Retail Therapy?

PLUS

Hormones at the heart of toxicology

BSF promotes practical skills

Defying the doubters: the origins of ICE
Welcome to the summer issue of The Endocrinologist! Already the football season is just a distant memory and the cricket season is upon us. Ah, the sound of rain dripping onto covers. Now that’s what summer is really about.

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

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

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

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

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

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

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

Have a good Summer.

JOY HINSON
(j.p.hinson@qmul.ac.uk)
Clinical Excellence Awards 2008

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

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

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


Call for members

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

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

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

Clinical Endocrinology free to Junior Members

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

DON’T LOSE TOUCH!

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

Congratulations... to Wiebke Arlt from the University of Birmingham, who has been awarded a personal chair in medicine.
PRIZE WINNERS AT BES 2007

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

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

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

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

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

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

We’re already looking forward to 2008 in Harrogate!
The injection device has just grown up

Prescribing Information - UK and Ireland

SOMATROPIN (rhGH) has been approved for the treatment of growth hormone deficiency in adults and children. It is indicated for the treatment of growth hormone deficiency in adults and children. It is indicated for the treatment of growth hormone deficiency in adults and children.

Indications

Deficiency in adults: Low daily doses of 0.15-0.3mg

Indications for the growing generation

Hormone administration is followed by a transient phase of growth hormone therapy has not been established. Growth hormone deficiency is also fulfilled by the following criteria:

- Childhood onset: Patients diagnosed as growth hormone deficient during childhood must have been deferred and confirmed before either replacement therapy with Somatropin. Add support. If the growth hormone dose is adequate (as a result of endogenous hypoplastic or primary insufficiency and have a serum or other hormone deficiencies diagnosed (except for phenylketonuria) and adequate replacement therapy instituted before treatment with growth hormone.

Device

Designed and manufactured by Serono SA, Switzerland. The device is designed for multiple use. The dose is injected under the skin. The recommended daily dose is 0.5 mg/kg body weight per day. Growth hormone is administered prior to starting Somatropin. Injections should be given in the morning of growth hormone.

Precautions

Antibodies to Somatropin can form in some patients. The injection site can prevent lipoatrophy. In persistent severe retinopathy, hyperglycaemia, and in some patients, hyperinsulinism and in some cases, hypoglycaemia. Use with caution in cases of previous or family history. In case of development of preproliferative changes and the presence of proliferative retinopathy, treatment should be discontinued. If the diagnosis of endogenous hyperinsulinism should be considered and growth hormone discontinuation therapy is restored followed by resumption of intravenous hyperinsulinism, treatment should be discontinued. In cases of severe or recurrent hormone, visual problems, nausea or flushing, a comprehensive examination is recommended. Fasting blood glucose should be examined for progression of renal insufficiency. Treatment should be discontinued in patients with renal transplantation. Growth sport may increase risk of joint problems. Medicines should be discontinued if the development of a lipoa or a decrease in children treated with Somatropin. In short children born SGA, additional medical measures may help to explain growth. Insulin should be taken care of children. The dose of growth hormone should be calculated to achieve and maintain a target height.

SAIZEN® 8 mg click easy® powder and solvent for injection.

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Side-effects

Serum glucose levels were monitored during the treatment period. The dose of growth hormone should be calculated to achieve and maintain a target height.

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Supporting other societies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Society Medal is awarded to an endocrinologist working in the UK, in recognition of outstanding studies. It has previously been awarded to HOD Critchley, BR Walker, VKK Chatterjee, JMC Connell, R Eastell, PJ Lowry, ICAF Robinson and PM Stewart.

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

Women in science, engineering and technology

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

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

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

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

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

ASK A BIOLOGIST

Concerned with accuracy of material on the web, and keen to encourage budding scientists, a number of active researchers and science enthusiasts have recently set up www.askabiologist.org.uk.

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

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

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

Please contact me direct if you have any questions about the site, at d hone@lrz.uni-muenchen.de.

DAVID HONE

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

JENNY KOENG
Presentation
Tostran 2% gel, contains testosterone, 20 mg/g.

Indications
Replacement therapy with testosterone for male hypogonadism when testosterone deficiency has been confirmed by clinical symptoms and laboratory analyses.

Posology
The recommended starting dose is 3 g gel (60 mg testosterone) applied once daily at approximately the same time each morning to clean, dry, intact skin, alternately on the abdomen or to both inner thighs. Application elsewhere should be avoided. The dose should be adjusted to the clinical or laboratory response. The daily dose should not exceed 4 g of gel (80 mg testosterone). The gel must not be applied to the genitals. Not for use in women, or children under the age of 18 years.

Contraindications
Androgens are contraindicated in known or suspected carcinoma of the breast or the prostate, known hypersensitivity to testosterone or any of the excipients, and in women.

Warnings and Precautions
Tostran should not be used to treat non-specific symptoms suggestive of hypogonadism if testosterone deficiency has not been demonstrated and if other aetiologies responsible for the symptoms have not been excluded. Tostran is not indicated for treatment of erectile dysfunction or sexual impotence. Prior to initiation of therapy, all patients must be examined to exclude a risk of pre-existing prostatic cancer. Careful and regular monitoring of breast and prostate must be performed. Testosterone may accelerate the development of subclinical prostatic carcinoma and benign prostatic hypertrophy. Oedema with or without congestive heart failure may be a serious complication in patients with pre-existing cardiac, renal or hepatic disease. The treatment must be discontinued immediately if such complications occur. Testosterone may cause a rise in blood pressure and Tostran should be used with caution in men with hypertension. Testosterone should be used with caution in patients with ischaemic heart disease, epilepsy, migraine and sleep apnoea as these conditions may be aggravated. Care should be taken in patients with skeletal metastases due to risk of hypercalcaemia/hypercalcuria. In diabetic patients, the metabolic effects of androgens may decrease blood glucose and therefore insulin requirements. Patients who wash in the morning should apply Tostran after washing. Avoid the potential for transfer of testosterone from the patient to another person by careful hand washing and the wearing of loose clothing after the gel has been applied and has thoroughly dried. Bathe or shower before any close contact with another person. Particular care must be taken to prevent transfer of testosterone to pregnant women or children via skin contact. Interactions When androgens are given simultaneously with anticoagulants, the anticoagulant effect can increase and patients receiving anticoagulants require close monitoring of their INR. Concurrent administration of testosterone with ACTH or corticosteroids may increase the likelihood of oedema and caution should be exercised. Undesirable effects They common (1/100, <1/10): peripheral oedema, hypertension, polycythaemia, increased protein specific antigen, haematuria, gynaecomastia. Certain effects may cause irritant and dry skin. Pack Size and Price Packs containing one, two or three 60 g metered-dose containers per pack. Price £26.67 per canister.

Legal Category
Prescription Only Medicine. Further information is available from the Marketing Authorisation Holder ProStrakan Limited, Galabank Business Park, Galashiels, TD1 1QH, United Kingdom. Marketing Authorisation Number PL16508/0025.

References
5. Dumas C. Poster presented at the 25th Scandinavian Meeting of Urology, Göteborg, June 2005

The first metered dose
Tostran® 2% testosterone gel
A simple solution to a serious problem

Adverse events should be reported to ProStrakan Limited on 01896 664000. Information about adverse event reporting can also be found at www.yellowcard.gov.uk

ProStrakan www.prostrakan.com

Low testosterone
The body of evidence

- Approximately 1 in 10 men aged 40 to 79 years have low testosterone with signs AND symptoms.
- 42% prevalence in men with Type 2 Diabetes and 10-20% prevalence with Erectile Dysfunction.
- Tostran® is the only 2% testosterone gel:
  - Accurate 10 mg dosing
  - Simple dose titration
  - Easy to apply, with minimal waste
- With Tostran®, 92% of patients are within normal range after only one dose adjustment.
Astrazeneca is a major international healthcare business engaged in the research, development, manufacture and marketing of ethical (prescription) pharmaceuticals and the supply of healthcare services. It is one of the top five pharmaceutical companies in the world and has leading positions in sales of gastrointestinal, oncology, cardiovascular, and respiratory products. With anaesthesia (including pain management), cardiovascular, endocrine, and dermatological medicines, Astrazeneca also holds significant global positions in the production of oncology and respiratory products.

Astrazeneca has a major interest in two other areas where there is a major endocrine component: diabetes and obesity, and stress-related disorders. In these conditions Astrazeneca is looking for novel therapies that are a significant improvement on current treatments. AstraZeneca, Morieside, Alderly Park, Macclesfield SK10 4TG, UK (Web: www.astrazeneca.com)

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BioScientifica provides a range of services of specific relevance to medical and scientific societies and the pharmaceutical industry. We can manage all aspects of your conference, and handle your secretariat and membership services, as well as your public relations. BioScientifica is an experienced publisher of books, journals, newsletters and conference proceedings. We can create and maintain web sites on your behalf. If you are looking for someone to provide you with any of these services, get in touch!

BioScientifica handles the external relations for the Society for Endocrinology, British Fertility Society, Cancer and Bone Society, British Oncological Society and Ipsen Pharmaceuticals. We provide a full online abstract publishing service for several clients.

We act as the standing office for five learned societies, offering full membership services, enquiry handling, committee meeting management, production of newsletters and advice regarding governance and other procedural matters.

BioScientifica handles the external relations for the Society for Endocrinology and the British Fertility Society.

The following publications are managed by BioScientifica:

- European Journal of Endocrinology, published in print and online with HighWire Press for the European Society of Endocrinology
- Reproduction, published in print and online with HighWire Press for the Society for Reproduction and Fertility
- A range of books including, Zuckerman: Scientist Extraordinary, Handbook of Acromegaly, also available as a CD-ROM, Molecular Pathology and Therapy of Pituitary Disease, and Pituitary and Periphery: Communication In and Out and Handbook of Neuroendocrine Tumours.

Our in-house web site management service has created and maintains more than ten web sites for societies and other organisations.

BioScientifica is owned by the Society for Endocrinology. BioScientifica Ltd, Euro House, 22 Apex Court, Woodlands, Bradley Stoke, Bristol BS32 4JT, UK (Tel: 01454-642240; Web: www.bioscientifica.com)

ARDANA BIOSCIENCE LTD

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

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

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

Ardana, 58 Queen Street, Edinburgh EH2 3NS, UK (Tel: 0131-2268550; Fax: 0131-2268551; Web: www.ardana.co.uk)

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

Founded in 1950 by Dr Frederik Paulsen, Ferring Pharmaceuticals is focused on the research and commercial development of peptides - natural compounds that play a role in virtually all of the body’s systems. Ferring produces pharmaceuticals in specific therapeutic areas to help clinicians treat patients on the body’s own terms. As a dedicated, research-driven biopharmaceutical company, Ferring identifies, develops and markets innovative products in the fields of fertility, obstetrics, endocrinology, urology and gastroenterology.

Ferring’s developmental activities are on a global scale and are conducted in collaboration with leading academic centres and teaching hospitals worldwide. Co-ordination of development is maintained from the International PharmaScience Center in Copenhagen, Denmark. The accumulated knowledge and experience of Ferring are paving the way for novel compounds that will become tomorrow’s pharmaceuticals.

Ferring Pharmaceuticals Ltd,
The Courtyard, Waterside Drive, Langley SL3 6EZ, UK
(Tel: 01753-214800; Web: www.ferring.co.uk)

**Genzyme Therapeutics**

Founded in 1981, Genzyme is now one of the world’s largest and most established biotechnology companies. With more than 25 major products and services marketed in over 60 countries, Genzyme is a global leader in the effort to develop and apply the most advanced capabilities in biotechnology, in order to address a range of unmet medical needs. With corporate headquarters in Cambridge, Massachusetts, USA, Genzyme has approximately 4600 employees working in 40 countries throughout the world. The European headquarters are in Naarden, The Netherlands, and the UK headquarters covering the whole of the British Isles are now based in Oxford.

Genzyme-sponsored R&D has led to the introduction of new treatments for many serious health problems, from rare and debilitating genetic diseases to renal disease, orthopaedic injuries, transplantation and thyroid cancer. One of Genzyme’s most significant successes is Thyrogen (thrytropin alfa), which contains a highly purified recombinant form of human thyroid-stimulating hormone. It can be used to eliminate the devastating and painful symptoms of thyroid hormone withdrawal that patients may experience when they are tested for a recurrence of thyroid cancer. Thyrogen will also lead to more accurate thyroglobulin measurements on thyroid hormone suppression.

Genzyme has a commitment to improving the lives of patients and supporting the work of doctors and other healthcare providers.

Genzyme Therapeutics Ltd, 4620 Kingsgate, Cascade Way, Oxford Business Park South, Oxford, OX4 2SU, UK
(Tel: 01865-405200; Web: www.genzyme.com)

**Ipsen Ltd**

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

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

Ipsen Limited’s Endocrinology and Oncology Business Unit is responsible for a portfolio of products with sophisticated sustained release delivery systems for the management of various hormone-related diseases.

Ipsen’s Research and Development (R&D) programme is based on four technological platforms; peptide engineering, protein engineering, medicinal chemistry and advanced drug delivery. The location of its four R&D centres (Paris, Boston, Barcelona and London) gives the group a competitive edge in gaining access to leading university research teams and highly qualified personnel. Nearly 700 people in R&D are dedicated to the discovery and development of innovative drugs for patient care.

Ipsen Ltd, 190 Bath Road, Slough SL1 3XE, UK
(Tel: 01753-627777; Fax: 01753-627778; Web: www.ipsen.co.uk)
Novo Nordisk manufactures and markets pharmaceutical products in 179 countries. It employs approximately 18,700 people in 68 countries and markets its products throughout the world. Novo Nordisk is a focused healthcare company with a leading position in areas such as diabetes, growth hormone therapy, haemostasis management, and hormone replacement therapy. With the broadest diabetes product portfolio in the industry, including advanced products within the area of insulin delivery systems, Novo Nordisk is the world leader in diabetes care.

Within the area of growth hormone therapy, Novo Nordisk has always been at the forefront of research into the use of human growth hormone (hGH). The company launched its first growth hormone product in 1966. Since then, Novo Nordisk has made a series of significant breakthroughs in the development of indications and convenient delivery systems for hGH. In 1999, Novo Nordisk launched the first ready-to-use liquid growth hormone, Norditropin® SimpleXx®. This is supplied in a pen system that was developed utilising existing diabetes experience, to ensure that people who use growth hormone can simply, comfortably and accurately administer their dose. Novo Nordisk also provides patients with the support of a homecare service and the convenience of home delivery.

Novo Nordisk manufactures and markets pharmaceutical products and services that make a significant difference to patients, the medical profession and society. With headquarters in Denmark, Novo Nordisk employs approximately 18,700 people in 68 countries and markets its products in 179 countries.

Novo Nordisk Ltd, Broadfield Park, Brighton Road, Crawley RH11 9RT, UK (Tel: 01293-762000; Web: www.novonordisk.com)

Nycomed is a pharmaceutical company dedicated to meeting medical needs in Europe. The company provides specialist hospital products throughout the UK and Ireland. Its core disease areas are currently in the cardiovascular, osteoporosis, pain management and surgical arenas.

New products are sourced through licensing agreements with research companies. Here, Nycomed provides late-stage clinical development, registration and marketing. Nycomed employs about 3300 people throughout Europe and Russia-CIS.

Nycomed UK, The Magdalen Centre, Oxford Science Centre, Oxford OX4 4GA, UK (Tel: 01865-784500; Fax: 01865-784501; Web: www.nycomed.co.uk)

Organon Laboratories Ltd, Cambridge Science Park, Cambridge CB4 0FL, UK (Tel: 01223-432700; Web: www.organon.co.uk)

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

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

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

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

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

ProStrakan Group plc is a rapidly growing specialty pharmaceutical company engaged in the development and commercialisation of prescription medicines for the treatment of unmet therapeutic needs in major markets. The company's development facilities are situated at ProStrakan's headquarters in Galashiels in Scotland. EU-wide sales and marketing of ProStrakan's portfolio of products are handled by commercial subsidiaries in the UK, France, Germany, Spain and other EU countries.

ProStrakan, Galabank Business Park, Galashiels TD1 2HB, UK (Tel: 01896-668060; Web: www.prostrakan.com)

Sandoz, a division of the Novartis group, is a world leader in high-quality generics and biopharmaceutical medicinal products. Sandoz develops and markets a wide variety of active ingredients and finished products, having a portfolio of more than 840 compounds in over 5000 forms. Novartis is the only major pharmaceutical...
company to have leadership positions in both patented prescription drugs and generic pharmaceuticals.

In 2005, Hexal AG (Germany) and EonLabs Inc. (US) became part of Sandoz. In 2006, the business employed about 21,000 people worldwide. It sold its products in more than 110 countries and posted sales of US$6 billion.

Sandoz's recombinant human growth hormone Omnitrope® received the Marketing Authorization by the European Commission in April 2006 and has been launched subsequently in several European countries. In the US, Omnitrope was launched in January 2007. In Australia, Omnitrope® is on the market since November 2005.

Biosimilar medicines made by Sandoz:
- fully adhere to the new and rigorous European standards for biosimilar medicinal products
- guarantee a high-quality production process as Sandoz ranks among the world's largest and most experienced manufacturers of biotechnological products
- ensure patient care and safety through appropriate pre-clinical development, clinical trials and post-marketing surveillance including a state of the art pharmacovigilance system
- help reduce the burden on health care systems by providing the public with safe and effective medicines at competitive prices.

Sandoz International GmbH,
Industriestrasse 25, 83607 Holzkirchen, Germany
(Tel: +49-8024-4762591; Fax: +49-8024-4762599;
Web: www.sandoz.com)

SHIRE PHARMACEUTICALS LTD
Shire's strategic goal is to become the leading specialty pharmaceutical company that focuses on meeting the needs of the specialist physician. Shire focuses its business on attention deficit and hyperactivity disorder (ADHD), human genetic therapies (HGT), gastrointestinal (GI) and renal diseases.

The structure is sufficiently flexible to allow Shire to target new therapeutic areas to the extent opportunities arise through acquisitions. Shire believes that a carefully selected portfolio of products with strategically aligned and relatively small-scale sales forces will deliver strong results.

The company's strategy is to develop and market products for specialty physicians. Shire's in-licensing and merger and acquisition efforts are focused on products in niche markets with strong intellectual property protection either in the USA or Europe.

Shire Pharmaceuticals Ltd, Hampshire International Business Park, Chineham, Basingstoke RG24 8EP (Tel: 01256-894000; Web: www.shire.com)
OUT OF THE ARCHIVES...

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

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

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

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

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

R D Bulbrook proposed the motion 'that international congresses are a waste of time and money', and his speech is hilarious. In picking out bits to quote, there's a danger of reproducing the whole lot, but try this: 'Giving a 10-minute lecture to start the day, followed by oral sessions. Some of these were organised as symposia, but all accepted submitted abstracts were also delivered as oral communications. Consequently there was a rather constraining formality about the whole thing, and not nearly the opportunity for informal discussions that we all now value.

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

It seems incongruous that, after all that, the silent majority had its day, and the motion was rejected with 9 for, 30 against. The Society for Endocrinology won its bid, and the 2nd International Congress of Endocrinology was held in London in 1964, with a format largely unchanged, by my recollection. I do recall that a bid to limit the numbers of delegates was stonily received, especially by the Americans, and this has not been tried again. But other ways of improving the conferences have been much more successful, in my view. It's difficult to believe we'll ever see such a debate again.

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

GAVIN VINSON

Organising an event?

Our online Calendar of World Events is a comprehensive listing of everything that's happening in endocrinology. If you would like us to include your meeting, remember you can submit the details yourself by entering them at www.bioscievents.com.
The practical challenge for bioscience

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

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

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

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

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

How has the present situation arisen? There is no single answer to this question, but the expansion of university bioscience courses forms an important component of the answer. With doubling, trebling and quadrupling of student numbers in the biosciences, it has often proved too difficult to find and pay for the space and staff to enable practical work of a high standard.

Indeed, as you will know, many courses are structured to minimise the need for practical training. It is possible to do an honours degree in pharmacology where, if you are predicted to obtain a lower second class degree, your honours project will be in the library. Graduates lacking practical skills will not usually attempt to find the time for more practical work when teaching in secondary schools.

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

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

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

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

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

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

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

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

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

Internet anabolics also have a softer side. Homeopathic growth hormone is something of a boom area. In many ways it's a perfect homeopathic product: a highly valuable initial product, which is diluted to near infinity, but magically retains both its original potency and its original price. But doesn't it have side effects?

Well, as one manufacturer of homeopathic growth hormone says '... because the HGH is homeopathic, you choose which hormonal effect your body will undergo, and its original price. But doesn't it have side effects? Well, as one manufacturer of homeopathic growth hormone says '... because the HGH is homeopathic, you know that it is as safe as it is effective'. Couldn't have put it better myself, and I'm genuinely very reassured by this.

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

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

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

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

TOM PARKHILL
Dabbling in toxicology...

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

As one of the Food Standards Agency’s science advisory committees, COT provides advice to enable the Agency to fulfil its statutory aim to ‘protect public health from risks which may arise in connection with the consumption of food’. I was a member of the COT Working Group that had reported on phytoestrogens and health in 2003 (www.food.gov.uk/multimedia/pdfs/phytoreport0503), the best review I have seen of the chemistry and physiology of oestrogens. We covered all aspects: dietary sources, the risks and benefits of consuming phytoestrogens, and the evidence for positive effects against cancer, the menopause and osteoporosis.

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

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

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

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

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

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

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

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

IEUAN A HUGHES

Learn more about the work of COT at www.food.gov.uk/science/ouradvisors/toxicity.
It was the response of a real academic: no hint of any emotional reaction to perceived personal insults, just cold critical analysis of the grammar used in the process of story-telling.

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

'How did you like the story?'
'I liked it but I did feel a little insulted.'

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

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

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

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

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

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

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

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**Perceptions, academia and misunderstandings**

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

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

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

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

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

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

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

'How did you like the story?'
'I liked it but I do have one quibble.'

'Was it about the suggestion of Alzheimer's?'
'No, I forgot that in an instant.'

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

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

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

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

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

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

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

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

**Primary aldosteronism**

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

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

The diagnostic and therapeutic approaches have evolved and been simplified over time. Originally, primary aldosteronism was not suspected unless a patient presented with hypertension and spontaneous hypokalaemia. It is now recognised that most patients with primary aldosteronism are not hypokalaemic. Identification of cases is based on the measurement of paired plasma aldosterone concentration and plasma renin activity. A positive test must be confirmed with sodium suppression testing for aldosterone autonomy. Differentiation between the seven subtypes remains the final step in the diagnostic approach.

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

**WT1 may regulate AR in male genital development**

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

A subset of patients with WT1 mutations and virilization defects were found to have normal testosterone-producing testes after birth, suggesting androgen resistance. This led to the hypothesis that WT1 and the AR might functionally interact during development of the external genitalia. Köhler and colleagues found that WT1 and the AR were coexpressed in the mesenchyme surrounding the urogenital sinus, mesonephros and Müllerian duct at 7 weeks p.c. and in the epididymis, vas deferens and gubernaculum testes from 13 to 27 weeks p.c. in human male embryos. They saw modification of AR expression by WT1 (WT1 +/-, WT1 +/- R394W) in CV1, Hela, LNCaP and T293 cells. LNCaP and T293 cells were considered to be the most physiological cell systems, as both originate from the human urogenital tract. In these cell lines, repression of AR expression (0.5-fold) by the mutant WT1 +/- R394W could be demonstrated in comparison with the wild-type WT1 +/-. The authors conclude that a functional interaction of WT1 and the AR might play a role during development of the male external genitalia, but, as the regulatory effects were moderate, this is most likely to be in concert with other local cofactors. SL (See the full article in Journal of Molecular Endocrinology 38(5), May 2007)

**New risk factors for breast cancer**

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

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

The Breast Cancer Prevention Collaborative Group have met to critically examine and prioritise risk factors that might be selected for further testing by multivariate analysis using existing clinical material. They have agreed that quantitative breast density, state of the art plasma oestradiol and androgen measurements, a history of fracture and height loss, BMI and waist/hip ratio have sufficient priority for further testing. AL (See the full article in Endocrine-Related Cancer 14(2), June 2007)
Pitfalls in Endocrine Testing
Contact: Samantha Tagg, Royal Society of Medicine, 1 Wimpole Street, London W1G 0AE, UK (Tel: +44-20-72903859; Fax: +44-20-72902989; Email: endocrinology@rsm.ac.uk; Web: www.rsm.ac.uk/endocrinology).

Bone Research Society Annual Meeting
Aberdeen, UK, 3-5 July 2007.
Contact: Janet Crompton, The Old White Hart, North Nibley, Dursley, Gloucestershire GL11 6DS, UK (Tel: +44-1453-549929; Fax: +44-1453-548919; Email: janet@janet-crompton.com; Web: www.brc.org.uk).

31st British Congress of Obstetrics and Gynaecology
Contact: Michelle Kane, 48, 50 Speirs Wharf, Port Dundas, Glasgow G4 9TB, UK (Tel: +44-141-3310123; Fax: +44-141-3310234; Email: info@bcog2007.co.uk; Web: www.bcg.org.uk).

Genomics of Common Diseases
Cambridge, UK, 7-10 July 2007.
Contact: Patricia van der Valk, Wellcome Trust Conference Centre, Wellcome Trust Genome Campus, Hinxton, Cambridge CB10 1RQ, UK (Tel: +44-1223-495000; Fax: +44-1223-495023; Email: p.vandervalk@wtconference.org.uk; Web: www.wcmh.info).

Life Sciences 2007: 1st Joint Meeting of the Biochemical Society, the British Pharmacological Society and the Physiological Society
Glasgow, UK, 8-12 July 2007.
Contact: Life Sciences 2007 (Email: info2007@lifesci.org; Web: www.lifesciences2007.org).

Advances in the Molecular Pharmacology and Therapeutics of Bone Disease
Contact: Janet Crompton, The Old White Hart, North Nibley, Dursley, Gloucestershire GL11 6DS, UK (Tel: +44-1453-549929; Fax: +44-1453-548919; Email: janet@janet-crompton.com; Web: www.paget.org.uk).

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

40th Annual Meeting of the Society for the Study of Reproduction
San Antonio, TX, USA, 21-25 July 2007.
Contact: Gruen Abramson, SSR, 1619 Monroe Street, Madison, WI 53711-2063, USA (Tel: +1-608-2562777; Fax: +1-608-2564610; Email: ssr-ar@nhs.org; Web: www.ssr.org).

13th International Conference on Second Messengers and Phosphoproteins
San Diego, CA, USA, 1-4 August 2007.

63rd Harden Conference: Protein Folding and Assembly In Vitro and In Vivo
Ambrëside, UK, 18-23 August 2007.
Contact: Biochemical Society (Tel: +44-20-72804150; Fax: +44-20-72804167; Email: meetings@biochemistry.org; Web: www.biochemistry.org/meetings/programme.cfm?Meeting_No=63HDN).

2nd International Meeting of the Academy of Forensic Paediatrics
Contact: Claudio Teloken, Fundacao Faculdade de Ciencias Medicas de Porto Alegre, RS, Brazil (Tel: +55-51-33282328; Fax: +55-51-33424316; Email: secretaria@ccmeventos.com.br; Web: www.ccmeventos.com.br).

25th International Congress of Paediatrics
Athens, Greece, 25-30 August 2007.
Contact: ICP 2007 Organiser, 16 Paradissou St, 5125 Athens, Greece (Tel: +30-210-6889100; Fax: +30-210-6844777; Email: icp2007@acnc.gr; Web: www.icp2007.gr).

Congress of the European Association for Clinical Pharmacology and Therapeutics
Amsterdam, The Netherlands, 29 August-1 September 2007.
Contact: Rene Croulls, Catharina Hospital, Michelangeloelaan 2, Eindhoven, 5602 ZA The Netherlands (Tel: +31-40-2398795; Email: kaprgs@czce.nl; Web: www.eact2007.nl).

Endocrine Nurse Training Course
Glasgow, UK, 4-6 September 2007.
Contact: Liza Jones, Society for Endocrinology, 22 Apex Court, Woodlands, Bradley Stoke, Bristol BS32 4JT, UK (Tel: +44-1454-642210; Fax: +44-1454-642222; Email: conferences@endocrinology.org; Web: www.endocrinology.org/meetings).

Mouse Molecular Genetics
Contact: Pam Garland, Wellcome Trust Conference Centre, Hinxton, Cambridge CB10 1RQ, UK (Tel: +44-1423-495000; Email: p.garland@wtconference.org.uk; Web: http://firstcontact.hinxton.wellcome.ac.uk).

1st World Congress on Controversies in Neurology (CONy)
Berlin, Germany, 6-9 September 2007.
Contact: Ruth Yahav (Tel: +992-35666161; Fax: +992-35666177; Email: cony@comtedmed.com; Web: www.comtedmed.com/cony).

Acute Diabetes and Endocrinology for the General Physician
Contact: Jennifer Lake, Academic Department, Royal Society of Medicine, 1 Wimpole Street, London W1G 0AE, UK (Tel: +44-20-72909199; Fax: +44-20-72902989; Email: jennifer.lake@rsm.ac.uk; Web: www.rsm.ac.uk/academ/c10-diabetes.htm).

4th Regional Postgraduate Course in Clinical Endocrinology
Contact: Prof Bohdan Huzsno (Web: www.euro-endo.org/meetings/meetings_courses.htm).

29th Annual Meeting of the American Society for Bone and Mineral Research
Honolulu, HI, USA, 16-19 September 2007.
Contact: ASBMR, 2025 M Street NW, Suite 800, Washington, DC 20036-3309, USA (Tel: +1-202-3671161; Fax: +1-202-3672161; Email: asbmr@asbmr.org; Web: www.asbmr.org/meeting/index.cfm).

43rd Annual Meeting of the European Association for the Study of Diabetes
Contact: EASD (Tel: +49-211-75846920; Fax: +49-211-75846925; Email: registrations@easd.org; Web: www.easd.org).

7th World Congress on Neurohypophysial Hormones
Regensburg, Germany, 18-22 September 2007.
Contact: Dr Olivier Bosch, Institute of Zoology, University of Regensburg, 93053 Regensburg, Germany (Email: wcnh2007@biologie.uni-regensburg.de; Web: www.uni-r.de/wcnh2007).

2nd International Congress IVI
Barcelona, Spain, 19-21 September 2007.
Contact: Noemi de Villasante, Joan Guell 144, 08028 Barcelona, Spain (Tel: +34-93-1633951; Fax: +34-93-4393594; Email: ivicongress@tecnicviajes.com).

9th Seminar of the European Society of Contraception: from Abortion to Contraception
Contact: Nancy Habils, European Society of Contraception, Opalfeneweg 3, 1740 Ternat, Belgium (Tel: +32-2-5820852; Fax: +32-2-5825515; Email: esccentraloffice@contraception-esc.com; Web: www.contraception-esc.com).

5th Biennial World Congress on Men’s Health and Gender: Men’s Health in Transition
Vienna, Austria, 21-23 September 2007.
Contact: Simone Veltier, Lazaretsgasse 9/5, 1090 Vienna, Austria (Tel: +43-1-4096010; Fax: +43-1-4096011; Email: office@wcnh.info; Web: www.wcnh.info).

50es Journées Internationales d’Endocrinologie Clinique
Contact: G Copinschi, Laboratory of Experimental Medicine, Brussels Free University, CP 618, 808 Route de Lennik, B-1070 Brussels, Belgium (Email: dr.g.copinschi@ulb.ac.be; Web: www.endocrinoclinic.net).

3rd EUGOGO International Teaching Course on Graves’ Orbitopathy
Mainz, Germany, 28-30 September 2007.
Contact: Susanne Pitz, Department of Ophthalmology, Gutenberg-University Hospital, Langenbeckstrasse 1, 55131 Mainz, Germany (Tel: +49-6131-176762; Fax: +49-6131-173455; Email: pitz@augen.klinik.uni-mainz.de; Web: www.eurothyroid.com).
Scenes from Society for Endocrinology BES 2007