CAPE NEWS

Newsletter of the Indian Society for Pediatric & Adolescent Endocrinology (ISPAE) ***www.ispae.org.in***

(Pediatric & Adolescent Endocrinology Chapter of IAP)

December 2009
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Inside this Issue

NOTICE OF THE ANNUAL GENERAL BODY MEETING

Notice is hereby given of the **Annual GBM** to be held on **8th Jan 2010** at 10.30 am during **Pedicon 2010** at the Hyderabad International Convention Centre, **Hyderabad**. The agenda is:

1. Confirmation of the minutes of the last AGBM in January 2009.
2. Presentation of detailed accounts for year 2008-2009, and confirmation of appointment of auditor.
3. Consideration and adoption of the annual report of the Society.
4. Welcoming of new members.
5. Presentation of brief report of ISPAE 2009, ISPAE-PET 2009, and discussion during GBM in Delhi in Nov 2009, including holding of ISPAE 2011 and ISPAE-PET 2011 in Calicut.
6. Discussion of other activities for 2010-2011, including Guidelines, popularizing Website/ growth charts/ orchidometers, links with international organizations, membership drive, scientific content of symposium in Pedicon 2011, other future meetings, and setting up of new formal pediatric endocrine courses in the country.
7. Maintenance of 80G status: educational & charitable activities for this.
8. Any other agenda with permission of the chair.

PRESIDENT'S MESSAGE

Dear members,

I am excited to share with you the progress over the past 4 months. The Delhi Programs: PET and Biennial Meeting, went very well, thanks to all your....

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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 2011: Calicut, Kerala: Nov, 2011. Organizing Secy: Vijayakumar M. email: vijayakumarmdr@yahoo.com. For more details, see website.

ISPAE-PET 2011 (Pediatric Endocrine Training program): Calicut Nov 2011.

APPES FELLOWS' MEETING: AYUTTHAYA, THAILAND

KVS Hari Kumar, Hyderabad,
hariendo@rediffmail.com

Every year the APPES Fellows' Meet is organized to impart pediatric endocrine education and professional guidance to young fellows. The 11th Meet was held in Ayutthaya, Thailand from 9th to 11th October 2009. I got the great opportunity to represent India among the 45 fellows from the Asia Pacific region. The majority of Fellows were from Thailand (13) and China (9), with only 2 of us from India.

The esteemed teaching faculty: Professors John Parks (USA), Louis Low (Hong Kong), Kah Yin Loke (Singapore), Suttipong Wacharasindhu (Thailand) and Maria Craig (Australia): were friendly and approachable. The talks given by them were up to date,

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PRESIDENT'S MESSAGE

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enthusiastic participation, the hard work of the organizing team, led by Drs Vijayalakshmi Bhatia, Archana Arya, Anju Seth, PSN Menon and Anju Virmani, and the support of Delhi IAP, ESPE and APPES.

The Biennial Meeting, from 13-15 November, had the objectives of "learning, teaching, sharing, deliberating, and networking". A total of 175 registered delegates from all over India, 34 posters, and our membership jumping from 148 to over 200 speak for themselves!! The scientific program, which aimed to deliver clear up-to-date, clinically relevant messages, was planned to make sure all the speakers were from out of Delhi, so that the audience got the benefit of speakers from the widest geographical spread. It was greatly appreciated by all. The gracious venue of India Habitat Center made sure everyone was comfortable.

The inauguration was made special by the Chief Guest, Dr Panna Choudhury, President of the Indian Academy of Pediatrics. He was gracious enough to take the trouble to come back to Delhi just for a few hours, to be able to keep his promise to address us. In a characteristically warm speech, Dr Panna said IAP looked forward to working with different sub-groups within the family, and promised us the continuing support of IAP. He highlighted the national relevance of the opening session which dealt with IUGR and its consequences. He pointed out we had three Past Presidents of IAP contributing to the inaugural session: Dr Santosh Bhargava, Dr Subhash Arya, and Dr Harshpal Singh Sachdev.

It also was the occasion to honor Prof Meena Desai, the founder of our Chapter in 1987, with the well deserved first ISPAE Lifetime Achievement Award for the enormous contributions made by her over four decades (she began the first ever pediatric endocrine service in India in BJ Wadia Hospital in January 1969). In her key note address Dr Desai traced out the effort involved over these 40 years in building up the specialization in India. She reminded us of the many problems encountered by pioneers like her in gathering data against all odds, with all kinds of constraints and investigative limitations in the initial two decades. With labs and assays in increasingly easy reach now, it is difficult for us to imagine the courage and conviction necessary for these scientists to chart new paths.

We had several distinguished international guests: Dr Jean-Claude Carel (France), Dr Franco Chiarelli (Italy), Dr Maria Craig (Australia), Dr Ze'ev Hochberg (Israel), Dr Ram Menon (USA), Dr Pik-To Cheung (Hong Kong), Dr Andrew Sinclair (Australia), Dr Olle Soder (Sweden), Dr Garry Warne and Dr Margaret Zacharin (Australia), and Dr Francis de Zegher (Belgium). Our own esteemed Indian Faculty was literally from across the country, with every part of India well represented. The local team had generously kept themselves off the podium, so give an opportunity to a wide spectrum of speakers!

ESPE contributed significantly to ISPAE by helping us with the initiation of PET, and by sending to this meeting four experts who are not only eminent but also great teachers: Dr Franco Chiarelli, who is presently Secretary-General of ESPE and will be the guiding spirit of the 9th ESPE/ LWPES Joint Meeting in Rome in 2013; Dr Olle Soder, Treasurer of ESPE; Dr Ze'ev Hochberg, Chairperson of GPEG, and initiator of several ESPE educational initiatives, and Dr Jean-Claude Carel, who has, among other ESPE responsibilities, organized the annual ESPE Summer School for several years. APPES also kindly sponsored Dr Maria Craig and Dr Pik To Cheung. Dr Craig is President of the Australasian Pediatric Endocrine Group, and both are members of the APPES Governing Council. The Government of Belgium kindly sponsored Dr Francis de Zerger. We were also fortunate in getting support from the Indian Council for Medical Research (ICMR), Council for Scientific and Industrial Research (CSIR) and Indian National Science Academy (INSA).

The scientific presentations were succinct and marked by lively discussions. In addition there was a poster walk, and the first 2 prizes of Rs 10,000 each were won by bright MD students: Sweta Mohanty (BJ Wadia Hospital, Mumbai) and Varun Agarwal (LHMC, Delhi). The judges also appreciated Leena Priambada's poster, but did not consider it for an award as it was a study done in adults.

The hard work over the past few months of Dr Aspi Irani and his team in formulating the guidelines of Type1 Diabetes Mellitus was evident in the form of a booklet of draft guidelines displayed during the Delhi Meeting.

Another attraction was a Diabetes Run, organized jointly with the Delhi Ophthalmic Society, on early morning of 14th November, to aptly commemorate both World Diabetes Day and Children's Day!

Many of you attended the GBM held on 14th November evening, and all of you were e-mailed the minutes of this meeting. It reflected the other activities of the Society, so I will not repeat those details.

On 12th November, I chaired a meeting with Drs Craig and Pik To, the APPES representatives, and we tried to explore areas of further collaboration with us, keeping in mind the tight financial position of APPES. During this meeting it was decided that applicants from India for the future APPES Fellowship courses will be selected through ISPAE executive.

On 14th November, I also chaired a meeting with the ESPE representatives, Drs Chiarelli, Soder, Hochberg, Carel, and de Zegher. We were assured that ESPE is committed to ISPAE programs in the form of sponsorship of 2 faculty members for 2011 meeting (both the PET program and the main conference). Regarding access to ESPE consensus guidelines and position statements, it was decided that Dr Vijayalakshmi Bhatia, webmaster, would liaise with Dr Garry Butler (in charge ESPE Central Publishing Committee). Dr Hochberg explained the GPED concept and agreed that an elected member of ISPAE could be invited to represent India (but with no budgetary support). Dr Chiarelli informed us that Indian fellows could apply and compete for the ESPE clinical fellowship program, and the ESPE Summer School.

I warmly welcome you to our next meeting points: PEDICON 2010 at Hyderabad, PEDICON 2011, and the next ISPAE meeting, ISPAE 2011 to be held in Calicut, being organized by Dr M Vijayakumar. Detailed information of all these and other events will as usual be available at our website **www.ispae.org.in**.

With best wishes,
Nalini Shah

AYUTTHAYA MEETING…

Contd from page 1…

lucid and very informative. The talk by Prof Loke on disorders of sexual differentiation (DSD) was excellent with good clinical cases. Dr John Parks, who had taught at the first APPES meet, came again after 10 years.

The 3 days were divided into sessions of fellow case presentations (topic wise) and relevant talks by the faculty, with separate sessions for clinical conundrums and endocrine emergencies, ending with a quiz. Prior to the meeting, all of us had submitted interesting and problematic pediatric endocrine cases; these were re-distributed among us for detailed discussions. The spectrum of cases was excellent and we requested Prof Craig to upload all the previous cases of APPES meetings also on the APPES website for the members to access and benefit from. It was also a wonderful opportunity to interact with Fellows from other countries of the region and share information about patient profiles, practice methods, hospital management etc. The management problems in most Asian countries - lack of drugs / investigations / affordability etc. – made these discussions very relevant to us working in India. The meeting was well organized in terms of travel and hospitality arrangements. It was a good opportunity to get the taste of original Thai cuisine. The social event was extremely delightful with an elephant ride and dinner on a cruise which was full of fun and enjoyment.

I was struck by the following important points in the discussions and presentations:

Calcium & Vitamin D

1.. Monitoring of hypophosphatemic rickets is with calcium, phosphorus, alkaline phosphatase and USG kidneys for nephrocalcinosis.

2.. Recombinant PTH is not yet recommended in management of pediatric autoimmune hypoparathyroidism because of the risk of osteosarcoma in growing children.

3.. Cinacalcet has a possible role in management of hypophosphatemic rickets to suppress secondary hyperparathyroidism.

4.. Allogenic bone marrow transplantation is the mode of therapy for osteopetrosis and may result in intermittent hypercalcemia in the post transplant period.

5.. Alopecia is seen in 75 – 80% of cases of Vitamin D deficiency rickets type II.

Puberty

1.. Normal timing of onset of pubertal development does not rule out a pathological condition and is especially important to evaluate in borderline cases.

2.. Gonadotrophin independent precocious puberty with increased testicular size is observed in testotoxicosis, testicular adrenal rest tumors and HCG secreting tumors.

3.. MRI in a known case of McCune Albright syndrome (MAS) helps in identifying pituitary adenomas (somatotropinomas are commonest).

4.. The border of café au lait macules is irregular in MAS and smooth in neurofibromatosis.

5.. In cases of MAS, the timing of post zygotic mutation determines clinical features. The occurrence in early embryogenesis results in classic widespread manifestations, whereas during late embryogenesis may result in only single adenoma or isolated organ dysfunction.

6.. Ovarian volume increases in patients with peripheral precocity MAS being treated with tamoxifen.

7.. To correctly interpret the GnRH stimulation test, one must consider the stimulant used, the mode of administration and the assay specificity and variability.

Diabetes/ Hypoglycemia

1.. In neonatal hypoglycemia, glucagon challenge test is not required if insulin levels are inappropriately elevated.

2.. Transient neonatal diabetes is more commonly associated with IUGR and less insulin requirement in comparison to permanent neonatal diabetes (PNDM).

3.. In PNDM with KCNJ11 mutations, 90% could be treated with sulfonylureas; higher doses per kg body weight are required.

4.. HNF 1β gene is associated with MODY and T2 DM.

5.. Metformin may be useful in girls with T1DM with insulin resistance and high insulin requirement.

6.. PCOS: the latest definition from the Androgen Excess Society is appropriate.

7.. Insulin resistance and hyperandrogenism in T1DM is due to non-physiological route of administration (SC route resulting in exposure of systemic organs to high concentrations of insulin) and lack of portal insulin, resulting in no effect on SHBG concentration.

8.. Preaxial polydactyly is a characteristic feature in an infant of diabetic mother.

9.. Abdominal pain can be an unusual presentation of adrenal insufficiency in T1DM with autoimmune thyroid disease.

10.. Ketosis prone T2DM is occasionally seen in adolescents and is subdivided based on insulin antibody and beta cell functional reserve.

11.. Thiazides may have to be used twice daily in cases of Persistent Hyperinsulinemic Hypoglycemia of Infancy being managed with diazoxide to decrease associated fluid retention. Use of diazoxide beyond 20 mg/kg/d is ineffective.

12.. There is no evidence to suggest that bicarbonate administration is necessary or safe during DKA.

Thyroid

1.. In the management of thyroid disorders, free T3 assay is not very reliable.

2.. Do not alter the doses of antithyroid drugs at intervals less than 4 weeks.

3.. In girls with Turners syndrome, hypothyroidism is mostly seen with 46 XX, iXq (isochromosome Xq) rather than 45 XO.

4.. Pyriform sinus fistula is responsible for suppurative thyroiditis and is usually seen on

the left side. The evaluation is with barium swallow or direct laryngoscopy.

5.. Streptococcus viridans is the commonest organism causing suppurative thyroiditis in children.

6.. Proptosis is seen in 2-5% of autoimmune hypothyroidism.

7.. Muscle cramps are the first symptom of hypothyroidism in a patient of hyperthyroidism on antithyroid drugs.

8.. Hashimoto's encephalopathy, also known as SREAT (Steroid Responsive Encephalopathy associated with Autoimmune Thyroiditis), is rarely seen in children.

9.. Propylthiouracil is contraindicated in management of thyrotoxicosis in children.

10.. Intra-amniotic thyroxin (150 - 500µg every 7–10 days) should be considered in a case of fetal hypothyroidism with difficult to control maternal hyperthyroidism.

11.. Amiodarone (one tablet of 200mg gives 6 mg iodine) causes hyperthyroidism in iodine deficient areas and hypothyroidism in iodine sufficient areas.

DSD

1.. WT-1 mutations result in 3 clinical syndromes (Frasier syndrome, Denys Drash syndrome, WAGR syndrome).

2.. In phenotypic girls or undervirilised boys with proteinuria – consider WT-1 mutation.

3.. XY sex reversal is seen in SF-1 mutation but not in DAX-1 mutation.

4.. WNT4 gene is important for ovarian development, which is not a passive process in absence of SRY gene.

5.. Antley-Bixler syndrome can present with normal genitalia (FGFR2 mutation) or ambiguous genitalia (POR mutation).

6.. DSD which can present in both sexes – Oxidoreductase deficiency and 3β HSD deficiency.

7.. In ovotesticular DSD, perineal hypospadias is most common and one gonad is invariably palpable in the labioscrotal fold.

8.. Mixed gonadal dysgenesis is the second commonest type of DSD after CAH.

9.. Hypertension may be delayed presentation in CAH with 11β hydroxylase and 17 α hydroxylase deficiency.

Pituitary & Growth

1.. The five 'P's in evaluation of short stature – Peers (percentile and SD), Parents (MPH), Progress, Puberty (bone age), Plumpness (obesity) – as told by sixth P (Dr Parks).

2.. The architect of CDGP was Dr Lawson Wilkins, the father of Pediatric Endocrinology in the US.

3.. In PROP-1 mutations growth failure presents late (usually about 6 yr of age).

4.. Blocking aromatase is still an experimental approach in CDGP cases.

5.. Craniopharyngiomas occur due to somatic cell mutations in the β catenin gene.

6.. In patients with significant SGA, consider transcription factor abnormalities and GH insensitivity.

7.. In a work-up of a case of suspected hypopituitarism, prolonged fasting also helps in inducing hypoglycemia and checking for GH and cortisol deficiencies.

8.. Blue sclera are also seen in Laron syndrome cases.

9.. Water deprivation test is usually not done for infants / neonates.

10.. In long standing primary polydypsia, there may be failure to concentrate with water restriction because of washout of renal medullary concentration gradient.

11.. Adrenal insufficiency can mask diabetes insipidus, which manifests after cortisol replacement.

12.. Long standing hypothyroidism may result in thyrotrophic hyperplasia and mimic a pituitary mass lesion. Surgery is not required for these cases, and may be disastrous.

13.. Children born after Assisted Reproduction (ART) have greater gain in height weight and BMI during infancy compared to controls.

I can sum up by saying that overall it was useful for getting exposure to good cases and difficulties in managing them, with excellent inputs from the faculty, and I am grateful to ISPAE for giving me this opportunity.

PET 2009: A REPORT

Anju Seth, Organizing Secretary

(Group Photo on page 7)

Pediatric Endocrine Training 2009 (PET 2009), the first of its kind in India, was organized by ISPAE in collaboration with ESPE and APPES, on 10-13th November, immediately preceding the first Biennial Meeting. The course content and structure were based upon the format intermediate between the Summer School and Winter School of ESPE, and similar to the APPES Fellows' Meet. The planning was done by an Organizing Group, comprising the ISPAE Scientific Committee, graduates of previous APPES Meets/ ESPE Schools, and myself. ESPE and APPES contributed by sending two eminent faculty members each, who not only participated in PET but were also actively involved in designing the course curriculum.

The main objectives of the program were to provide up to date clinical training to young entrants in the field of pediatric endocrinology, create a forum for bringing together individuals with a common interest in the field, and promote opportunities for long term mentoring by proficient pediatric endocrinologists of the participants, so that they in turn could give their patients better care and hopefully get involved in research in the field.

PET 2009 was an intensive, interactive, wholly residential program held in the spacious, self-contained campus of the National Institute of Biologicals at NOIDA, 6 km outside Delhi. The faculty comprised of 6 eminent Indian pediatric endocrinologists (Drs Meena Desai, PSN Menon, P Raghupathy, Nalini Shah, Vijayalakshmi Bhatia, and Priti Dabadghao) as well as 6 international experts (Drs Jean-Claude Carel from INSERM, Paris, Olle Soder from Karolinska, Stockholm, Ram Menon from Ann Arbor, Michigan, Margaret Zacharin from Royal Children's Hospital, Melbourne, Maria Craig from Westmead, Sydney, and Pik To Cheung from University of Hong Kong, Hong Kong.

Potential participants had been asked in their application to provide not just their CV, but also the extent of their involvement in pediatric endocrinology, and a summary of a clinical case in whose care they had been involved. We received 65 applications. Selection was done on the basis of their background and their approach to the case. All possessed varying degrees of involvement in pediatric endocrinology, and approximately one third of the selected participants came from each of the following backgrounds: young

pediatric faculty from medical colleges and providing pediatric endocrinology care; pediatricians practising/ starting to develop a practice in pediatric endocrinology, including those who had done the PDCC course in pediatric endocrinology; and DM/ DNB endocrinology residents with a more adult background. The selected participants were then divided into 6 groups, each with 2 mentors (one Indian, one international), and allotted a case (as far as possible their own). Care was taken to ensure the cases covered almost the entire spectrum of pediatric endocrinology. They were asked to prepare a presentation in advance, with the e-help and guidance of their 2 mentors. Many of them were surprised and even overwhelmed by the level of pre-course work required of them! Finally 34 participants (30 selected from India, 2 from Indonesia and 2 from Bangkok sponsored by APPES) attended.

The teaching format was mainly centered around discussions on the prepared cases, presented by participants and moderated by faculty. Each case was first presented to and intensively discussed by the small group of 6 participants and 2 faculty, further modified a little, and then presented to the entire plenum in sessions which covered different aspects of pediatric endocrinology. This format provided opportunity for maximum interaction between participants and faculty, and the plenary sessions exposed the participants to a wider variety of approaches. There were also a few relevant faculty lectures to cover topics which did not lend themselves so easily to case based discussions. A rapid fire Quiz prepared by Dr Anurag Bajpai was also enjoyed by the participants as it gave them a competitive surge of adrenalin!

The days of hard work were followed by relaxed, fun-filled evenings that promoted bonding among the entire group. These included an introductory dinner with music, a trip to Akshardham temple, and a drive to Delhi, around India Gate and a few other monuments.

The program was generously sponsored by an educational grant from Novo Nordisk.

Feedback received from faculty and participants indicated that both the contents and the structure of the program were highly appreciated. It also provided ideas for improvements in future PET programs. Encouraged by the response to the first PET, it has been decided by ISPAE that PET would henceforth be a biennial event, preceding the Society's Biennial Meetings. We therefore look forward to an improved version at Calicut in 2011.

MORE ISPAE NEWS

NEW MEMBERS: A VERY WARM WELCOME!!

1. Dr VARUN AGARWAL, Delhi
2. Dr ALTAMASH MOHD YUSUF SHAIKH, Mumbai
3. Dr RICHA ARORA, Delhi
4. Dr G ARUNA, Bangalore
5. Dr VIKAS BHALLA, Sirsa
6. Dr PRASANNA S BHAT, Delhi
7. Dr S BHATTACHARYA, Kolkata
8. Dr APARNA CHAKRAVARTY, Delhi
9. Dr MADHU CHAUDHARY, Sanganer
10. Dr KRISHAN GOPAL, Ghaziabad
11. Dr REETHA GOPINATH, Calicut
12. Dr PRAGYA JAIN, Delhi
13. Dr KE URMILA, Calicut
14. Dr CECIL C KHAKHA, Delhi
15. Dr RAKESH D MALHOTRA, Mumbai
16. Dr EUNICE MARUMUDI, Delhi
17. Dr LULU MATHEWS, Calicut
18. Dr AVINASH MISHRA, Allahabad
19. Dr SWETA MOHANTY, Mumbai
20. Dr VEENA NAIR, Trivandrum
21. Dr GADEKAL RAJGOPAL, Tirupati
22. Dr GOUTAM SADHUKHAN, Kolkata
23. Dr SK SINGH, Patna
24. Dr TRIPTI SINHA, Patna
25. Dr MAMTA WAIKAR, Faridabad

OUR MEMBERS' PUBLICATIONS

Acharya SV, Gopal RA, George J, Bandgar TR, Menon PS, Shah NS. Utility of single luteinizing hormone determination 3 h after depot leuprolide in monitoring therapy of gonadotropin-dependent precocious puberty. Pituitary 2009;12(4):335-8.

Ekbote VH, Khadilkar AV, Mughal MZ, Hanumante N, Sanwalka N, Khadilkar VV, Chiplonkar SA, Kant S, Ganacharya R. Sunlight exposure and developement of rickets in Indian toddlers. Indian J Pediatr. 2009 Nov 20.

Fall CH, Sachdev HS, Osmond C, Lakshmy R, Biswas SD, Prabhakaran D, Tandon N, Ramji S, Reddy KS, Barker DJ, Bhargava SK; New Delhi Birth Cohort. Adult metabolic syndrome and impaired glucose tolerance are associated with different patterns of BMI gain during infancy: Data from the New Delhi Birth Cohort. Diabetes Care 2008 Dec;31(12):2349-56. Epub 2008 Oct 3.

Gopal RA, Acharya SV, Bandgar T, Menon PS, Marfatia H, Shah NS. Clinical profile of ectopic thyroid in Asian Indians: a single-center experience. Endocr Pract 2009 Jul-Aug;15(4):322-5.

Kadam N, Khadilkar A, Chiplonkar S, Khadilkar V, Mughal Z. Variation in lumbar spine bone mineral content by age & gender in apparently healthy Indians. J Bone Miner Metab. 2009 May 15.

Kalra P, Bansal B, Nag P, Singh JK, Gupta RK, Kumar S, Rathore RK, Bhatia V, Bhatia E. Abdominal fat distribution and insulin resistance in Indian women with polycystic ovarian syndrome. Fertil Steril 2009; 91: 1437 - 40.

Khadilkar A, Mughal MZ, Hanumante N, Sayyad M, Sanwalka N, Naik S, Fraser WD, Joshi A, Khadilkar V. Oral calcium supplementation reverses the biochemical pattern of parathyroid hormone resistance in underprivileged Indian toddlers. Arch Dis Child. 2009 Aug 9. [Epub ahead of print]

Khadilkar A, Crabtree NJ, Ward KA, Khadilkar V, Shaw NJ, Mughal MZ. Bone status of adolescent girls in Pune (India) compared to age-matched South Asian and white Caucasian girls in the UK. Osteoporos Int. 2009 Sep 1. [Epub ahead of print]

Marwaha RK, Tandon N, Desai AK, Kanwar R, Aggarwal R, Sastry A, Singh S, Narang A, Ganguly SK, Mani K. Reference range of thyroid hormones in healthy school-age children: Country-wide data from India. Clin Biochem 2009 Mar 11. [Epub ahead of print]

Marwaha RK, Tandon N, Desai A, Kanwar R, Mani K. Iodine Nutrition in Upper Socioeconomic School Children of Delhi. Indian Pediatr 2009 Jul 1. [Epub ahead of print]

Menon SK, Sarathi V, Bandgar TR, Menon PS, Goel N, Shah NS. Autoimmune hypophysitis: a

single centre experience. Singapore Med J 2009 Nov;50(11):1080-4.

Nihal L, Bapat MR, Rathi P, Shah NS, Karvat A, Abraham P, Bhatia SJ. Relation of insulin-like growth factor-1 and insulin-like growth factor binding protein-3 levels to growth retardation in extrahepatic portal vein obstruction. Hepatol Int 2009 Mar;3(1):305-9. Epub 2008 Sep 20.

Pandit D, Chiplonkar S, Khadilkar A, Khadilkar V, Ekbote V. Body Fat Percentages by Dual-energy X-ray Absorptiometry corresponding to Body Mass Index cutoffs for overweight and obesity in Indian children. Clinical Medicine: Pediatrics 2009:3 55–61.

Rohilla S, Rawal M, Yadav RK, Ahuja A, Nanda S, Dhaulakhandi DB. Neurocysticercosis presenting as central diabetes insipidus in a boy. J Pediatr Neurol 2009; 7(3).

Sachdev HP, Osmond C, Fall CH, Lakshmy R, Ramji S, Dey Biswas SK, Prabhakaran D, Tandon N, Reddy KS, Barker DJ, Bhargava SK.Predicting adult metabolic syndrome from childhood body mass index: follow-up of the New Delhi birth cohort. Arch Dis Child 2009 Oct;94(10):768-74. Epub 2008 Nov 17.

Sahu M, Das V, Aggarwal A, Rawat V, Saxena P, Bhatia V. Vitamin D replacement in pregnant women in rural north India: a pilot study. Eur J Clin Nutr 2009 Sep;63(9):1157-9. Epub 2009 May 20.

Sahu R, Boddula R, Sharma P, Bhatia V, Greaves R, Rao S, Desai M, Wakhlu A, Phadke S, Shukla M, Dabadghao P, Mehrotra RN, Bhatia E. Genetic analysis of the SRD5A2 gene in Indian patients with 5alpha-reductase deficiency. J Pediatr Endocrinol Metab 2009 Mar;22(3):247-54.

Seth A, Marwaha RK, Singla B, Aneja S, Mehrotra P, Sastry A, Khurana ML, Mani K, Sharma B, Tandon N. Vitamin D nutritional status of exclusively breast fed infants and their mothers. J Pediatr Endocrinol Metab 2009 Mar; 22(3):241-6.

Zaidi G, Sahu RP, Zhang L, George G, Bhavani N, Shah N, Bhatia V, Bhansali A, Jevalikar G, Jayakumar RV, Eisenbarth GS, Bhatia E. Two novel *AIRE* mutations in autoimmune polyendocrinopathy-candidiasis-ectodermal dysplasia (APECED) among Indians. Clin Genetics 2009; 76 (5): 441-8.

[Editor's note: Please send us information, and even a short summary of your recent publications.]

8th JOINT LWPES/ ESPE MEETING, NEW YORK: September 2009

Vijyalakshmi Bhatia, vbhatia@sgpgi.ac.in

SHOX gene (Gudrun Rappold):
100% Turner girls, 80% Leri Weill syndrome, and about 3-5% of idiopathic short stature children have SHOX gene abnormalities. An increased number of SHOX copies are seen in tall stature. SHOX target: one target is brain natriuretic peptide, BNP, expressed in the growth plate.

Craniopharyngioma (Hermann Mueller):
Faltering of growth and increase in weight occur 2-3 years before the clinical diagnosis of craniopharyngioma (cranio). Physical activity is particularly poor in obese cranio children, and is the bigger problem than increased diet. Gastric banding a good option for intractable morbid obesity in cranio, and perhaps works through damage to the vagal nerve.

Calcification often indicates recurrence or remnant of cranio, so while looking for recurrence in follow up, CT scan is an additional modality other than MRI.

Adrenarche (Richard Auchus):
Definitions:
Clinical: symptoms/ signs before 8 years (girl) or 9 years (boy).
Biochemical: DHEAS > 15 ug/dl.
Histopath: Appearance of zona reticularis in the adrenal.

"Missing adrenarche" in a case of familial 17-20 lyase where the boy had undervirilised external genitalia, and the sister had absent adrenarche.

Chronic complications of diabetes (Lori Laffel):
Ten years after the DCCT, participants in the intensive arm showed further decreasing incidence of retinopathy, seen even though their current A1c were the same as of those in the then conventional arm. This suggests the possibility of "metabolic memory".

About 50% of microalbuminuria in pediatric age group regresses, so be sure of persistence of microalbuminuria before putting the child on ACE inhibitors.

ISPAD guidelines on Goals of A1c by age group:
< 6 years: < 8.5 %
6-12 years: < 8 %
> 12 years: < 7.5 %

CAH (Lucia Ghizzoni):
In a study of 14 patients untreated during the first 2yrs of life, there was no rapid increase in growth velocity or bone age: these changes happen only later. There seems to be a relative "androgen resistance" in the first 2 yrs.

Meta-analysis of 500 cases of CAH: mean final height was – 1.37 SDS. Adjusted for target height: – 1.21 SDS.

A modified release hydrocortisone tablet, suitable for monthly dosing, was reported in adult patients in JCEM '09.

Congenital Lipoid Adrenal Hyperplasia (Toshihire Tajima):
The presentation of patients with P450scc deficiency shows a wide spectrum, age at presentation varying from 4 days to 9 years; and genitalia from completely female to mild clitoromegaly with labial fusion, to hypospadias with cryptorchidism. Imaging of adrenals can also look completely normal.

In contrast in StAR deficiency, majority of patients present with adrenal crisis in the neonatal period. However, Tajima described an infant with mild clitoromegaly and labial fusion, who did not present in adrenal crisis, and another report of 3 patients (one XX, 2 XY) presenting with just increased pigmentation at 2-4 years of age. Both boys went into normal puberty, and showed sperm production.

Year book session:

Thyroid:
Two papers, one on 92 children from Italy, and another on 121,052 children from Israel, showed 70-80% of TSH

values of 5-10 uIU/ml normalized on follow up, indicating such values should NOT be treated, but just followed up.

In the largest pediatric follow up data on Graves disease in childhood, a paper from France suggested that relapse is lower in children treated with anti-thyroid drugs for > 24mo vs. < 24 mo. The only drawback is that this was a retrospective study.

Growth and growth factors:

A single case report of a boy with Prader Willi syndrome, with deletion of a paternally inherited small nucleolar RNA cluster (snoRNAs) within the chromosome 15q 11-13 region, which is a well known region of loss of paternally inherited genes in PWS. If corroborated by other studies, this would represent the first human disorder to be associated with defect in the (non-coding) snoRNAs.

FORTHCOMING MEETINGS

1. **PEDICON 2010**: 47th National Conference of the IAP: Hyderabad, AP: 7-10 Jan 2010. Contact: Dr Sanjay Srirampur, pedicon2010.org
2. **Symposium in PEDICON 2010**: 8 Jan: 8-9.30 am: Role of Investigative Evaluation in Pediatric Endocrine Disorders.
8-8.50 am: Imaging in Endocrinology (25 min): Vaman Khadilkar (Chair: Archana Arya); Role of Nuclear Medicine in Endocrinology (25 min): P Raghupathy (Chair: Sudha Rao).
8.50-9.30 am: Panel Discussion on Dynamic Endocrine Testing. Chair: P Raghupathy; Panelists: Vaman Khadilkar, Sudha Rao, Shaila Bhattacharya, Sangita Yadav.
3. **PACD14**: 14th Pan Arab Conference on Diabetes: Cairo, Egypt: 23-26 March 2010. Contact: www.arab-diabetes.com; pure@onlinediabetes.org.
4. **PAG 2010**: 16th World Congress of Pediatric & Adolescent Gynecology: Montpellier, France: 22-25 May 2010. Contact: Prof Charles Sultan, www.figij2010.com.
5. **ISPAD 2010**: 35th Annual Meeting: Buenos Aires, Argentina: 5-11 Sep 2010. Contact: Olgar Ramos, ramoso@interlink.com.ar.
6. **ESPE 2010**: 49th annual ESPE Meeting: Prague, Czech Republic: 22-25 Sep 2010. www.espe2010.org
7. 4th International Congress on **Prediabetes and Metabolic Syndrome**: Madrid, Spain: 6-9 April, 2011. www.kenes.com/prediabetes.
8. **Endocrine Society (USA)** 2011: Boston, Mass, 4-7 June, 2011.
9. **ESPE 2011**: 50th ESPE Meeting: Glasgow, Scotland: 25-28 Sep, 2011.
10. **EASD 2011:** 47th Annual meeting: Lisbon, Portugal: 12-16 Sep, 2011.
11. **ISPAD 2011**: 36th Annual Meeting: Miami, USA: 19-22 Oct 2011.
12. **ISPAE 2011**: 2nd Biennial Meeting: Caliut, Kerala: Nov 2011. Contact: M Vijayakumar, vijayakumarmdr@yahoo.com
13. **ESI 2011**: Pune (dates not fixed).
14. **ESPE 2012**: 51st ESPE Meeting: Leipzig, Germany: 20-23 Sep, 2011.
15. **ESPE-LWPES**: 9th Joint ESPE/ LWPES Meeting: Rome, Italy: 18-21 Sep, 2011.

LETTERS

Dr Swati Banerjee wrote from UCSF Fresno, CA:

I wanted to share with you a case we reported in the 8th Joint Meeting in New York), which would be of interest to your members. We recently encountered a 15 year old boy with new onset Type 1 diabetes who had rapid and extreme weight gain after initiating insulin therapy. He presented with DKA, was treated and discharged on basal/ bolus insulin (~0.5 unit/ kg/day). Within 7 days, he gained 28.7 kg, with edema of lower extremities and lower abdomen, diet history of very high sodium intake (> 10 gms/ day, i.e. 176mEq/ day), and no clinical distress. With reduction in insulin doses and low-sodium diet, he had diuresis, with loss of 9.6 kg in 3 days. He tolerated the rapid weight changes well. We believe, in addition to the edematous properties of insulin therapy, the very high sodium intake played a role in fluid retention in this teenager with new onset Type 1 DM. This case suggests that dietary sodium intake education in children and adolescents should be considered in addition to carbohydrate counting for new onset diabetes mellitus. In our center, we now recommend that daily sodium intake should be no higher than the recommended amount for diabetic adults. In adults, the American Heart Association (AHA) recommends a lower sodium intake (less than 2000mg, 34.5 mEq) for diabetic patients compared to 2300mg (40 mEq) in non diabetic adults.

CONGRATULATIONS!

Prof Dinesh Kumar Dhanwal was awarded the Commonwealth Academic Fellowship at Medical Research Center, Epidemiology Resource Center, University of Southampton, United Kingdom. He is working from October 2009 for 6 months as Visiting Scientist with Prof Cyrus Cooper, learning Epidemiology of Osteoporosis.