CAPE NEWS

Newsletter of the Indian Society for Pediatric & Adolescent Endocrinology (ISPAE)

www.ispae.org.in

December 2008
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Inside this Issue

NOTICE OF THE ANNUAL GENERAL BODY MEETING

V Bhatia, Secretary-Treasurer, ISPAE

Notice is hereby given of the annual GBM of ISPAE, to be held on 21 Jan 09 at 5 pm (after the Pre-confenrence Workshop), at Sagar Hospital, Bannerghatta Road, Tilak Nagar, Bangalore. The agenda is:

1. Welcoming of new Office bearers and new members.
2. Presentation of accounts for the year ended 31st March 2008, and confirmation of appointment of auditor for YE 31 March, 2009.
3. Confirmation of minutes of Annual GBM of February 2008.
4. Consideration and adoption of the Report of the Society.
5. Discussion of activities for the year 2008-09 and 2009-2010, including ISPAE 2009, ISPAE-PET 2009, as well as future meetings, popularizing website, links with international organizations, increasing awareness of growth charts and orchidometers.
6. Membership drive.
7. Setting up of new formal pediatric endocrine courses in the country and DNB fellowship.
8. Any other agenda with permission of the chair.

Tenth APPES Fellows' Meet

Leena Priyambada,JIPMER, Puducherry, & J Muthukrishnan,Medwin Hospital, Hyderabad

The 10th APPES Fellows' Meeting in Seoul on 27-29 October 2008, was co-hosted by the Korean Society of Pediatric Endocrinology. Meant as a workshop for trainees in pediatric endocrinology, it presented a wonderful opportunity for education and interaction with ...

contd on page 3

BEST WISHES FOR A WONDERFUL 2009!

ISPAE WEBSITE

Have you seen our website? www.ispae.org.in. Please use it, send contributions, suggest changes and improvements for it, and inform others who are likely to find it useful.

ISPAE MEETINGS

ISPAE 2009 is in New Delhi: 13-15th November, 2009. Organizing Secretaries: Dr Archana Arya & Dr V Bhatia, Email: ispae2009@gmail.com.

We proudly announce the first PET (Pediatric Endocrine Training program): ISPAE-PET 2009, to be held at the National Institute of Biologicals, NOIDA: 10-13 Nov 2009. Contact: Prof Anju Seth, anju_seth@yahoo.com

ISPAE NEWS

Office Bearers and Executive for 2009-2010

V Bhatia, Returning Officer, ISPAE

I have great pleasure in announcing the results of the elections for 2009-2010. There was no contest for any post, so voting was not needed, and these members are declared elected uncontested:

President: Dr Nalini Shah, Mumbai

Secretary-Treasurer: Dr Archana Dayal Arya, Delhi

Joint Secretary: Dr Sudha Rao, Mumbai.

Executive Members: Anurag Bajpai (Kanpur), Dr Krishna Biswas (Delhi), Dr Preeti Dabadghao (Lucknow), Dr Subrata Dey (Kolkata), Dr Aspi Irani (Mumbai), Dr Anju Seth (Delhi), Dr Vijayakumar (Calicut).

Congratulations to all the new members of the executive! They take over at the AGBM in Bangalore.

SECRETARY'S MESSAGE

As I hand over the baton of Secretary-ship to Dr Archana Arya, and look back over the past 3 years, I feel it is time for a summing up and for trying to peer into the crystal ball to see what the future holds for us! This has been a hectic period for Anju and me, but a reasonable amount has been achieved.

For one, the tribe of pediatric endocrinologists has been gradually increasing. Many members are active in furthering awareness among health care personnel and patients and families. The most significant was the National meeting organized by Drs Meena Desai, Nalini Shah and Sudha Rao in February 2008 in Mumbai, much appreciated! It was attended by a galaxy of eminent speakers from various parts of the globe. If you missed the meeting, you can buy the CD of the proceedings. In Nov 2007, a national meeting of growth experts and representatives of Central IAP was convened in Mumbai by Drs Vaman and Anuradha Khadilkar. Growth charts derived from Dr KN Agarwal's data were recommended by this committee, and endorsed by Central IAP as nationally representative for all pediatricians to use. The resultant IAP Guidelines are in the April 2008 issue of Indian Pediatrics. The annual national symposium at the Bhuvaneshwar Pedicon, covering the impact of technology on type 1 diabetes; and a panel discussion on various aspects of GH use, was well attended.

As far as regional meetings were concerned, in October 2008, as part of the IAP's EDUSAT initiative, a telemedicine conference was organized at Hassan (Karnataka) by Dr Shaila Bhattacharya. At Kolkata, Dr Subrata Dey organized very successful CMEs in April and November 2008. Other meetings this year: workshop by Dr Khadilkar in Mumbai in Sep; (lectures by Dr Desai and him in Surat in Oct, and by him in Anand in Dec), update by Dr Ravikumar in Chennai in October, CME by Dr Vrind Bhardwaj in Jabalpur in November, as well as activities for young diabetics in different corners of the country, reported elsewhere in this issue.

We have recently started our website, www.ispae.org.in. Made with a skeleton budget, it is utterly simple and functional, but provides the ability for faster and better communication with each other, and also more easily with international pediatric endocrine and diabetes societies; it also allows wider dissemination of news and knowledge. The Members' area allows us to stay in touch with each other, making patient referral and planning research and

advocacy activities easier. We are trying to make our newsletter, in the days before the internet the lifeline of our communication, more full of content and color, and yet nearly free to send, by going increasingly electronic. In the pipeline is a Yahoo group which would allow us to discuss difficult patient problems and use local, locally relevant (!) expertise most effectively. With a lot of time spent on paperwork, with our Chartered Accountant, and at the IT Department, we have succeeded in getting our PAN, as well as income tax exemption and 80G status.

This in the realm of the virtual world. Coming to more concrete objects which would help pediatricians monitor growth and puberty better, we are making available at a low cost, locally made orchidmeters, as well as India-specific growth charts based on Dr KN Agarwal's data. The second edition of Dr Desai's basic bible on "Pediatric Endocrine Disorders" is out, and is well accepted not only in India, but also neighboring countries.

We are in active touch with the major regional body APPES. Dr Menon is already on the advisory council, and I will be joining him from 2009 in representing India and Indian interests. The 5 Indian fellows who participated in the annual APPES Fellows' Meeting did us proud. In addition, ESPE approached us in 2007 as part of their initiative to

further ped endo education in India and China, the two major developing countries. Prof Hochberg, Prof Chiarelli and Prof Greuters attended the Mumbai meeting as representatives of ESPE, and invited Dr Anju Virmani to attend the ESPE Summer School preceding the annual ESPE meeting in Istanbul in September 2008. The outcome of this initiative is the first pediatric endocrine training (PET) program we are planning in Delhi in November 2009, in which 2 faculty members: Prof Jean-Claude Carel and Prof Olle Soder, are being sponsored by ESPE.

All this has been satisfying, even though it was achieved with much hard work. It was made easier by the constant support and advice of Dr Meena Desai and Dr PSN Menon, and seamless teamwork with Anju Virmani. As we all get busy with the planning of the biennial meeting and the preceding PET program in Delhi in November 2009, I hope we would be able to carry this tiny specialty further in India, so we can work together in providing our children with optimum care in coping with these difficult, chronic disorders.

PRESIDENT'S MESSAGE

The Ped Endo Chapter has always been dear to my heart, and two events I am very proud of are the Special Prize our Chapter got from Central IAP in 2002, and the 10th birthday of CAPENEWS! I have lost count of the hours spent getting CAPENEWS ready, requesting for articles or news, cajoling colleagues to become members, tracking changed email ids or addresses… I am sure "pest" comes to many people's minds when my name is mentioned! Then quite unexpectedly I was the one being pressured… into taking over as President. My initial trepidation was short-lived, however, because of the rapport Vijayalakshmi and I have shared. So she got to do the hard work and the pestering, and in the process she has achieved a lot! The new avatar of the e-newsletter, the website, and the prospect of an e-group, are all very satisfying. I also got an opportunity to go as an observer to the ESPE Summer School and to speak on the impact of poverty on endocrine care in the annual ESPE meeting. We are continuing to work with Prof Lars Svendahl, who has been the Chair of the Steering Committee of the ESPE School for the past 5 years, and are also putting together the experiences of former APPES Fellows, to organize the PET program, which will be for the first time in India, and should meet a felt need.

ISPAD honored our Chapter and me by appointing me as their Educational Ambassador for pediatric diabetes in India. We hope with their active collaboration, to have periodic training programs focusing on pediatric diabetes, also an urgent need. In addition, there has been some effort to getting Eli Lilly to print insulin inserts in Hindi as well as English (and other languages later).

I am sure with the new dynamic team at the helm of affairs, headed by Dr Nalini Shah, and with Dr Arya, Dr Rao, and an excellent Executive Council, that ped endo will go from strength to strength in the years to come.

Contd from page 1…

colleagues and faculty from the Asia Pacific region. The eminent faculty included Dr Maria Craig (University of New South Wales, Australia), Prof Louis Low (Hong Kong), Prof Nalini Shah (India), Dr Yung Seng Lee (Singapore), Prof Paul Hoffman (New Zealand), Dr Chris Cowell (Australia), Prof Erica Eugster (USA), Dr Xiaoping Luo (China), Prof Leo Dunkel (Finland), Prof Ho Seong Kim (Korea), and Prof Sei Won Yang (Korea).

Representing India were 5 of the 40 fellows, selected from the Asia-Pacific region, and one of the faculty, selected from all over the world (Dr Nalini Shah). The Indian fellows were Dr Vandana Jain and Dr K Achouba Singh (both AIIMS, New Delhi), Dr J Muthukrishnan (Medwin Hospital, Hyderabad), Dr Rajesh Joshi (BJ Wadia Hospital, Mumbai), and Dr Leena Priyambada (JIPMER, Puducherry).

The fellows were required to submit interesting case scenarios. The cases selected for discussion were sent to all the fellows prior to the meet, to help preparations and encourage participation in the sessions.

An introductory welcome dinner, where the faculty and the fellows interacted, set the pace for the excellent academic sessions that followed over the next 2 ½ days. Interactive case-based discussions were followed by lectures on pertinent subjects. The topics for the sessions included calcium metabolism, delayed puberty, precocious puberty, thyroid disorders, diabetes and obesity, pituitary

problems, disorders of sexual differentiation, growth and adrenal insufficiency. We were divided into small groups, led by a faculty member, and allotted topics, to ensure intensive discussion and participation.

The next day ended with a quiz which was a visual delight: an excellent collection of clinical photographs! We are proud that we Indians secured second (J Muthukrishnan) and third (Rajesh Joshi) positions in the quiz!

The meet was also an excellent platform for interaction amongst us in the Asia – Pacific region, providing an opportunity to observe at close quarters how pediatric endocrinology is practiced in places different from our own. We got valuable insights into how people think, work and innovate in both resource-poor and resource-rich nations, and realized again that there is no substitute to clinical judgment.

Seoul is a great city and the Koreans a very hospitable people. The accommodation and arrangements were superb, the specialty Korean cuisines with varied fare of seafood, in the evenings and the insight into the Korean tradition and culture, including the traditional Korean tea ceremony, were delightful. All this made the trip even more memorable.

Below are some pearls from the academic discussions:

Calcium and bone metabolism

Neonatal hypocalcemia:
** The definition of subnormal serum calcium is age dependent; <8 mg/dl in term babies and <7 mg/dl in preterms.
** When working up neonatal hypocalcemia, maternal hypocalcemia and Vitamin D deficiency (asymptomatic/ symptomatic) should always be looked for. If maternal abnormalities are found, the other siblings and father should also be evaluated.
** Long term side effects of neonatal hypocalcemia, including reduced bone mineral density, increased fracture risk, delayed dental eruption and enamel hypoplasia, risk of joint infection, and possible risk of Type 1 diabetes mellitus should be evaluated in follow up.
** For treatment, if hypocalcemia is severe, IV calcium may be used. Else oral calcium 50-100 mg/kg/d and calcitriol 40-50 ng/kg/d should be given. When calcium normalizes, the neonate is advised calcium supplements and cholecalciferol 5000 U/day for 3 months, followed by 400 U/day.

** In DiGeorge syndrome, hypocalcemia may not be permanent. Patients on replacement therapy need periodic reassessment of requirement.

** In hypophosphatemic rickets, ideally neutral phosphate mixture should be administered 5-6 times a day for optimum benefit.

Non calcemic activities of 1,25 (OH)2 D3:
** Most tissues in the body express Vitamin D receptors. 1,25 $(OH)_2$ D_3 inhibits the proliferation and terminal differentiation of keratinocytes, cancer cells (prostate, colon, breast, lung and lymphoproliferative cells). It also helps in intrauterine growth and patterning for bone mass. It acts on the β cells of the pancreas to increase insulin secretion. Activated T and B cells, monocytes and macrophages respond to 1, 25 (OH)2 D3; hence there may be a potential role in decreasing the incidence of multiple sclerosis, Crohn's disease, rheumatoid arthritis, and type 1 diabetes mellitus.

Velocardiofacial syndrome:
** This condition should be suspected when hypocalcemia is associated with congenital heart disease and facial dysmorphism. Endocrine abnormalities associated with this 22q11.2 microdeletion are hypoparathyroidism, thyroid dysfunction especially autoimmune thyroiditis and Graves' disease, short stature and GH deficiency. The parathyroid dysfunction can manifest in different ways: severe neonatal hypocalcemia which can resolve completely over weeks/months or recur; late onset hypocalcemia at any age; latent hypoparathyroidism unresponsive to a hypocalcemic challenge; or prolonged mild undetected hypocalcemia. Hence, the serum calcium levels should be periodically monitored on follow up in such patients even if they appear to have normalized.

Congenital hypothyroidism and rickets:

An interesting report of a child with congenital hypothyroidism on therapy presenting with rickets at 4 years of age was discussed. Biochemistry revealed low normal serum calcium, phosphorous and normal serum 25 (OH)D. Despite extensive discussion a cause or association of these two conditions could not be arrived upon. On internet search, a couple of case reports are available where these two conditions co-exist, but these were described mainly in preterms with congenital hypothyroidism presenting with rickets of prematurity.

Hypercalcemia was discussed at length, stressing management with bisphosphonates.

Delayed puberty

** We were reminded that no single test can reliably differentiate constitutional delay (CDGP) from isolated hypogonadotropic hypogonadism (HH). Non-progression of puberty even after 17 years is suggestive of hypogonadism. Children with hypogonadism may not have short stature, have a normal adrenarche, and may have facial, skeletal or CNS malformations with abnormal MRI findings. They have a prepubertal response to GnRH analogues and prepubertal LH pulsatility.

** Cases presenting with delayed puberty due to DAX 1 (NROB1) gene mutation (associated adrenal insufficiency), celiac disease (malabsorption, anemia, auto-immune thyroid dysfunction, short stature), and Klinefelter syndrome (gynecomastia, small firm testes) were discussed.

** The commonest referral for hypogonadism is obesity with buried penis in boys.

Childhood Obesity & Diabetes

** Red flags while evaluating childhood obesity include: height centile below mid-parental centile, suboptimal growth velocity, recent onset, associated developmental delay, pubertal delay, abnormal neurological signs and a delayed bone age.

** In PWS screening, if only FISH is done, the diagnosis can be missed in about 30% of cases.

** In a study from Singapore, 4% of severe obese children had T2DM whereas 25% had an impaired glucose tolerance test.

** Metformin lowers HbA1c and decreases insulin requirement in poorly controlled type 1 diabetic patients. *(Diabet Med 2006 Oct; 23(10): 1079-84, Diabetes Care 2003 Jan; 26(1):138-43)*

Neonatal diabetes mellitus:

** Transient neonatal diabetes mellitus may recur later especially with a recurrent (R201H) Kir6.2 mutation.

Type 1 vs. Type 2 DM:

** In newly diagnosed DM in an obese adolescent with hyperinsulinism- when in doubt start treatment with insulin and later decide whether to switch therapy to oral drugs on follow up.

** Do not start with insulin pump therapy in the beginning. Always start with injectable insulins, even in patients who can afford pumps, so that they are trained to self-inject and can manage injections in case of pump failure.

Adrenal disorders

Congenital Lipoid Adrenal Hyperplasia:

** StAR protein deficiency (38 of the 89 cases reported from Japan, JCEM 2005; 90:6303) is the second commonest cause of CAH after CYP21A1 deficiency in Japan and S Korea. Though patients are usually symptomatic within 2 months, presentation as late as 12 months has been seen, due to low levels of StAR independent steroidogenesis. Since there is a autosomal recessive inheritance, antenatal diagnosis may be done in subsequent pregnancies by chorionic villus sampling.

Adrenal rest tumor:

** In cases of CAH with uncontrolled 17OH progesterone and testosterone levels despite supraphysiological doses of hydrocortisone, testicular adrenal rests should be suspected. These may rarely also present as diffuse enlargement of the testes.

** Adrenal rest tumors are not uncommon in CAH, hence periodic ultrasounds should be done in such children, especially during adolescence.

Disorders of Sexual Differentiation

** In bilateral cryptorchidism, HCG stimulated AMH is 92% sensitive and 98% specific in

detecting the presence of testis cf. HCG stimulated testosterone which is 69% sensitive and 83% specific *(Lee MM. NEJM 1997; 336:1480-6)*. Basal inhibin levels may be of comparable value.

** A karyotype obtained from amniocentesis should always be repeated on the newborn as maternal cells can contaminate the amniotic fluid analysis and give misleading results.
** WNT4 loss-of-function mutations may present similar to Mayer-Rokitansky-Kustner-Hauser syndrome.

Thyroid
** It was reiterated that treatment of subclinical hypothyroidism continues to be debatable, with definite recommendations for treatment if TSH> 10 mIU/L.
** Congenital central hypo-thyroidism due to TSHβ-gene mutation was one of the case scenarios illustrated in a 15 month old boy with clinical features of hypothyroidism.

Growth

** In migrant populations, ethnic-specific growth charts should be used for the first generation, and local growth charts from the second generation onwards.

** In suspected GH insensitivity, IGFBP3 measurement has no role beyond age 3y as values may overlap with the normal range. IGF-1 levels alone are adequate.

** Children with non-familial short stature and family history of delayed puberty have a better final height prognosis with GH therapy than those with h/o familial short stature or those with no h/o delayed puberty in parents.

Pituitary
** The most common causes for central DI in children and adolescents are idiopathic (52%), Langerhans cell histiocytosis (15%) and germinoma (8%). If associated with anterior pituitary defects, a strong suspicion of LCH or other tumorigenesis should be kept. If the pituitary looks normal on MRI, it should be imaged periodically, as tumor or LCH may have delayed presentation, but how often or how long should serial follow up MRI be performed, remain an unanswered question.

Nephrogenic DI

Avoid excess osmolar load by avoiding protein and sodium excess. Excess osmoles cannot be retained by thiazide therapy, and this would lead to polyuria.

Precocious puberty
** Secondary sexual development occurring in girls before the age of 7½ years (African American, Hispanics) or 8 years (Caucasians) and in boys before the age of 9 years has been the traditional teaching. Trends have shown an early onset of puberty, though average age of menarche has been stable over the decades *(Bourguignon JP, in Pescovitz & Eugster, eds, Pediatric Endocrinology: Mechanisms, Manifestations and Management, LWW 2004)*.

Premature Thelarche:
** While evaluating premature thelarche, bone age should be done; E2 assays were not recommended and the child should be followed up 6 monthly. A third resolve, a third, remain static and the rest progress, requiring subsequent evaluation.

Mc Cune Albright syndrome:
** MAS is most often diagnosed in girls < 1-6y usually presenting with sudden onset vaginal bleeding with acute (typically mild) breast enlargement. Bone age may not be advanced at initial diagnosis, as it takes time for the skeletal maturational changes to manifest. The elevations in serum estradiol are episodic. The gonadotropins are suppressed and there may be large, asymmetric ovarian cysts.
** MAS must be kept in mind as a differential before performing an oophorectomy in a girl with peripheral precocity puberty and ovarian cyst *(Nabhan Z, Eugster EA. Journal of Pediatric Surgery 2007)*. Presence of vaginal bleeding, café au lait macules and absence of tumor markers help in differentiating from a tumor.
** RadioIsotope bone scan is more sensitive than skeletal survey for MAS.
** Interesting reports of peripheral precocity due to lavender oil, tea tree oil, and hair products were also illustrated.
** A 5 yr old boy with precocity and hemiplegia and 6 ml testicular volume was presented,

misleading one to a diagnosis of central precocious puberty initially. However, gonadotropins were suppressed, and it turned out that he had an HCG secreting germ cell tumor.

FIRST PRACTICAL PEDIATRIC ENDOCRINE UPDATE (PPEU)

Subrata Dey, Apollo Gleneagles Hospiatl, Kolkata

The 1st Practical Pediatric Endocrine Update was organized by the Division of Pediatric Endocrinology, at Apollo Gleneagles Hospital, Kolkata in collaboration with IAP West Bengal Branch on 20th April, 2008. A power one-day program, it was designed to address the common queries of practicing pediatricians and post graduates. Topics varied from newborn thyroid screening and goiter to rickets, puberty, PCOS and childhood metabolic syndrome. The array of speakers included Dr Margaret Zacharin from Australia, Dr Nalini Shah, Dr Anju Virmani and Dr Vijayalakshmi Bhatia. Attendance was excellent, with several delegates from Bangladesh and from all over the northeast and the audience was extremely enthusiastic in its participation. Registration fees were nominal. It was a resounding success for a first of its kind CME in East India.

KOLKATA PEDIATRIC ENDOCRINE GROWTH UPDATE 2008

Subrata Dey, Apollo Gleneagles Hospiatl, Kolkata

Following the success of the PPEU in April 2008, this meeting was organized on 29th Nov 2008, by the Division of Pediatric Endocrinology, Department of Pediatrics, Apollo Gleneagles Hospital, Kolkata, in association with Endocrine Society of India, West Bengal and Indian Academy Pediatrics, West Bengal Branch. It was a historic occasion because IAP WB and ESI WB were provided a common platform to seek early recognition and solutions for growth failure. This CME was designed to address cutting edge endocrinology issues in evaluation and management of growth disorders in childhood and the expanded role of growth augmentation therapy. Registration fees were waived. Dr P Raghupathy and Dr Archana Dayal Arya were the guest speakers. The delegates were very happy with the entire program.

CME: GROWTH & PUBERTY

Vrind Bhardwaj, NSCB Medical College, Jabalpur

This CME was organized on 29th Nov 2008 by the Department of Pediatrics, NSCB Medical College, Jabalpur, and the IAP Jabalpur branch, with postgraduates and practicing pediatricians as the target audience. The 97 registrations included 43 practising pediatricians, 3 consultants and 6 residents from the Department of Obs. & Gyn., the rest being the residents, senior residents and consultants from the Department of Pediatrics.

The program started with installation of new Executive body of the IAP Jabalpur branch, followed by the formal inauguration of the CME by the chief guest, Prof K D Baghel, Dean of the NSCB Medical College.

The CME comprised of a pre-lunch session on growth, in which Prof. Sangeeta Yadav (MAMC, New Delhi) discussed different growth curves, interpretation of growth data and

FORTHCOMING MEETINGS

1. PEDICON 2009: 46th Annual Conference of the Indian Academy of Pediatrics: 22-25 Jan 2009, Palace Grounds, Bangalore. Dr R Nisarga, pedicon2009@gmail.com..
PROGRAMS OF INTEREST:
22 Jan 2009: CME: **12-12.20pm**: Approach to renal rickets and renal tubular acidosis. **2-3pm:** Compre-hensive management of a) type 1 diabetes mellitus b) childhood hypertension. **3-4pm:** a) Enzymatic and metabolic disorders- the burden & prevention b) Genetic syndromes.
23 Jan 2009: 9.30-10.15am: How do I approach the dysmorphic child? **10.15-11.15am**: I am not growing well: approach to short stature. **3.15-5.15pm**: Rational use of steroids. **3.15-5.15pm**: Neonatal hypothyroidism. **3.15-5.15pm**: Maternal diabetes and infant of diabetic mother. **3.15-5.15pm:** Hypovitaminosis beyond rickets.
24 Jan 2009: **9.30-10.15 am**: How do I approach obesity in children? **3.15-5.15pm:** Newborn screening. **3.15-5.15pm:** PW Syndrome.

2. PEDICON 2009 Symposium: 25 Jan 2009, 8-9.30 am. **Theme:** Adolescent Endocrinology in Pediatric Office Practice (**Chair:** Dr Meena Desai, Mumbai). Obesity: is it a problem in Indian children? Dr Vijayakumar. **Symposium (Moderator:** Dr Vaman Khadilkar): 1. Management of menstrual disorders in adolescence. Dr Archana Arya. 2. Management of hirsutism. Dr Sudha Rao. 3. Early puberty in girls. Dr Anju Seth. 4. Late puberty in boys. Dr Anna Simon.

approach to a short child. This was followed by the presentation of 5 year longitudinal data of two sisters with isolated growth hormone deficiency being treated with rhGH. The Z score of the girls' heights changed from a baseline of -4.5 and -4.8 to -1.1 and -0.9 respectively after 5 years of treatment. Prof S K Singh from IMS, BHU, Varanasi, then discussed the benefits of GH therapy beyond the period of growth and in non-GH-deficient conditions.

The post-lunch session was devoted to disorders of puberty. Dr Yadav described causes of delayed puberty in boys and girls, approach to a child referred for delayed puberty and its management. Dr Preeti Dabadghao (SGPGI, Lucknow) deliberated upon the definition, classification and causes of precocious puberty, approach to a child presenting with precocious puberty and various options for its management. She highlighted the fact that precocious puberty is more likely to be idiopathic in girls while in boys, as many as 50% cases may have an organic pathology. Dr VK Bhardwaj presented a case of a boy presenting with precocity due to Leydig cell tumor of the left testicle. He developed central precocity after left orchidectomy and was treated with Inj. Depot Medroxy progesterone acetate. The last presentation of the CME was on gynecomastia, by Dr Dabadghao. She discussed the etiopathogenesis, evaluation and management of gynecomastia in boys, highlighting the point that in the majority of children, the problem subsides on its own by late teen years.

The valedictory function was presided over by Prof KK Kaul, former president of national IAP, former HOD and Dean of the college who retired in 1992 and still leads an active life including limited consultation practice.

DIABETES NEWS

WEST INDIA: Dr Aspi Irani has been organizing annual winter camps for young diabetics at Lonavala, near Mumbai, for the last 2 decades, the next one being in Dec '08. If you would like to attend these camps, e-mail him, or call Ms Tanushri (the Secretary at the JDF office) on 022-26352752 on any working day (best: Saturday 9-12) for details.

EAST INDIA: Dr D. Maji has been organizing annual diabetes camps for over 10 years. The next camp is in Ranchi, Jharkhand in Dec '08. Contact Mr Asoke Das, mobile 09334876711, email asoke.das@schenckprocess.in. For future camps, contact Dr Maji

SOUTH INDIA: DISHA 2008 YOUTH SUMMIT: 26-28 December 2008, at RV Dental College, 24th Main, JP Nagar Phase 1, Bangalore 560078.

DISHA (Diabetes Interaction Support Health Achievement) is a self initiated, voluntary, nonp-rofit initiative by JSINDIA and Bangalore Diabetic Youth Forum. Contact: Mr Subash Dhanjani (Chairperson) 09741333333; Mr Ashok Shahdeo (Secretary) 09886052854. Mr VA Ramakrishna (Treasurer) 9844025881. http://www.jsindia.org. Email dishaproject@gmail.com; Blog http://projectdisha.wordpress.com.

Mission: To inspire, motivate and help children and youth with Type I diabetes and their families

3. PRE-PEDICON WORKSHOP: 21 Jan 2009, 8.30am – 5pm. Sagar Hospital, Bannerghatta Road, Tilaknagar, Bangalore. Convenors: Drs Shaila Bhattacharyya & P Raghupathy, p.raghupathy@gmail.com
1. Practical aspects of growth and puberty assessment. Dr Sudha Rao. 2. Useful tips for managing children with short stature. Dr Shaila Bhattacharya. 3. Is growth hormone therapy practical and useful? Dr Vaman Khadilkar. 4. Approach to a newborn with congenital hypo-thyroidism. Dr Meena Desai. 5. Clinical approach to goiter and/or acquired hypothyroidism. Dr Anju Seth. 6. How helpful is treatment for precocious puberty? Dr Archana Arya. 7. Management of neonates/ children born with uncertain sex. Dr Vaman Khadilkar. 8.Comprehensive management of CAH, including prenatal aspects. Dr Anna Simon. 9. Optimal workup and management for a child with rickets. Dr V. Bhatia. 10. Parent education regarding home management of type 1 diabetes mellitus. Dr Vijayakumar. 11. Case demonstrations/ discussions. Drs Ahila & Raghupathy

4. ESPE/LWPES: 8th Joint Meeting: 9-12 Sep 2009: New York, USA. Contact: Paul Saenger, Fax: +856.439.0525. phsaenger@aol.com. & lwpes-espe2009@ahint.com. www.lwpes-espe2009.org

5. ISPAD 2009: 35th Annual Meeting: 16-18 Sep 2009, Ljubljana, Slovenia. Contact: Tadej Battelino, E-mail: tadej.battelino@mf.uni-lj.si

6. EASD 2009: 44th Annual Meeting, 26 Sep- 1 Oct, 2009: Vienna, Austria. www.easd.org/customfiles/easd/45th/45th-welcome.html

7. ISPAE-PET 2009: First Pediatric Endocrine Training Program: 10-13 November, 2009: New Delhi.

8. ISPAE 2009: Biennial Meeting: 13-15 November, 2009: New Delhi.

9. ISPAD 2010: 36th Annual Meeting: 5-11 Sep 2010, Buenos Aires, Argentina. Contact: Olgar Ramos, E-mail: ramoso@interlink.com.ar

in India, achieve and maintain highest health, happiness, well being, productivity and prosperity. Any donations towards DISHA 2008 would be highly appreciated, and is exempt under section 80 (C) of Income tax ACT.

NORTH INDIA: Mr Aditya Rajora has started a Yahoo Group for GYD (Group of Young Diabetics), so our families can stay in touch with each other. This is particularly so that they can also pool information about local resources eg good meters, good prices, any bad experiences, etc. You can view and post messages to this group at http://in.groups.yahoo.com/group/young_diabetes_guide.

INTERNATIONAL: *Dr Ragnar Hanas, MD, PhD, ISPAD Secretary General, writes:*

ISPAD is a professional organization which aims to promote clinical and basic science, education and advocacy in childhood and adolescent diabetes. It is the only international society focusing specifically on all types of childhood diabetes. Its lies in the scientific and clinical expertise of its members.

Who may become a member? Medical health professionals (pedia-tricians, internists, other disciplines), non-medical health professionals (diabetes nurses, dieticians, psychologists, social workers and other members of diabetes teams) and scientists committed to clinical care, education, research or advocacy relevant to children and adolescents with all forms of diabetes.

Our official journal is **Pediatric Diabetes**; subscription and free web-access is included in the membership fee. The first 2 years' membership is free for applicants from non-high income countries according to the World Bank list (http://go.worldbank.org/D7SN0B8YU0)

Our activities include:
** The Annual Scientific Meeting held yearly in different international locations.
** Publication of Clinical Practice Consensus Guidelines in Pediatric Diabetes. The 2007/2008 Guidelines are freely accessible through our website www.ispad.org.
** The yearly ISPAD Science School which offers research training in the field of diabetes for young doctors.
** Annual ISPAD Science School for Health Professionals, organized for nurses, dietitians, psychologists and other allied health professionals. Participation in the Science Schools is for members only, and includes free travel, accommodation and meals.**
The ISPAD Rare Diabetes Collection provides clinical details on rare types of diabetes, as well as serving as a repository of stored DNA for research. For example, genetic analysis of children who had their diabetes onset below 6 months' of age is done for free by the Exeter Centre (www.diabetesgenes.org).

Other activities include postgraduate courses, symposia, work-shops and training programs, facilitation of collaborative studies, individual training programs, assistance with other organizations and societies in promoting education and research on childhood and adolescent diabetes mellitus as well as raising public awareness about diabetes.

ISPAD very much welcomes new members from India: we invite you to join the international professional pediatric diabetes community by filling in the registration form on our website www.ispad.org. We also welcome you to our next annual meeting, which will be held in Ljubljana, Slovenia September 2-5, 2009 (www.ispad2009.com).

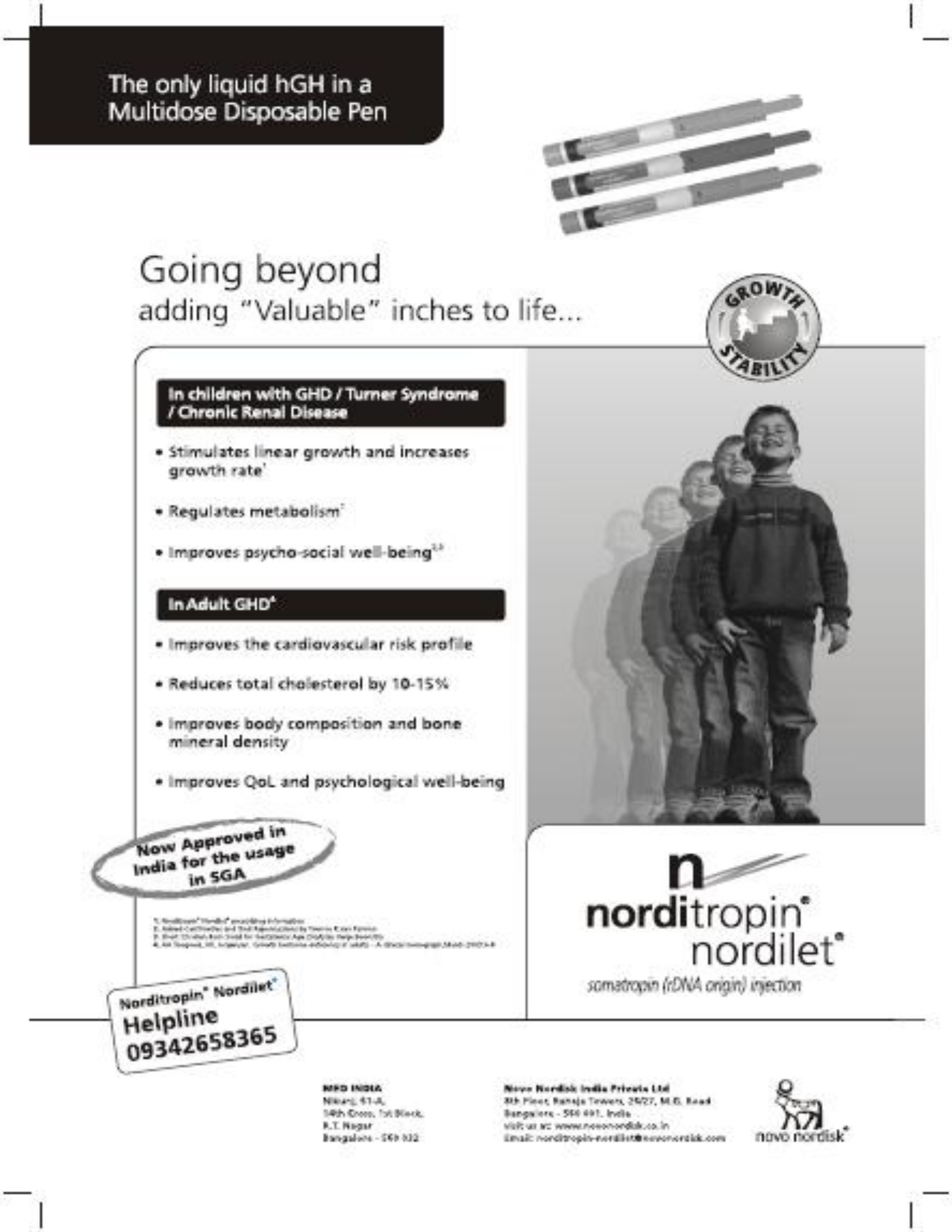
NEWS YOU CAN USE

Growth charts (based on KN Agarwal reference data) are available with Dr V Bhatia, vbhatia@sgpgi.ac.in

Locally made **orchidometers** are available with Dr V Bhatia.

The **Greulich and Pyle bone age atlas** is available for on-line purchase from Amazon.com, and costs US $ 145.

The Pediatric Endocrinology list serve is a useful place to discuss difficult cases and learn from others' experience. To subscribe, send an email to peds-endo-subscribe@yahoogroups.com.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