

The Endocrinologist

THE NEWSLETTER OF THE SOCIETY FOR ENDOCRINOLOGY • ISSUE 78

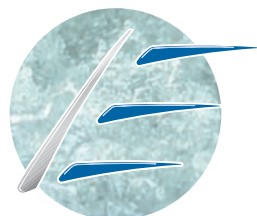
WINTER 2005/06

HRT who, when and why?

PLUS

Endocrinology
in Nigeria

Verity: truly
supporting PCOS



► My last editorial - before Peter Trainer takes over the reins and Joy Hinson becomes Associate Editor. It's been a lot of fun, but I can't help thinking that the real credit should go to many of the staff at our Bristol office. I have simply posed as a 'front', and without them there would be no newsletter. So my thanks to all those committed supporters who really are the backbones behind the production.

In the last Christmas issue I wrote my editorial with a seasonal flavour. However, this issue's cover, flaunting a middle-aged female frolicking in blue waters, seems the antithesis of Christmas (in the UK at least). Whilst I would love to know whether the cover 'gal' is on HRT, it reminds me of a photograph published in a tabloid newspaper a few years ago. The subject was Wendy Cooper, aged 70 plus, splashing about in the cold waves of an English beach to advertise her 'youthfulness'.

'Who was Wendy Cooper?' you may ask. The answer is a journalist. An ardent pro-activist of HRT, Wendy visited eminent gynaecologists in the USA, such as Robert Wilson. She then published a series of articles in the *London Evening News* in 1973, followed by the first edition of her book *No Change* in 1975. This widely acclaimed book provided the ammunition to put HRT into the public domain in the UK. It addressed British women's apparent ignorance of HRT compared with their counterparts elsewhere, like the USA and Germany. Interestingly, the publication of her book coincided with a series of clinical studies showing an increased incidence of endometrial cancer with unopposed oestrogen replacement therapy. Progestagens were taken up for women (with wombs) requesting HRT.

Today we have the backlash of the controversial outcomes of the Million Woman Study and the Woman's Health Initiative. On page 8, Helen Buckler looks at the dilemma faced by doctors in light of current concerns regarding HRT, while, on page 9, Tom Parkhill investigates the advice about HRT that is available in the public domain. Not good news.

You can find a flavour of endocrinology in Nigeria on page 10, courtesy of Ayoade Adedokun. Meanwhile, Steve Byford contemplates the best way forward for peer-reviewed science publications. On page 11, he asks just who will pick up the bill. Page 12's tale of the ups and downs of conference life will probably remind you of several young meeting delegates of your acquaintance.

On page 7, Catherine Williams gives us an insight into the work of Verity, the support group for women with PCOS (polycystic ovary syndrome). This is the most common endocrine disorder amongst women, and Verity's work is supported by medical and scientific advisers who are members of the Society.

We must also welcome John Wass as the new Chairman of the Society, Julia Buckingham as General Secretary and David Ray as Programme Secretary. And one final reminder - don't forget that the 'earlybird' deadline to register for the 8th European Congress of Endocrinology is 10 February 2006. The Congress, which incorporates the BES, takes place on 1-5 April in Glasgow and shouldn't be missed; see page 13 for further details.

And on that final note, seasonal greetings and success for the new year.

SAFFRON WHITEHEAD

ECE 2006 abstract submissions over 1000

► We are very pleased to be able to announce that 1070 abstracts have been submitted for the upcoming European Congress of Endocrinology to be held in Glasgow on 1-5 April 2006.

This indicates an extremely high level of interest in what promises to be an exciting international meeting. Register now on www.ece2006.com for earlybird registration fees and to take advantage of the special reduced rate for Society for Endocrinology members at www.ece2006.com. If you have mislaid the password emailed to you earlier, email shirine.borbor@endocrinology.org.

Don't forget the earlybird deadline is 10 February.



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

Deadline for news items for the Spring
2006 issue: 12 December 2005. Please send
contributions to the above address.

New Officers and Council Members

► Following their election in 2004, three new Society Officers took up their posts at the recent AGM. We are pleased to welcome Professor John Wass to his new role as Chairman, Professor Julia Buckingham as General Secretary, and Professor David Ray as Programme Secretary. We thank Professor Steve Bloom and Professor Ann Logan who have now retired from office.

Professor Anne White will continue as Treasurer until November 2006, when her 5-year term ends. The recent call for nominations for the post of Treasurer produced one nominee. We are therefore very pleased to announce that Professor Michael Sheppard from Birmingham was officially elected at the recent AGM and will take up office from the 2006 AGM.

Professor Kevin Docherty, Dr Rob Fowkes and Dr Mike Wallace were elected to Council at the recent AGM in London, following a ballot amongst the membership and will serve for 4 years. They replace Dr Robert Abayasekara, Dr Joy Hinson and Professor Phil Lowry, who we would like to thank for their contributions over the past 4 years.

Medals

► We are delighted to announce that Council has approved the following medallists, after their recommendation by the Awards Committee. The 2006 medallists will lecture at the next November meeting, and the 2007 medallists at the Society's subsequent BES 2007 meeting.

2006 SOCIETY FOR ENDOCRINOLOGY MEDAL Professor Krish Chatterjee (Cambridge)

2006 EUROPEAN MEDAL Professor Christian Strasburger (Munich)

2006 ASIA & OCEANIA MEDAL Professor Gail Risbrdiger (Clayton, Victoria)

2006 JUBILEE MEDAL Professor Stephen Hillier (Edinburgh)

2007 TRANSATLANTIC MEDAL Professor Bruce Spiegelman (Boston)

2007 DALE MEDAL Professor Steven Lamberts (Rotterdam)

SOCIETY CALENDAR

15 February 2006
Society for Endocrinology
Clinical Cases Meeting
Royal Society of Medicine, London

11 July 2006
Society for Endocrinology
Molecular Endocrinology
Workshop at Summer School
The Möller Centre, Cambridge

12-13 July 2006
Society for Endocrinology
Advanced Endocrine Course
at Summer School
The Möller Centre, Cambridge

14 July 2006
Society for Endocrinology
Clinical Practice Day
at Summer School
The Möller Centre, Cambridge

5-7 September 2006
Society for Endocrinology
Endocrine Nurse Training Course
University of Southampton

6-8 November 2006
197th Meeting of the
Society for Endocrinology
Kensington Town Hall, London

Congratulations

► We are pleased to report that David Ray (Manchester), the Society's new Programme Secretary and Saffron Whitehead (London), the retiring editor of *The Endocrinologist*, have both been awarded a Chair.

With regret

► We are very sorry to announce the deaths of Mr Louis Gordon Skinner and Professor Keith Buchanan, who were members of the Society.

Don't forget to check the Special Interest Groups web site at [http:// www.endocrinology.org/SFE/sigs.htm](http://www.endocrinology.org/SFE/sigs.htm)

2006 SUMMER SCHOOL

11-14 July 2006

THE MÖLLER CENTRE, CAMBRIDGE

Clinical Practice Day abstract deadline: 12 April 2006

Grants are available for Society members to attend the Molecular Endocrinology Workshop.

See www.endocrinology.org/sfe/grants.htm for further details.

Deadline for grant applications **15 April 2006**

11 July	Molecular Endocrinology Workshop
12-13 July	Advanced Endocrine Course
14 July	Clinical Practice Day

Committee News

The latest
from each of
the Society's
committees.

Council of Management

Council has recently approved:

- the financial accounts for the year to 30 April 2005
- the Society's reserve policies (maintained at a level to provide income in a financial emergency)
- the reappointment of the auditors (Chantrey Vellacott DFK)
- applications for membership (81 new members and 6 Senior members)
- the Publications Committee policy regarding peer review
- journal and membership prices for 2006
- nominations for several 2006 and 2007 medals

A full report on the strategy review will be presented in the next issue.

Awards

Recommendations made to Council regarding medallists for 2006 and 2007 have been approved (details can be found on page 3).

Clinical

As there will be no Society November meeting after 2006, the Committee is developing a proposal for a new autumn Clinical Update meeting.

Finance

As mentioned in the last issue, the Society's financial results for the year to 30 April 2005 were very satisfactory. The Committee has reviewed the reserves policy and updated this for the current position, so the minimum level of reserves is now £1.9m. The readily usable reserves exceeded this level at 30 April 2005, and the recent strategic review has considered plans to use these funds for the future of the Society.

The level of funding for travel grants has been increased, in addition to an agreement to provide support for clinical biochemists to attend Society meetings. The Committee will re-visit the performance of the investment managers at their next meeting in December. They look forward to welcoming Michael Sheppard as Treasurer elect.

Nurse

Nikki Kieffer from Leicester has recently been appointed as Vice-Chair, following a call for nominations and a ballot within the Nurse Committee. The Nurse Committee also welcomes Karen Campbell from Glasgow,

Christine Gibson from Manchester and Viv Thornton-Jones from Oxford as newly elected members. All three begin their term of office on 1 January 2006. Several portfolios from nurse members who are hoping to complete the Certificate of Adult Endocrine Nursing are being assessed.

Science

The Committee has recently approved the draft programme for the Molecular Endocrinology Workshop at Summer School 2006, designed by Dr Mark Gurnell. The workshop will be entitled 'Molecular approaches to understanding human endocrine and metabolic disorders', and will use a theme-based approach to explore general endocrine techniques. Summer School 2006 is being held in The Möller Centre, Cambridge from 11 to 14 July.

Young Endocrinologists

New basic scientist members were recently sought for the Steering Group. We are pleased to announce that Dr Mabrouka Maamra (University of Sheffield) and Dr Kim Jonas (Royal Veterinary College, London) have now joined the Group.

ENDOCRINOLOGY 'GOES PUBLIC'

► The 2006 November meeting included an event aimed at educating and engaging the general public in the science of endocrinology. Co-hosted with the Royal College of Physicians (RCP) and entitled 'Stress, Hormones and your Health', the evening was chaired by the writer and broadcaster Vivienne Parry and included Professors Stafford Lightman and Simon Wessely as very impressive guest speakers.

Vivienne, who has referred to herself as a 'hormone cheerleader', opened the evening with an entertaining introduction to hormones. Along with her layman's guide to what they are and how they work, she included a brief history of Ernest Starling's first use of the word hormone 100 years ago. Ironically, on an evening devoted to stress, the failure of Vivienne's laptop just before the event provided some unwelcome first-hand experience!

Stafford Lightman's talk looked at the science behind stress. An important aspect of life, our adaptive response to stress is a perfectly natural bodily function. However, if it becomes prolonged, the continual activation of the stress response instead becomes a health risk. His insight into how our responses to stress are influenced by childhood experiences and genetic factors provided an informative

view of the significance of stress on our well-being.

Lending a different perspective to the event, psychiatrist Simon Wessely's amusing presentation looked at our modern perception of stress. He suggested that our understanding of stress may be more negative than the problem itself, and that the perceived rise in people suffering from chronic stress could result from people deciding to report their problems. Simon brought us back to the present day with a bang, compelling us to look at our perceptions of stress from a very different angle.

In conclusion, an evening of hormones and stress through the ages succeeded in enthusing and entertaining the audience (an impressive total of 70) and fuelling some very colourful debates. The feedback has been extremely positive, mainly commenting on the quality and humour of the presentations. It seems that bringing endocrinology to the people was a popular idea - well worth the associated stress! We would like to extend our thanks to the RCP, whose invaluable help and expertise enabled us to make the evening such a success.

Keep your eyes peeled for another public session at ECE 2006.

JO THURSTON

His mind

His body

His spirit

His Testim

John is among the 1 in 10 men over 50 with late-onset hypogonadism (LOH).¹

New Testim Gel, is doing far more than just normalising his testosterone level.² This new patient-friendly approach to testosterone replacement therapy (TRT) is also helping to address the symptoms associated with LOH like increased body fat, reduced bone mineral density, low mood, sexual dysfunction and a generally reduced sense of well being.²⁻⁴

And John feels in control of his life again.



Far more than just the right level of testosterone

PRESCRIBING INFORMATION Testim® 50mg Gel (testosterone)

Presentation: Tube of 5g containing 50mg testosterone in a clear gel.

Indications: Testosterone replacement therapy for male hypogonadism when testosterone deficiency has been confirmed by clinical features and biochemical tests. **Dosage:** One 5g tube daily. If serum testosterone concentrations are below the normal range, the dose may be increased from 50mg (one tube) to 100mg (two tubes) once daily. Once the tube is opened, apply immediately to clean, dry, intact skin of the shoulders and/or upper arms, preferably in the morning. Do not apply to genital area. **Children:** Not for use in children. Not clinically evaluated in males under 18 years of age. **Contraindications:** Known or suspected prostate or breast cancer. Hypersensitivity to testosterone or any excipients of the gel. **Warnings and Precautions:** Prior to therapy, exclude prostate cancer. Examine breast and prostate gland at least annually and twice yearly in elderly or at risk patients (clinical or familial factors). Monitor serum calcium levels in cancer patients at risk of hypercalcaemia/hypercalciuria. Testosterone may cause oedema with or without congestive cardiac failure in patients with severe cardiac, hepatic or renal insufficiency. In this case, stop treatment immediately. Use with caution in patients with hypertension, ischaemic heart disease, epilepsy

and migraine. Possible increased risk of sleep apnoea in patients who are obese or with chronic respiratory disease. Improved insulin sensitivity may occur. Irritability, nervousness, weight gain, prolonged or frequent erections may indicate excessive androgen exposure requiring dosage adjustment. If severe application site reactions occur, discontinue if necessary. Periodically monitor testosterone concentrations, full blood count, lipid profile and liver function. Testosterone may produce a positive reaction in anti-doping tests. Not for use in women. The gel may be transferred to others by close skin to skin contact, which could lead to adverse effects (inadvertent androgenisation) on repeated contact. Inform the patient about transfer risk, which can be prevented by covering or washing the site prior to contact. Testim Gel should not be prescribed for patients who may not comply with safety instructions (e.g. severe alcoholism, drug abuse, severe psychiatric disorders). Pregnant women and children must avoid any contact with application sites. **Interactions:** Interactions reported with oral anticoagulants, ACTH or corticosteroids, propranolol and thyroxine-binding globulin in laboratory tests. **Side effects:** Common (4%): skin reactions and increased PSA. Also reported: worsening hypertension, acne, rash, application site reactions, gynaecomastia, increased haematocrit, red blood

cell count and haemoglobin. Other known reactions to testosterone treatments: prostate abnormalities and prostate cancer, pruritus, vasodilation, emotional lability, nausea, alopecia, cholestatic jaundice, generalised paresthesia, hirsutism, seborrhoea, decreased libido, anxiety, altered blood lipid levels including a reduction in HDL cholesterol and alteration in liver functions tests. In high dose, prolonged treatment: electrolyte disturbances, oligospermia, frequent and/or prolonged erections. **NHS Cost:** £33.00 per pack of 30 x 5g tubes **POM:** PL 06958/0027 **MA holder:** Ipsen Ltd, 190 Bath Road, Slough, Berks SL1 3XE **Date of preparation:** March 2005. Testim® Gel is a registered trademark. **References:** 1. Harman SM *et al. J Clin Endocrinol Metab* 2001; **86:** 724-731. 2. McNicholas TA *et al. BJU Int* 2003; **91:** 69-74. 3. Steidle C *et al. J Clin Endocrinol Metab* 2003; **88:** 2673-2681. 4. Dean JD *et al. Rev Urol* 2004; **6(Suppl 6):** S22-S29.

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Backing for humane animal research

► In August 2005, the Research Defence Society (RDS) launched a Declaration on Animals in Research signed by over 500 leading academic UK scientists and doctors.

The declaration states that 'Throughout the world people enjoy a better quality of life because of advances made possible through medical research, and the development of new medicines and other treatments. A small but vital part of that work involves the use of animals.'

It reinforces positive statements about the need for animal research, made by the Royal Society in 2004 and the House of Lords Select Committee on Animals in Scientific Procedures in 2002. It states that researchers should achieve the medical and scientific benefits of animal research with minimal suffering and distress to the animals involved, and make every effort to safeguard animal welfare. Wherever possible, animals must be replaced by non-animal methods and the number of animals reduced. An ethical judgement must be made about each animal study to assess its validity, usefulness and relevance.

The declaration is signed by scientists as individuals, and does not necessarily indicate the support of their institution of affiliation. It will remain open for signatures until the end of the year, so if you are a scientist or doctor working in the UK and would like to sign, please email declaration@rds-net.org.uk for further details.

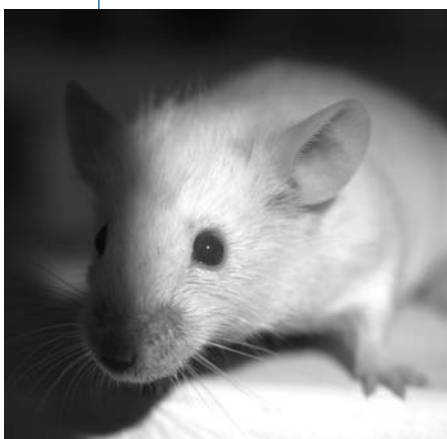
Careers Abroad

► Fancy whale shark tagging in the Seychelles or jaguar monitoring in Mexico? Global Vision International and its partner organisations offer paid jobs and exciting voluntary field work opportunities.

Placements are available worldwide in education, research, environmental management and wildlife research. They are aimed at students, graduates and professionals with a background in biological and environmental sciences and related subjects. The experience will enhance your career as well as benefiting local non-governmental or aid-reliant organisations. Details can be found at www.careersabroad.co.uk.

Prize to reduce animal use

► A new £10 000 prize is available in recognition of published work that has the potential to advance the replacement, refinement and reduction of animals in research (the '3Rs').



The award will be made to an individual or team for a piece of work published between September 2004 and September 2005. Publications within all areas of biological, medical and veterinary research or testing will be considered by a distinguished panel. The prize will be awarded in January 2006.

The National Centre for the Replacement, Refinement and Reduction of Animals in Research (NC3Rs) is seeking entries for the award, which is sponsored by GlaxoSmithKline. It replaces the GlaxoSmithKline Laboratory Animal Welfare Prize previously administered by the RDS.

NC3Rs has provided a UK focus for the advancement of the '3Rs' since September 2004.

The centre aims to increase the development and implementation of the 3Rs in biomedical, biological and veterinary research in academia and industry.

For further details visit www.nc3rs.org.uk.

SOCIETY FOR
ENDOCRINOLOGY



197th Meeting of the Society for Endocrinology

*Celebrating the Society's
Diamond Jubilee*

**PLEASE NOTE NEW VENUE:
Kensington Town Hall, London**

6 – 8 November 2006

Contact: Feona Horrex
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Spotlight on... Verity

► Verity is a self-help and support group for women with polycystic ovary syndrome (PCOS). PCOS is a complex hormonal disorder that causes a range of distressing symptoms. The condition has been described as 'The Thief of Womanhood', and here's why.

If you could select three things to make a woman feel less feminine, excess facial hair, acne and weight problems would probably be among the most frequently chosen. Women with PCOS can have all three of these, in addition to irregular periods or no periods at all, irregular ovulation or no ovulation at all, fertility problems, recurrent miscarriage and male pattern hair loss. There is also an increased risk of type 2 diabetes and endometrial cancer if periods are very infrequent. Furthermore, PCOS is a long-term medical condition with no cure. Only the symptoms can be treated, with varying degrees of success and often a host of side effects. Is it any wonder that women with PCOS suffer from low self-esteem and, sometimes, depression as well?

Are there any positives? Well, apparently the chances of survival in a famine situation are much greater, because women with PCOS are very good at conserving energy - not much value in today's society of plenty. PCOS also appears to have some protective effect on bone mass, so osteoporosis is less likely to be a problem (although this benefit probably doesn't extend to slim 'cysters').

The main positive is that women with PCOS can do a lot to help themselves, particularly in terms of good nutrition and exercise, provided they have been given accurate and appropriate information - and this is where Verity comes in.

Verity was founded in 1997 with the aim of providing information about PCOS and support for women diagnosed with the condition. I joined Verity in 1998 and found that the best thing was being able to talk directly with other women who truly understand what it's like to be 'fat, spotty and hairy because of my ovaries'.

It was also a huge relief to find that I was not the only one struggling with the various symptoms. On the contrary, PCOS is a very common condition. It is estimated that around 20% of women have polycystic ovaries and 50-75% of these will develop the full-blown syndrome.

Verity has developed tremendously as an organisation during the last 8 years. It is a registered charity with around 1600 members. There are no employees, and Verity is managed entirely by its Board of Directors/ Trustees, who are all women with PCOS.

But despite the absence of staff, we have achieved a great deal.

- Three conferences/support group meetings were held in 2004 and another in October 2005 with expert speakers and the opportunity to meet other women with PCOS.
- Two newsletters are produced every year, full of the latest information about PCOS, as well as research

updates from our medical and scientific advisers, and features with case histories on various aspects of the condition.

- A range of factsheets cover symptoms and aspects such as the long-term health consequences of PCOS and the benefits of exercise.
- Earlier in 2005, we distributed our basic information leaflet to practice nurses via their professional journal.
- Our poster will soon be distributed to endocrinology and gynaecology departments in hospitals across the UK.
- We have a popular web site, www.verity-pcos.org.uk, which has received an average of over 7000 visits per month in the last year, and has over 1000 registered users of its message boards.

Verity is well respected among those medical professionals who know us. We are fortunate to have two of the top professors in the field as our medical advisers: Stephen Franks from Hammersmith Hospital and Adam Balen from Leeds General Infirmary. Our scientific adviser is Helen Mason from St George's Hospital Medical School, a highly esteemed Senior Lecturer in reproductive endocrinology. They certainly know what they are talking about, and this helps Verity to ensure that its information is accurate and as up to date as possible.

We have a new trading subsidiary, PCOS UK. This has been established initially to organise conferences for health professionals about PCOS. The first will be held in February 2006. This company also has no employees, but we have sub-contracted the conference organisation to a specialist provider of medical education services. The executive committee comprises all three of Verity's advisers, two of Verity's directors and other experts in the fields of obesity, dermatology, psychology, dietetics and, of course, endocrinology.

We also hope to secure sufficient financial resources to appoint our first members of staff. We could do a great deal more for women with PCOS if we at least had an administrator to reduce the volume of work currently undertaken by the trustees and other volunteers.

We are currently only reaching a small percentage of the women who could be helped by our services. So, if one of your patients has a diagnosis of PCOS, please do tell her about Verity.

CATHERINE WILLIAMS
CHAIR, VERITY



HORMONE REPLACEMENT: the doctors' dilemma

Helen Buckler
weighs up
the facts
about HRT.

► Postmenopausal hormonal therapy has been used to manage climacteric symptoms since the 1950s. Several large observational studies suggested that hormone replacement therapy (HRT) might also have a role in the prevention of chronic conditions in the postmenopausal woman. As a result, physicians often prescribed HRT for the prevention of cardiovascular disease, osteoporosis and Alzheimer's disease.

In 1998, a Department of Health survey indicated that 38% of women in England aged 45-54 years had used HRT. However, the past 3 years have seen a marked fall in prescribing rates due to the publication of several studies. The noteworthy trials include the Women's Health Initiative (WHI) and the Million Women Study (MWS).

The WHI consisted of two parallel multicentre double-blind randomised controlled trials of HRT, to evaluate whether conjugated equine oestrogens alone or in combination with medoxyprogesterone acetate had a role in the primary prevention of cardiovascular disease in postmenopausal women. The combined HRT arm was halted at 5 years, as there were indications that health risks exceeded benefits. The oestrogen-only group was halted at around 7 years due to an increased risk of stroke. The combined arm showed an early, although transient, increase in coronary events. The oestrogen-only arm showed neither risk nor benefit, although there was a trend towards a reduction in cardiovascular disease in younger women. Both arms showed an increased risk of stroke.

However, it was the reported breast cancer data from the study that resulted in heightened anxiety about the risks of HRT. In the combined arm, there was an increased risk of breast cancer which started to emerge at 3 years when compared with placebo (hazard ratio 1.24; 1.01-1.54), but there was no increase in breast cancer in the oestrogen-only arm.

The MWS was an observational cohort study that recruited women from breast screening centres. This also showed an increased risk of breast cancer with combined treatment (relative risk 2.0; 1.91-2.09) and a smaller but increased risk in the oestrogen-only and tibolone arms. The design, analysis and conclusions of this study have been questioned and it is felt that this study has probably over-estimated the risk of breast cancer.

Information about the breast cancer risk of HRT remains conflicting. Use of HRT increases a woman's cumulative risk only slightly, and this risk is not the same for every individual or every type of HRT.

The above concerns about HRT's safety have led to major changes in the prescription and continuation of this form of therapy. Women and their doctors have a substantial new body of high quality information on which to base decisions. However, there remain uncertainties

amongst health professionals, and many postmenopausal women have been frightened and misled by confusing and occasionally inaccurate interpretation of the data.

Guidelines have been developed to try and guide health professionals and their patients. These largely suggest prescribing short-term HRT for moderate to severe symptoms at as low a dose as possible in women with no contra-indications. As a result, many women now resort to using complementary therapies, though there is little evidence to support their effectiveness, and there may also be concerns about long term safety and interactions with other medications. No therapy for menopausal vasomotor symptoms has stood the test of time as well as oestrogen therapy.

There is no doubt that oestrogen has many beneficial effects on the skeleton. Although its long-term use should not be routinely recommended for prevention of osteoporosis, it is the only treatment option supported by high quality evidence for women with osteopaenia. The risk:benefit ratio changes favourably in targeting patients at risk of osteoporosis.

In the WHI, the mean age of women recruited was around 63 years, and they were recruited to look at the preventative role of HRT. Most women had no relevant indication to take HRT. The results may not necessarily be relevant to a younger group of postmenopausal women and may not apply to different HRT preparations. Although the findings of the study are of major concern, the HRT preparation used in the study caused neither harm nor benefit to over 99% of the study population.

It is important to assess the merits of HRT use on an individual basis. The degree of symptoms, personal risk factors and type of HRT should be fully discussed. We already know that all HRT preparations are not the same, and we should not forget that there was no increase in breast cancer in the oestrogen-only arm of the WHI. Observational studies continue to show reduced mortality in younger women taking HRT.

In the UK, most women who request HRT do so at the perimenopause for symptom relief, and use it only for a short time. In these women, HRT treatment may be associated with little risk. We should offer relevant advice and not discourage women who may benefit from receiving treatment. However, at present, HRT should not be used solely for the prevention of cardiovascular disease or dementia. Further studies are needed, particularly in younger women.

It is important that women with a premature menopause receive appropriate care and support. This group should continue to take HRT until the time of the normal menopause, and should not be concerned about these new data in older women.

HELEN BUCKLER

HORMONE REPLACEMENT: the patients' puzzle

► The day before I wrote this, Wyeth announced that they were closing their New York plant which produces the hormone replacement therapy (HRT) Premarin, largely because of the drop in demand. The Woman's Health Initiative (WHI) study (July 2002) stopped HRT in its tracks; since then use has dropped dramatically.

Yet the controversy surrounding HRT rumbles on. Leaving aside the initial flurry of HRT-related stories after the WHI and Million Woman Study (MWS) reports, the BBC web site has covered 17 HRT stories since January 2004: just less than one a month. These range from 'HRT cancer-causing, says WHO', 'Dementia risk increased by HRT' and 'HRT could affect ability to hear' to the very occasional 'good news' HRT story. But the press love death and destruction, so not much has been upbeat. Anyway, at best, it's a mixed message.

So what's a woman to do, if she wants to find out about HRT? Well, the news isn't good. There's a lot of information on HRT on the web, but much is commercial or of questionable quality. Magazines carry a lot of information, but of course many magazines will balance an HRT article with an article on management of the menopause with reflexology, aromatherapy or herbs. The Amarant Trust is the main patient group for HRT in the UK. While their web site still works, their telephone helpline stopped functioning in June 2005, due to lack of funds.

A call to the Department of Health reveals that the official Government advice on HRT is provided by the Medicines and Healthcare Products Regulatory Agency, the MHRA. The MHRA working party on HRT advises Government, and also provides the official advice to the NHS. So how do they impart their information?

If you don't have information to hand, you look at the web. If you go to the MHRA web site, there is no specific information on the home page. Nothing wrong with that, they deal with a lot of medicines. But if you take the trouble to look for the information, there simply isn't any there! As it stands today, there is effectively NO HRT information available on the MHRA web site. There should be information, but none of the links work or links take you areas which don't have any HRT information. Frankly, as the authoritative source of information, it's not acceptable. Hopefully you won't be able to check this yourself when you read this, because I'll be phoning the MHRA to complain*. In any case, the full MHRA guidance has not been updated since late 2002, although there are later documents which refer to the guidance. There's no single, regularly updated guidance which is readily available to GPs or patients.

What about other bodies? Searching on the Department of Health web site showed that their

guidance had been updated in December 2003 (remember there have been 17 press stories since then).

To be fair, other bodies have issued guidance since the WHI study came out. These include the Royal College of Physicians of Edinburgh Consensus Guidelines in October 2003, the Royal College of Obstetrics and Gynaecology (RCOG) Menopause and Hormone Replacement Study Group Recommendations in December 2004, and the British Menopause Society Consensus Statement on HRT in June 2005.

But which is the accepted view? They can't all be the accepted view. Some have come out later than others and contain slightly different advice. In fact, a press statement issued at the time of the RCOG guidance hoped that the MHRA would revise their guidance in line with the RCOG recommendations (this hasn't happened).

What's a woman to think? In fact, what's a GP to think? It's the prospect of possibly adding to the confusion which has stopped the Society for Endocrinology issuing guidelines. We might be very pleased with ourselves if we issue guidance, but would a statement of ours clarify anything, or would it simply be another contribution to the pile of advice?

But does any of this make any difference to the patients themselves? Well the European Menopause Survey (March 2005, industry-sponsored) indicated that 91% of women were happy with the information they had. But doctors only came third as sources of information on HRT. Newspapers and magazines were the main source, followed by TV. In fact, 22% of women questioned were taking HRT. But 19% were also on natural, herbal or homeopathic treatments. Let me put this another way: about the same number of women take untested products of perhaps dubious efficacy to combat menopausal symptoms as take HRT. Women are taking their advice from where they can get it, and it's not always good advice.

As a middle-aged man, I don't need to worry about it, but if I had to consider taking HRT, then I'd be pretty confused. I suspect that most GPs would also be pretty confused. There is no single, authoritative, easily accessible, publicly understandable source of up to date HRT information. To be fair to all concerned, there's a difficulty in getting consensus from the clinical community. Broadly speaking, gynaecologists are more positive about HRT than are endocrinologists, so consensus is difficult to achieve. Nevertheless, 3 years after the WHI bombshell, while we have a better idea of what to advise, our failure to put this information out in a coherent way means that the UK health community is failing in its responsibilities to the public.

*Tom Parkhill
tries to make
sense of HRT
advice in the
public domain.*

**In response to
Tom's concerns
the MHRA has
reactivated its
website's links.*

TOM PARKHILL

ENDOCRINOLOGY IN NIGERIA

▶ As a western lifestyle is embraced by the people of Nigeria, endocrinology assumes an ever-increasing importance. A trend of urbanisation, 'fast food' and sedentary life has triggered a growing awareness of diabetes mellitus. But while endocrine medicine becomes increasingly relevant, health insurance is still unfamiliar terrain, and most people are yet to embrace it. Payment for medical services is usually out-of-pocket.

Diabetes mellitus provides the main focus for Nigerian endocrinology. Four years ago, a national study found it had a prevalence of 2.2%, with most cases detected in the urban areas. Recent reports from hospital-based surveys have shown a surge in the number of cases diagnosed, with diabetes mellitus accounting for 11% of all medical admissions. Unfortunately, 25% of newly diagnosed cases already have diabetes mellitus-related complications.

Thyroid disorders are the second greatest area of endocrine concern. About 90% of all cases are noticed in females. The most common thyroid disorder in Nigerian women is Graves' disease, which is often documented in those of child-bearing age. However, laboratory facilities and immunoassays for diagnosis and follow up are not readily available. There is no centre in Nigeria that offers facilities for radioactive thyroid scanning. Only one centre, a private health facility, offers radio-iodine services for treatment, and this is often the exclusive preserve of the rich.

Acromegaly and Cushing's disease are two areas in which treatment is particularly problematic. Little can be offered in terms of medical or surgical management. Such problems are compounded by the lack of adequate government funding of the health sector. Even efforts at medical research are self-financed.

The Nigerian Society of Endocrinology and Metabolism (NSEM) is on hand to provide advice to Nigerian medical professionals and the public in general. This professional body was established in 1978 and is made up of medical personnel from various fields. Of its 120 members, 34 are physicians/endocrinologists; the others include surgeons, biochemists, physiologists, anatomists, dieticians and nurses. It is led by Professor A E Ohwovoriole, an erudite scholar and distinguished professional.

The Society's remit includes promotion of research in endocrinology and metabolism. It formulates guidelines and liaises with appropriate authorities on policies concerning endocrine practice, public education, procurement and equitable distribution of drugs for the management of endocrine disorders. The involvement of the NSEM means that Nigerian patients with endocrine disorders can have adequate care if referred on time to appropriate centres.

The Society holds an annual scientific conference, usually in September. Members are also encouraged to join other international endocrine bodies to improve their exposure in the field. (More information about NSEM can be found at www.nsem.org.)

So, in the face of these various problems, endocrinology in Nigeria is at least finding its feet. It is our hope that health insurance schemes, improved funding of the health sector and the formulation of a policy for endocrine and metabolic diseases will go a long way to achieve our aims for the future.

AYOADE ADEDOKUN
LAGOS STATE UNIVERSITY TEACHING HOSPITAL, NIGERIA

Scientist at the Seat of Power

Zuckerman: Scientist extraordinary

By Bernard Donovan

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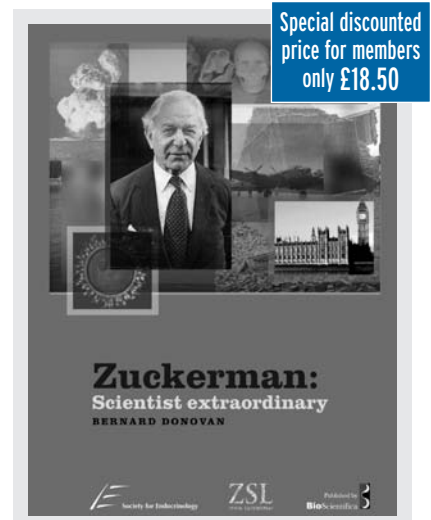
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This is one facet of the Open Access movement. The other is to champion the author-pays, free-access business model for journals in place of subscriptions. The Society has some enthusiasm for this approach, at least in theory (see *The Endocrinologist*, Autumn 2004 73 8-9). The call to make copies on so-called online 'repositories' (run, for example, by universities or funding bodies) is seen by some as complementary.

Early in 2005, the US National Institutes of Health announced that it would request, but not require, authors it had funded to deposit their final manuscripts, as accepted by a peer-reviewed journal (but prior to copy editing, page layout and proofing), onto PubMed Central. Authors can specify an embargo of anything up to 12 months from publication in the journal, after which the manuscript will be made freely available to all.

Research Councils UK have issued a position statement detailing a similar draft policy. They propose compulsory deposit in an online repository where one is available to the author, with public release as soon as possible after publication. This could be subject to the publisher's copyright or licensing arrangements, but the detailed paper appeared to contain an agenda to set limits on what these could be.

The Wellcome Trust has now announced an even more aggressive 'final' policy. As a compulsory condition of its grants, its authors will have to deposit the accepted manuscript on PubMed Central, with public release set no more than six months from publication. They also plan to set up 'UK PMC', a UK mirror of the USA's PubMed Central.

There are fundamental problems with this type of proposal, especially with Wellcome's. Almost everyone agrees that biomedical researchers value the 'quality stamp' that peer review provides. Of course, the peer review process itself needs to be paid for somehow. Traditionally this has been by charging for journal subscriptions, but it could perhaps ultimately be paid for by author fees, if that model lives up to its promise - although no one has yet demonstrated its sustainability. Revenue would be especially vulnerable during any transition period.

It's also difficult to see how the Society could accept responsibility for articles claiming to be accepted by its journals if they are hosted, perhaps in multiple versions, on web sites over which it has no control. Readers need a web site on which they can check the definitive version. That means that the Society must continue to incur the

considerable costs of providing online journals, and all of the processes leading from acceptance to final publication - in addition to the core peer review task, which is an essential part of validating it. Wellcome's policy seeks to appropriate the Society's quality stamp without payment, and encourages readers to bypass the means by which, for the time being, we attempt to recover our costs. This could threaten the very viability of the Society and its peer review quality stamp.

It's not at all clear what problem these repositories are trying to address. Why go to all the trouble of making a second-rate imitation of what journals already provide? Wellcome say the problem is with the subscription business model - author-pays, free-access would be better. If so, why not work with us to test what models can make journals sustainable in the long term? Why spend money undermining them? The Society, together with other learned societies, has made representations to RCUK and will also seek dialogue with Wellcome.

The Society's policy at the time of writing is in conflict with Wellcome's demands. Your Publications Committee and Council have sought a balance between maximising dissemination and financial sustainability. Authors of accepted articles may deposit their final manuscripts, provided they ensure that it does not become freely available until 12 months from publication. This coincides with the date that the definitive published version becomes free on the Society's HighWire web sites. Authors must also ensure that the posted manuscript includes a standard disclaimer, stating that it is not the version of record. These stipulations are now conditions of publication, and form part of the assignment of copyright form which all authors must sign. This policy is under review - please check the web site (details below) for the latest position.

Meanwhile, the Society has launched its own author-pays experiment: authors submitting research papers to *Endocrine-Related Cancer* can now choose a Free Access Option. If they choose to pay a special introductory fee of US\$1500 (including VAT), their published article will be made freely available to all in its definitive version. If they prefer not to pay, their paper will be restricted to subscribers in the normal way. Research funders may well be prepared to provide the fee. This will enable us to test author demand, the effects on subscriptions, and will help shed light on how workable the new model is. It is a real test of the viability of opening the online literature, whilst limiting the risks to the Society.

STEVE BYFORD

As Steve Byford explains, it's a testing time for journal publishers.

Find more on the Society's policy on repositories and self archiving, and the Endocrine-Related Cancer Free Access Option, at www.endocrinology-journals.org.

A tale of two delegates

Recognise these two from the last meeting you attended? You won't be the only one...

► 'Ha! What a land of opportunity...' Tristan, a fully fledged lecturer of, well, at least 3 weeks, strode purposefully into the conference venue. Following a post-doctoral stint in the USA (which, even if he said so himself, had been rather successful), he was now ready, ready to take on the world.

Networking was the name of the game. Memorising the names of all the committee members had taken some effort, but he would make sure of 'bumping' into them during this 2-day event. Day 1 was already looking promising. He had managed to tell the meetings secretary what an absolutely splendid meeting it was. It was a shame that the secretary had, at that very moment, needed to hurry away and had only been able to mumble an incomprehensible acknowledgement.

Tristan diligently attended a good selection of sessions, and asked several questions to make sure he was noticed, even if he knew nothing about the subject. Then, after stopping at a few posters to make some enquiring remarks, he attended to the most important business of the day - booking his seat at the Society dinner.

Stroking his ticket in his suit pocket, he was desperately trying to remember names. Table 3 looked promising, and there were definitely familiar names, even though he didn't know who they belonged to. He scribbled his name into the slot for the one remaining seat and felt satisfied. Perhaps he should now hang out round the exhibition stands, fill his pockets with a few freebie pens, boiled sweets and note pads, and find out if any representative from a grant-awarding body was attending the meeting. He adjusted his name badge, picked up his shining brief case and went in search of new connections.

Meanwhile, Gemma was manning her poster, number 179, over the lunch break. A graduate student of 2 years, her supervisor had given her strict instructions to be there at the allotted times. She was trying to look nonchalant whilst glancing at her wrist watch. Thirty-five minutes to go. Three more delegates walked past her poster without even a sideways glance.

She noticed that poster 187 was attracting considerable attention. There were at least eight delegates pointing, checking and pontificating around the display. She ruefully glanced at her own poster. It looked good, a nice balance of text and diagrams, readable, colourful, hypothesis stated and science at the cutting edge. So why wasn't anyone even taking her photocopied miniatures? An age went past and she looked at her watch again. Thirty minutes to go, and that seemed like a life time.

The afternoon continued and at six o'clock Gemma returned to her halls of residence to change for dinner and Tristan to the cheapest hotel offered by the conference organisers. He was annoyed that there was no trouser press. His eyes hurt from squinting surreptitiously at name badges all afternoon. Why, on those rare occasions when he had spotted a committee member, had they always seemed to be deep in conversation with someone else?

The dinner was uneventful although Tristan noted, through his haze of red wine, that any conversation had been stilted. And he was still none the wiser about the identities of the other people at table 3. Despite his efforts, he was not invited to any of the little pub gatherings that followed the dinner. Still, he reasoned, that was probably a good thing. He needed to be at his best for his oral presentation the following afternoon.

The next day Gemma went back to her poster as instructed. Miniatures were down 50% and someone looking 'very important' told her what an innovative approach she was taking and how interesting her results were. Gemma felt quite elated. Time flew and yesterday's disappointment was soon forgotten. Being part of the meeting was actually rather good.

Meanwhile Tristan, a little hung-over and somewhat irritated that his trouser knees were distinctly ballooning, headed for the lecture theatre. His communication was the last presentation of the day. While this was clearly a totally inappropriate time slot, it was understandable that the organising committee would want to leave the best to last. That must be the reason. It would prevent the meeting from finishing early, after lunch.

Although there were fewer than a dozen delegates in the audience, Tristan delivered his word-perfect talk on the effects of gibenfectin on thyroid function. He was happy that all those rehearsals had paid off, even though he was a little perturbed that an elderly gentleman, clearly retired, had snored quietly throughout his entire presentation. There was a weak clap at the end before the elderly gentleman, aroused from his snooze, stood up to ask a question. 'I wonder,' he said, 'have you tried looking at gibenfectin? It is known to inhibit thyroid function.' Tristan was speechless. There were no further questions.

Walking disconsolately out of the meeting he spotted Gemma approaching, wielding her poster with a broad smile on her face. Before he could duck behind the nearest exhibition stand, Gemma called out, 'I know you, don't I? Weren't you a demonstrator in my practical classes?'

Tristan's head at last cleared its heavy fog of half-remembered committee members' names and facts about gibenfectin.

'Fancy a post-meeting drink?' said Gemma.

'Make that a post-mortem drink,' said Tristan, 'it's been a long 2 days!'

'T-THREE'



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Ghrelin stimulates osteoblast growth

Ghrelin gene expression is widespread in human tissues, and greatest in the stomach mucosa. Ghrelin is known to stimulate release of GH, but its role in human bones has not been clear until now.

This study by Delhanty and co-workers reveals that not only is ghrelin produced by human bone cells, but that, in both acylated and unacylated forms, it also stimulates osteoblast proliferation via the MAPK and PI3K signalling pathways. The authors found that ghrelin mRNA is expressed in human bone biopsies and osteoblasts, and that expression is greater in differentiating than in non-differentiating osteoblast cells. The mRNA of one of ghrelin's two receptor splice variants, GH secretagogue receptor 1b (GHS-R1b), was also identified in these tissues. Unlike similar studies with rats, GHS-R1a was not identified in bone or osteoblasts, indicating inherent differences between species.

The decline in the osteoblasts' proliferative response to ghrelin *in vitro* may be related to changes in receptor signalling pathways over time. Further studies could be directed to identify a receptor for ghrelin in peripheral tissues. **JG** (See the full article in *Journal of Endocrinology* 188(1), January 2006)

MicroRNAs in endocrine biology

Non-protein-coding small RNAs, appropriately dubbed microRNAs (miRNAs), are said to have the potential to regulate a large proportion of protein-encoding genes in animals. Recently, the roles of these molecules have become better understood. In this Starling Review, Cuellar and McManus examine the potential contributions of miRNAs to endocrine function.

Several specific endocrine roles have been proposed for miRNAs, although the mechanisms involved are little understood. The authors suggest that dysregulation of such miRNAs could facilitate the development of diseases like cancer and diabetes. The recent discovery of a miRNA that inhibits insulin secretion

HOT TOPICS

Jolene Guy, Andrew Lowe, Jayanthi Mondi and Vicki Norton bring you updates from the Society's journals

in mice may lead to a better understanding of the mechanisms of insulin secretion and better treatment for type 2 diabetes. Another miRNA has been discovered that may modulate adipocyte differentiation. It therefore seems that miRNAs may be influential in fat metabolism, and further understanding of the mechanisms involved is likely to have a massive impact on the treatment of common diseases such as hypertension, type 2 diabetes and coronary heart disease. **VN** (See the full article in *Journal of Endocrinology* 187(3), December 2005)

Cell type-specific influence of tamoxifen

Tamoxifen is widely used as an adjuvant in breast cancer treatment. However, epidemiological evidence shows an increase in endometrial cancers in treated women. Tamoxifen acts as an oestrogen antagonist in the breast and as an oestrogen agonist in the uterus. It exerts its tissue-specific effects through the oestrogen receptor (ER) subtypes: ER α and ER β . While rapid targeting and proteasomal degradation of ER α have been reported in previous studies, little is known about the response of the ER subtypes in the uterus to tamoxifen or oestradiol.

Here, Horner-Glister and co-workers provide evidence for the involvement of membrane-associated ER in rapid non-genomic signalling pathways both in the uterus and in breast cells. ER α and ER β are degraded via the proteasome

pathway in response to oestradiol, whilst tamoxifen stabilises both subtypes in breast cells. In uterine cells, both oestradiol and tamoxifen stabilised ER α but degraded ER β . This study demonstrates for the first time that the Erk signalling pathway is activated in Ishikawa uterine cells following oestradiol treatment.

The authors show that control of ER subtype regulation by tamoxifen or oestradiol, as well as the non-genomic activation of transcription pathways, is cell type-specific. **JM** (See the full article in *Journal of Molecular Endocrinology* 35(3), December 2005)

Somatostatin receptor targeting in neuro-endocrine tumours

Neuroendocrine tumours are a heterogeneous group, which can arise from the pituitary, parathyroid, adrenal medulla and the endocrine cells of the digestive and respiratory tracts. Most neuroendocrine tumours express somatostatin receptors (SSTRs), with gastroenteropancreatic tumours often showing especially high SSTR expression. This class of receptor is therefore an ideal drug target.

Radiopharmaceutical therapy exploits antigens and receptors that are over-expressed in tumour cells to deliver radioactive payloads. In this review, Kaltsas and colleagues outline treatment using radiolabelled receptor-binding somatostatin analogues in recurrent, malignant and disseminated neuroendocrine tumours, where surgical excision is often not appropriate or possible.

Different radioisotopes have different physical properties and can confer different characteristics and pharmacokinetics upon indium-111-based somatostatin analogue therapeutics. This can lead to higher tumour payload uptake, with reduced dosing to vulnerable tissues such as the spleen, bone marrow or kidneys, but has failed to increase clinical efficacy greatly. The development of a new peptide chelator to bind yttrium-90 has opened up possibilities in this field. In addition to positive tumour response rates in early trials, it promises some SSTR subtype-specific targeting. **AL** (See the full article in *Endocrine-Related Cancer* 12(4), December 2005)

A Practical Guide to Improving Diabetes Care

Manchester, UK, 10 January 2006. Contact: Healthcare Events, 1 Acre Road, Kingston KT2 6EF, UK (Fax: +44-20-85472300; Email: jayne@healthcare-events.co.uk; Web: www.healthcare-events.co.uk).

Hormones, Nutrition and Physical Performance

Torino, Italy, 28-31 January 2006. Contact: Mariuccia Enria (Email: mariuccia.enria@congress.iefiere.com; Web: www.hormones.it).

Prolactin Family Gordon Research Conference

Ventura, CA, USA, 29 January-3 February 2006. Contact: Arthur Gutierrez-Hartmann (Chair) or Hallgier Rui (Co-Chair), Department of Medicine, Mail Stop 8106, University of Colorado HSC, RC-1 South, 12801 East 17th Ave, Room L18-7108, PO Box 6511, Aurora, CO 80045, USA (Tel: +1-303-7243921; Fax: +1-303-7243920; Email: a.gutierrez-hartmann@uchsc.edu; Web: www.grc.org).

Late Effects in Cancer Survivors

Sheffield, UK, 9-10 February 2006. Contact: Tamara Lloyd, BioScientifica Ltd, 22 Apex Court, Woodlands, Bradley Stoke, Bristol BS32 4JT, UK (Tel: +44-1454-642231; Fax: +44-1454-642222; Email: tamara.lloyd@endocrinology.org; Web: www.endocrinology.org/sfe/sfevents.htm).

Society for Endocrinology Clinical Cases Meeting

London, UK, 15 February 2006. 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: ann.lloyd@endocrinology.org; Web: www.endocrinology.org/sfe/train.htm).

10th Congress of the Asian Association of Endocrine Surgeons

Hong Kong, 12-15 March 2006. Contact: Edith Tong, Department of Surgery, University of Hong Kong Medical Centre, Queen Mary Hospital, Pokfulam, Hong Kong (Tel: +852-28180232/28554235; Fax: +852-28181186; Email: AsAES06@hku.hk; Web: www.AsAES2006.org).

1st Postgraduate Course in Clinical Endocrinology of the European Society of Endocrinology

Belgrade, Serbia and Montenegro, 17-18 March 2006. Contact: Prof. Dr Vera Popovic, Neuroendocrine Unit, Institute of Endocrinology, University Clinical Center, Dr Subotic 13, 11000 Belgrade, Serbia (Tel: +381-11-684177; Fax: +381-11-685357; Email: popver@eunet.yu; Web: www.ese1belgrade2006.org).

Frontiers of Skeletal Biology: 11th Workshop on Cell Biology of Bone and Cartilage in Health and Disease

Davos, Switzerland, 18-22 March 2006. Contact: Heidi Triet, Office of Prof. H Fleisch, Effingerstrasse 40, CH-3008 Bern, Switzerland (Tel: +41-31-3899276; Fax: +41-31-3899284; Email: secretariat@hfleisch.ch; Web: ibmsonline.org/conferences/cellbio06.cfm).

Compartmentalization of Cyclic AMP Signalling

Cambridge, UK, 29-30 March 2006. Contact: Helen Davies (Email: meetings@biochemistry.org; Web: www.biochemistry.org/meetings/programme.cfm?Meeting_No=SA045).

Biochemical Society Annual Symposium: the Cell Biology of Inositol Lipids and Phosphates

Birmingham, UK, 29-31 March 2006. Contact: Helen Davies (Tel: +44-20-72804150; Email: meetings@biochemistry.org; Web: www.biochemistry.org/meetings/programme.cfm?Meeting_No=SA048).

Meiosis and the Causes and Consequences of Recombination

Warwick, UK, 29-31 March 2006. Contact: Helen Davies (Email: meetings@biochemistry.org; Web: www.biochemistry.org/meetings/programme.cfm?Meeting_No=SA049).

8th European Congress of Endocrinology

Glasgow, UK, 1-5 April 2006. 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).

Joint 62nd Harden Conference/EMBO Symposium: NO - a Radical in Control

Cirencester, UK, 4-8 April 2006. Contact: Helen Davies (Email: meetings@biochemistry.org; Web: www.biochemistry.org/meetings/programme.cfm?Meeting_No=62HDN).

Neurotrophins: a Role in Mechanisms and Therapy in Disease

Bristol, UK, 6 April 2006. Contact: Natalie (Email: meetings@biochemistry.org; Web: www.biochemistry.org/meetings/programme.cfm?Meeting_No=SA034).

14th European Workshop on the Molecular and Cellular Endocrinology of the Testis

Bad Aibling, Germany, 22-26 April 2006. Contact: Prof. Dr Eberhard Nieschlag, Institute of Reproductive Medicine of the University, Domagkstrasse 11, D-48129 Münster, Germany (Tel: +49-251-8356096; Fax: +49-251-8356093; Email: eberhard.nieschlag@ukmuenster.de; Web: www.etw2006.de).

33rd European Symposium on Calcified Tissues

Prague, Czech Republic, 10-14 May 2006. Contact: Amanda Sherwood, PO Box 337, Patchway, Bristol BS32 4ZR, UK (Tel: +44-1454-610255; Fax: +44-1454-610255; Email: admin@ectsoc.org; Web: www.ectsoc.org).

1st World Congress on Controversies in Obesity, Diabetes, and Hypertension (CODHY)

Berlin, Germany, 25-28 May 2006. Contact: Z Ben-Rafael (Email: codhy@codhy.com; Web: www.codhy.com).

2nd EUGOGO Teaching Course on Graves' Orbitopathy

Pisa, Italy, 6-8 June 2006. Contact: Claudio Marcocci, Department of Endocrinology and Metabolism, University of Pisa, Via Paradisa 2, 56124 Pisa, Italy (Tel: +39-050-995078; Fax: +39-050-995078; Email: c.marcocci@endoc.med.unipi.it; Web: www.eugogo.org).

International Neuroendocrine Federation:

6th International Congress of Neuroendocrinology

Pittsburgh, PA, USA, 19-22 June 2006. Contact: Tony Platt (Tel: +1-412-6489395; Email: plant1@pitt.edu; Web: ccehs.upmc.edu/course2/187b).

ENDO 2006

Boston, MA, USA, 24-27 June 2006. Contact: The Endocrine Society, 8401 Connecticut Avenue, Suite 900, Chevy Chase, MD 20815-5817, USA (Tel: +1-301-9410200; Fax: +1-301-9410259; Email: endostaff@endo-society.org; Web: www.endo-society.org/scimeetings).

National Osteoporosis Society:

11th Conference on Osteoporosis

Harrogate, UK, 25-28 June 2006. Contact: Sarah Phillips, National Osteoporosis Society, Camerton, Bath BA2 0PJ, UK (Tel: +44-1761-473106; Email: s.phillips@nos.org.uk; Web: www.nos.org.uk/conference).

45th Annual Meeting of the European Society for Paediatric Endocrinology

Rotterdam, The Netherlands, 30 June-3 July 2006. Contact: Britta Sjöblom (Tel: +46-8-4596650; Email: britta.sjoblom@congrex.se; Web: www.espe2006.org).

Society for Endocrinology Molecular Endocrinology Workshop at Summer School

Cambridge, UK, 11 July 2006. 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: ann.lloyd@endocrinology.org; Web: www.endocrinology.org/sfe/train.htm).

Society for Endocrinology Advanced Endocrine Course at Summer School

Cambridge, UK, 12-13 July 2006. 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: ann.lloyd@endocrinology.org; Web: www.endocrinology.org/training).

Society for Endocrinology Clinical Practice Day at Summer School

Cambridge, UK, 14 July 2006. 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: ann.lloyd@endocrinology.org; Web: www.endocrinology.org/training).

8th International Symposium on Neurobiology and Neuroendocrinology of Aging

Bregenz, Austria, 23-28 July 2006. Contact: Richard Falvo, Department of Cell and Molecular Physiology, School of Medicine, Medical Biomolecular Research Building, 103 Mason Farm Road, University of North Carolina at Chapel Hill, Chapel Hill, NC 27599-754, USA (Tel: +1-919-9661099; Fax: +1-919-9666927; Email: rfalvo@med.unc.edu; Web: www.neurobiology-and-neuroendocrinology-of-aging.org).

Summer School on Endocrinology

Bregenz, Austria, 30 July-3 August 2006. Contact: Elke Abdel-Karim (Fax: +49-30-450524922; Email: elke.abdel-karim@charite.de; Web: www.charite.de/expendo).

10th International Congress on Obesity

Sydney, NSW, Australia, 3-8 September 2006. Contact: ICO 2006 Secretariat, GPO Box 2609, Sydney, NSW 2001, Australia (Tel: +61-2-92411478; Fax: +61-2-92513552; Email: enquiries@ico2006.com; Web: www.ico2006.com).

197th Meeting of the Society for Endocrinology

London, UK, 6-8 November 2006. 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).

CHANGING THE FACE OF FEMALE HIRSUTISM



THE ONLY TOPICAL PRESCRIPTION MEDICINE TO SLOW
THE GROWTH OF EXCESSIVE FACIAL HAIR IN WOMEN

Vaniqa 11.5% Cream Prescribing Information

Presentation: Cream containing 11.5% w/w eflornithine (as monohydrate chloride). Also contains cetostearyl alcohol, macrogol 20 cetostearyl ether, dimeticone, glyceryl stearate, macrogol 100 stearate, methyl parahydroxybenzoate (E218), mineral oil, phenoxyethanol, propyl parahydroxybenzoate (E216), purified water and stearyl alcohol.
Indication: Treatment of facial hirsutism in women. **Dosage and Administration:** Apply a thin layer of the cream to clean and dry affected areas of face and under chin twice daily, at least eight hours apart. Rub in thoroughly. For maximal efficacy, the treated area should not be cleansed within four hours of application. Cosmetics (including sunscreens) can be applied over the treated areas, but no sooner than five minutes after application. Improvement in the condition may be noticed within eight weeks of starting treatment. Continued treatment may result in further improvement and is necessary to maintain beneficial effects. The condition may return to pre-treatment levels within eight weeks following discontinuation of treatment. Use should be discontinued if no beneficial effects are noticed within four months of commencing therapy. Patients may need to continue to use a hair removal method (e.g. shaving or plucking) in conjunction with Vaniqa. In that case, the cream should be applied no sooner than five minutes after shaving or use of other hair

removal methods, as increased stinging or burning may otherwise occur. **Elderly:** (> 65 years) no dosage adjustment is necessary. **Children and Adolescents:** (< 12 years) safety and efficacy of Vaniqa have not been established. **Hepatic/renal impairment:** the safety and efficacy of Vaniqa in women with hepatic or renal impairment have not been established. **Pregnancy and Lactation:** Pregnant or breast-feeding women should not use Vaniqa. **Contra-indications:** Hypersensitivity to eflornithine or to any of the excipients. **Special Warnings and Precautions:** Excessive hair growth may be as a result of serious underlying disorders (e.g. polycystic ovary syndrome, androgen secreting neoplasm) or certain medications (e.g. cyclosporin, glucocorticoids, minoxidil, phenobarbitone, phenytoin, combined oestrogen-androgen hormone replacement therapy). These factors should be considered in the overall medical treatment of patients who might be prescribed Vaniqa. Contact with eyes or mucous membranes (e.g. nose or mouth) should be avoided. Transient stinging or burning may occur when the cream is applied to abraded or broken skin. If skin irritation or intolerance develops, the frequency of application should be reduced temporarily to once a day. If irritation continues, treatment should be discontinued and the physician consulted. It is recommended that hands are washed following use. **Undesirable Effects:** The mostly skin related adverse reactions reported were

primarily mild in intensity and resolved without discontinuation of Vaniqa or initiation of medical treatment. Most events were reported at similar rates between Vaniqa and vehicle. * denotes when higher levels in Vaniqa treated patients were reported: Very common (> 10%); acne. Common (> 1% to < 10%); pseudofolliculitis barbae, alopecia, stinging skin*, burning skin*, dry skin, pruritus, erythema*, tingling skin*, irritated skin, rash*, folliculitis. Uncommon (> 0.1% to < 1%): ingrown hair, oedema face, dermatitis, oedema mouth, papular rash, bleeding skin, herpes simplex, eczema, cheilitis, furunculosis, contact dermatitis, hair disorder, hypopigmentation, flushing skin, lip numbness, skin soreness. Rare (> 0.01% to < 0.1%): rosacea, seborrhoeic dermatitis, skin neoplasm, maculopapular rash, skin cysts, vesiculobullous rash, skin disorder, hirsutism, skin tightness. **Legal Category:** POM. **Price:** 1 x 30g tube £26.04. **Marketing Authorisation Holder:** Shire Pharmaceutical Contracts Ltd., Hampshire International Business Park, Chineham, Basingstoke, Hampshire RG24 8EP, UK. **Marketing Authorisation Number:** EU/1/01/173/002. **Date of Preparation:** July 2004. **Further Information is Available from:** Shire Pharmaceuticals Ltd., Hampshire International Business Park, Chineham, Basingstoke, Hampshire RG24 8EP. Code: 039/0086 Date of item: November 2004

New

VANIQA[®]

EFLORNITHINE 11.5% CREAM

Shire