in obesity, whereas at the same time there is resistance to the satiety and weight-reducing actions of leptin. These findings have prompted speculation that leptin in the physiological range may regulate cardiovascular function, whereas hyperleptinaemia may act as a pathophysiological trigger and/or marker for cardiovascular disease due to tissue leptin resistance.

Understanding the signalling mechanisms behind selective leptin resistance and searching for strategies to alleviate this resistance should have significant clinical value in managing obesity and obesity-associated cardiovascular dysfunction. **MM**

(See the full article in Journal of Endocrinology ***181(1)****, April 2004)*

Serum proteomic hope for ovarian cancer

Since the 1960s, 80% of American women with epithelial ovarian cancer have been diagnosed only once the disease has spread to the upper abdomen or beyond. These women have a much lower 5-year survival rate (15%) than women who are diagnosed earlier (almost 90% of whom survive for 5 years following diagnosis). There is clearly an urgent need to improve diagnosis.

Here, Conrads and colleagues describe the use of serum proteomic patterns to improve diagnoses of ovarian cancer. High resolution mass spectral data containing multiple diagnostic signatures were found, in a blind analysis, to be 100% specific and sensitive in distinguishing between serum samples acquired from unaffected women and those from women suffering from ovarian cancer. The authors have outlined the methodology they have used to achieve these exciting results and emphasise the need for a large clinical study that may subsequently lead to nationwide screening programmes in the USA and elsewhere. **NG**

(See the full article in Endocrine-Related Cancer ***11(2)****, June 2004)*

13th International Workshop on the Development and Function of the Reproductive Organs

Copenhagen, Denmark, 12-16 June 2004.

Contact: Congress Secretariat (Tel: +45-3946-0500; Fax: +45-3946-0515; Email: repro2004@ics.dk; Web: www.repro2004.ics.dk).

ENDO 2004: 86th Annual Meeting

New Orleans, LA, USA, 16-19 June 2004.

Contact: Beverly Glover, Administrative Assistant, Meetings, The Endocrine Society, 8401 Connecticut Avenue, Suite 900, Chevy Chase, MD 20815-5817, USA (Tel: +1-301-9410220; Fax: +1-301-9410259; Email: bglover@endo-society.org; Web: www.endo-society.org).

9th International Workshop on Multiple Endocrine Neoplasias (MEN 2004)

Bethesda, MD, USA, 20-22 June 2004.

Contact: Constantine Strakatis, c/o Sue Perdue (Tel: +1-301-4964686; Fax: +1-301-4020574; Email: strakakc@mail.nih.gov).

20th Annual Meeting of the European Society of Human Reproduction and Embryology

Berlin, Germany, 27-30 June 2004.

Contact: ESHRE Central Office, Van Akenstraat 41, 1850 Grimbergn, Germany (Email: info@eshre.com; Web: www.eshre.com).

1st Milan Thyroid Cancer Conference

Milan, Italy, 1-2 July 2004.

Contact: Francesca Marangoni, ESO Teaching Division, Vle Beatrice D'Este 37, 20122 Milan, Italy (Tel: +39-02-43359629; Fax: +39-02-43359640; Email: conferences@esoncology.org; Web: www.cancerworld.org).

UK Advanced Diabetes Course

Exeter, UK, 7-9 July 2004.

Contact: Rosemary Sowden, R&D Office, Exeter Postgraduate Medical Centre, Barrack Road, Exeter EX2 5DW, UK (Tel: +44-1392-403012; Fax: +44-1392-403012; Email: rosemary.sowden@rdehc-tr.swest.nhs.uk).

Techniques and Applications of Molecular Biology: a Course for Medical Practitioners

Coventry, UK, 12-15 July 2004.

Contact: Charlotte Moonan, Biological Sciences, University of Warwick, Coventry CV4 7AL, UK (Tel: +44-24-76523540; Fax: +44-24-76523701; Email: charlotte.moonan@warwick.ac.uk; Web: www.bio.warwick.ac.uk/shortcourses).

Society for Endocrinology Molecular Endocrinology Workshop

Oxford, UK, 13 July 2004.

Contact: Ann Lloyd, Society for Endocrinology, 22 Apex Court, Woodlands, Bradley Stoke, Bristol BS32 4JT, UK (Tel: +44-1454-642200; Fax: +44-1454-642222; Email: info@endocrinology.org; Web: www.endocrinology.org/sfe/train.htm).

Society for Endocrinology Advanced Endocrine Course

Oxford, UK, 14-15 July 2004.

Contact: Ann Lloyd, Society for Endocrinology, 22 Apex Court, Woodlands, Bradley Stoke, Bristol BS32 4JT, UK (Tel: +44-1454-642200; Fax: +44-1454-642222; Email: info@endocrinology.org; Web: www.endocrinology.org/sfe/train.htm).

Society for Endocrinology Clinical Practice Day

Oxford, UK, 16 July 2004.

Contact: Ann Lloyd, Society for Endocrinology, 22 Apex Court, Woodlands, Bradley Stoke, Bristol BS32 4JT, UK (Tel: +44-1454-642200; Fax: +44-1454-642222; Email: info@endocrinology.org; Web: www.endocrinology.org/sfe/train/htm).

35th Annual International Society of Psychoneuroendocrinology Conference: the Impact of Stress on the HPA and Immune Axes

Glasgow, UK, 18-21 July 2004.

Contact: Northern Networking Ltd, 1 Tennant Avenue, College Milton South, East Kilbride, Glasgow G74 5NA, UK (Tel: +44-1355-244966; Fax: +44-1355-249959; Email: ispne2004@glasconf.demon.co.uk; Web: www.northernnetworking.co.uk/files/ispne_proposal.pdf).

7th International Symposium on Neurobiology and Neuroendocrinology of Aging

Bregenz, Austria, 18-23 July 2004.

Contact: Conference Secretariat, Andrzej Bartke, Director of Research, Geriatrics Initiative, Southern Illinois University School of Medicine, PO Box 19636, Springfield, IL, USA (Tel: +49-30-24603-0; Fax: +49-30-24603-200; Email: abartke@siumed.edu; Web: www.neurobiology-and-neuroendocrinology-of-aging.org).

12th International Conference on Second Messengers and Phosphoproteins

Montreal, Canada, 37 August 2004

Contact: Events International Meeting Planners Inc, 759 Victoria Square, Suite 300, Montreal, Québec, Canada H2Y 2J7 (Tel: +1-514-2860855; Fax: +1-514-2866066 Email: smp2004@eventsintl.com; Web: www.smp2004.com

22nd Conference of European Comparative Endocrinologists

Uppsala, Sweden, 24-28 August 2004.

Contact: Dan Larhammar, Department of Neuroscience, Unit of Pharmacology, Uppsala University, Husargatan 3, SE-75124 Uppsala, Sweden (Tel: +46-18-4714173; Fax: +46-18-511540; Email: kongress@ukkab.se or dan.larhammar@neuro.uu.se; Web: www.neuro.uu.se/medfarm/cece2004/cece.htm).

International Society of Endocrinology Congress 2004

Lisbon, Portugal, 31 August-4 September 2004.

Contact: ISE, KIT GmbH, Association and Conference Management Group, Kurfurstendamm 71, DE-10709 Berlin, Germany (Tel: +49-30-246030; Fax: +49-30-24603200; Email: info@ice2004.com; Web: www.ice2004.com).

40th Annual Meeting of the European Association for the Study of Diabetes

Munich, Germany, 5-9 September 2004.

Contact: Rheindorfer Weg 3, D-40591 Düsseldorf, Germany (Tel: +49-211-7584690; Fax: +49-211-75846929; Email: annual-meeting@easd.org; Web: www.easd.org/customfiles/easd/40th/welcome.html).

Aromatase 2004

Edinburgh, UK, 6-8 September 2004.

Contact: William R Miller, Edinburgh Breast Unit Research Group, Paderewski Building, Western General Hospital, Edinburgh EH4 2XU, UK (Tel: +44-131-5572501/5; Fax: +44-131-5572449; Email: mail@aromatase2004.net; Web: www.aromatase2004.net).

Society for Endocrinology Endocrine Nurses Training Course: the Thyroid Gland

Bristol, UK, 9-11 September 2004.

Contact: Ann Lloyd, Society for Endocrinology, 22 Apex Court, Woodlands, Bradley Stoke, Bristol BS32 4JT, UK (Tel: +44-1454-642200; Fax: +44-1454-642222; Email: info@endocrinology.org; Web: www.endocrinology.org/sfe/train.htm).

43rd Annual Meeting of the European Society of Paediatric Endocrinology (ESPE) 2004

Haifa, Israel, 10-13 September 2004.

Contact: Professor Ze'ev Hochberg, Department of Pediatrics, Rambam Medical Center, PO Box 9602, Haifa 31096, Israel (Tel: +972-4-8542157; Fax: +972-4-8542157; Email: z_hochberg@rambam.health.gov.il; Web: www.eurospe.org/meetings.jsp).

3rd European Congress of Andrology and 16th Congress of the German Society of Andrology

Münster, Germany, 11-14 September 2004.

Contact: Prof. Dr E Nieschlag, Institute of Reproductive Medicine of the University, D-48129 Münster, Germany (Tel: +49-251-8356096; Fax: +49-251-8356093; Email: nieschl@uni-muenster.de; Web: www.3rd-eca.de).

30th Annual Meeting of the European Thyroid Association

Istanbul, Turkey, 18-22 September 2004.

Contact: Congress Secretariat, Zeynep Aksoy, Halaskargazi Cad. 207/A, Osmanbey, 34380 Istanbul, Turkey (Tel: +90-212-2191925; Fax: +90-212-2473085; Email: eta2004@intratravel.com; Web: www.eta2004.org).

11th World Congress of Gynecological Endocrinology

Florence, Italy, 27-30 September 2004.

Contact: Biomedical Technologies srl, Via Trieste 1, 56126 Pisa, Italy (Tel: +39-050-501934; Fax: +39-050-501239; Email: biomedical@tin.it; Web: www.gynecologicalendocrinology.org).

2nd Macedonian Congress on Endocrinology, Diabetes and Metabolic Disorders

Struga, Macedonia, 29 September-3 October 2004.

Contact: Goran Petrovski (Email: info@endocrinology.org.mk; Web: www.endocrinology.org.mk).

76th Annual Meeting of the American Thyroid Association

Vancouver, Canada, 29 September- 3 October 2004.

Contact: ATA, 6066 Leesburg Pike, Suite 650, Falls Church, VA 22041, USA (Email: admin@thyroid.org; Web: www.thyroid.org).

26th Annual Meeting of the American Society for Bone and Mineral Research

Seattle, WA, USA, 1-5 October 2004.

Contact: ASBMR, 2025 M Street, NW Suite 800, Washington, DC 20036-3309, USA (Tel: +1-202-3671161; Email: asbmr@dc.sba.com; Web: www.asbmr.org).

60th Annual Meeting of the American Society for Reproductive Medicine (ASRM 2004)

Philadelphia, PA, USA, 16-21 October 2004.

Contact: ASRM, 1209 Montgomery Highway, Birmingham, AL 35216-2809, USA (Tel: +1-205-9785000; Fax: +1-205-9785018; Email: asrm@asrm.org).

3rd International Workshop on the CCN Family of Genes

St Malo, France, 20-23 October 2004.

Contact: David Brigstock, Center for Cell and Vascular Biology, Children's Research Institute, Columbus, OH 43205, USA (Tel: +1-614-7222840; Fax: +1-614-7222716; Email: brigstod@pediatrics.ohio-state.edu; Web: ccnworkshop3.free.fr).

5th International Symposium on GH Secretagogues: Ghrelin and its Analogues across the Lifespan

Portofino Vetta, Italy, 28-31 October 2004.

Contact: Elisabetta Bersezio (Email: elisabetta.bersezio@unito.it).

195th Meeting of the Society for Endocrinology
London, UK, 1-3 November 2004.
Contact: Feona Horrex, 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).

International Conference on Steroid Hormone Receptor Superfamily and Molecular Signaling
Kerala, India, 18-20 November 2004.
Contact: Raghava Varman Thampan, Rajiv Gandhi Centre for Biotechnology, Thycaud PO, Thiruvananthapuram 695014, Kerala, India (Tel: +91-471-2347975; Fax: +91-471-2348096; Email: steroidrgcb2004@yahoo.com).

All India Congress of Obstetrics and Gynaecology: AICOG 2005
Aurangabad, India, 6-9 January 2005.
Contact: Conference Secretariat AICOG 2005, Ashwini Hospital 12, Samarthnagar, Aurangabad 431 001 (MS), India (Tel: +91-240-2348731; Email: conference@aicog2005.com; Web: www.aicog2005.com).

5th European Congress on Clinical and Economic Aspects of Osteoporosis and Osteoarthritis
Rome, Italy, 16-19 March 2005.
Contact: YP Communication, Boulevard G Kleyer 108, 4000 Liège, Belgium (Tel: +32-4-2541225; Fax: +32-4-2541290; Email: yolande@piettecommunication.com).

BES 2005: 24th Joint Meeting of the British Endocrine Societies
Harrogate, UK, 4-6 April 2005.
Contact: British Endocrine Societies, 22 Apex Court, Woodlands, Bradley Stoke, Bristol BS32 4JT, UK (Tel: +44-1454-642200; Fax: +44-1454-642222; Email: info@endocrinology.org; Web: www.endocrinology.org/sfe/confs.htm).

1st International Congress on 'Prediabetes' and the Metabolic Syndrome: Epidemiology, Management and Prevention of Diabetes and Cardiovascular Disease
Berlin, Germany, 13-16 April 2005.
Contact: Kenes International (Tel: +41-22-9080488; Fax: +41-22-7322850; Email: prediabetes@kenes.com; Web: www.kenes.com/prediabetes).

Diabetes UK Annual Professional Conference 2005
Glasgow, UK, 20-22 April 2005.
Contact: Conference Team (Tel: +44-20-74241156; Email: conferences@diabetes.org.uk).

16th IFCC-FESCC European Congress of Clinical Chemistry and Laboratory Medicine
Glasgow, UK, 8-12 May 2005.
Contact: EuroMedLab Glasgow 2005 (Tel: +44-141-4341500; Fax: +44-141-4341500; Email: euromedlab2005@meetingmakers.co.uk; Web: www.glasgow2005.org).

2nd Joint Meeting of the European Calcified Tissue Society and the International Bone and Mineral Society
Geneva, Switzerland, 25-29 June 2005.
Contact: European Calcified Tissue Society, PO Box 4, Dursley GL11 6YL, UK (Tel: +44-1453-549929; Fax: +44-1453-548919; Email: admin@ectsoc.org; Web: www.ectsoc.org).

7th European Congress of Endocrinology
Göteborg, Sweden, 3-7 September 2005.
Contact: Congrex Göteborg AB, ref ECE 2005, PO Box 5078, SE-402 22 Göteborg, Sweden (Tel: +46-31-7086000; Fax: +46-31-7086025; Email: ece2005@gbg.congrex.se; Web:

Pussy Galore

Tom Parkhill relates a 'tail' of feline endocrinology...

There's Field Marshall Montgomery, Montgomery Burns, and, of course, the full Monty. And then there's Monty the cat. Monty was named after another cat, but this was in 1992, when the name was in the air following REM's song about Montgomery Clift.

All the well-known humans by the name of Monty tended to be thin, weedy guys, but Monty the cat is huge. Whenever I visit Stephanie, Monty bounds out to meet me, leaving me feeling that I am being affectionately done over by the Beast of Bodmin.

Stephanie found him in Greece, when she was working there for the British Council. A tiny 8-week-old squiggle peeked out from underneath the stationary car in front, in the middle of the arcade game which doubles as the junction of the Athens ring road and the Pireaus road. Dusted down and rescued, Monty eventually came back to lead a life of love and indulgence with Stephanie's other cats in darkest Vauxhall.

'Monty got a raw deal' is the title of the REM song and, aside from Stephanie's conspicuous pampering, the song could have been written about Monty the cat's recent life. Nine years after his original lucky break on the road to Pireaus, he developed diabetes. But this wasn't just any diabetes, within a couple of years his insulin dose had to be increased dramatically, but he still didn't respond. Stephanie's vet eventually sent him to the Queen's Veterinary School Hospital in Cambridge, where they found that Monty had developed acromegaly.

Sara Gould, who now treats Monty, says that they get around four or five, generally male, cats with acromegaly each year. They tend to be big cats, with big feet. They also snore a lot, but as most cats I know sleep a lot, I suspect that they snore because they get lots of practice. They present as unstable diabetics, with extremely high insulin requirements. Measurement of growth hormone is difficult in cats (like many other things), so they measure IGF-I and confirm the diagnosis by MRI.

Sara explains that the most effective treatment is using radiotherapy. This has the effect of bringing down the growth hormone levels, sometimes to the extent that the cats can come off insulin completely. Monty had the highest IGF-1 level they had recorded, but now he's back down to acceptable levels.

The Queen's Vetinary School Hospital runs the only animal-dedicated radiotherapy machine in the UK where acromegalic cats are treated. Sara told me they also have dogs presenting with acromegaly, although, in contrast to cats, these tend to be bitches, who can develop the condition when they come out of season. Treatment is by neutering, so yet again cats get a better deal.

So it's a happy ending. Stephanie can relax knowing that Monty can live out his remaining years in comfort. And the next time I visit Stephanie I won't feel so victimised when I'm roughed up by the big cat. 'Everybody hurts,' as REM might say.

TOM PARKHILL

Sara Gould can be contacted at smg29@cam.ac.uk.
Below, Monty catches up on snoring practice.

INTRODUCING

a breakthrough treatment for acromegaly…

SOMAVERT®

(pegvisomant powder and solvent for solution for injection)

IGF-1 normalisation is within reach

Somavert® (pegvisomant) Prescribing Information.
Presentation: Somavert powder and solvent for solution for injection is supplied in vials containing 10mg, 15mg or 20mg of pegvisomant. After reconstitution, 1ml of solution contains 10mg, 15mg or 20mg of pegvisomant. **Indications:** Somavert is used in the treatment of patients with acromegaly who have had an inadequate response to surgery and/or radiation therapy and in whom an appropriate medical treatment with somatostatin analogues did not normalise IGF-I concentrations or was not tolerated. **Dosage:** Adults including elderly: A loading dose of 80mg should be administered subcutaneously under medical supervision. Following this, 10mg reconstituted in 1ml of water for injections should be administered once daily. Dose adjustments should be based on serum IGF-I levels, measured every four to six weeks, and appropriate dose adjustments made in increments of 5mg/day in order to maintain the serum IGF-I concentration within the age-adjusted normal range. The maximum dose should not exceed 30mg/day. Children: The safety and effectiveness of Somavert have not been established. **Contra-indications:** Hypersensitivity to pegvisomant or any of the excipients. **Warnings and precautions:** Growth hormone-secreting pituitary tumours may sometimes expand, causing serious complications (for example, visual field defects). Treatment by Somavert does not reduce tumour size. All patients with these tumours should be carefully monitored. Serum concentrations of alanine aminotransferase (ALT) and aspartate transaminase (AST) should be monitored at four to six week intervals for the first six months of treatment with Somavert, or at any time in patients exhibiting symptoms suggestive of hepatitis. Evidence of obstructive biliary tract disease should be ruled out in patients with elevations of ALT and AST or in patients with a prior history of treatment with any somatostatin analogue. Administration of Somavert should be discontinued if signs of liver disease persist. In patients with diabetes mellitus, doses of insulin or hypoglycaemic medicinal products may need to be decreased. Patients should be advised to use adequate contraception if necessary. The use of Somavert in combination with other medicinal products for the treatment of acromegaly has not been extensively investigated. **Pregnancy and lactation:** Somavert is not recommended during pregnancy and lactation. **Interactions:** Interactions between Somavert and other medicinal products have not been evaluated in formal studies. Patients receiving insulin or oral hypoglycaemic medicinal products may require dose reduction of these therapeutic agents due to the effect of Somavert on insulin sensitivity. Somavert cross-reacts in commercially available growth hormone assays. Treatment should therefore not be monitored or adjusted based on serum growth hormone concentrations reported from these assays. **Side effects:** In clinical trials, for patients treated with Somavert, the majority of adverse reactions to Somavert were of mild to moderate intensity, of limited duration and did not require discontinuation of treatment. The most commonly reported adverse events considered related to Somavert occurring in ≥ 5% of patients with acromegaly during the clinical trials were injection site reactions 11%, sweating 7%, headache 6%, and asthenia 6%. Most injection site reactions characterised as localised erythemas and soreness, spontaneously resolved with local symptomatic treatment, while therapy continued. The development of isolated low-titre anti-growth hormone antibodies was observed in 16.9% of patients. The clinical significance of these antibodies is unknown. **Overdose:** There is limited experience of overdosage with Somavert. In the case of overdose, Somavert should be discontinued and not resumed until IGF-I levels return to within or above the normal range. **Legal category:** POM. **Date of revision:** March 2004. **Package quantities, Marketing Authorisation numbers and basic NHS price:** Somavert 10mg, (30 vials of powder & 30 vials of solvent), EU/1/02/240/001, £1500. Somavert 15mg, (30 vials of powder & 30 vials of solvent), EU/1/02/240/002, £2250. Somavert 20mg, (30 vials of powder & 30 vials of solvent), EU/1/02/240/003, £3000 & (1 vial of powder & 1 vial of solvent), EU/1/02/240/004, £100. **Marketing Authorisation Holder:** Pfizer Limited, Sandwich, Kent CT13 9NJ, United Kingdom. Somavert is a registered trade mark. Ref: SV 1_3. Further information is available on request from: Medical Information Department, Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS. **Date of Preparation:** April 2004. **Item code:** SOM 124.

Pfizer

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