

Transition to Adulthood of Growth Hormone Deficient Children

This "Approach to the Patient" review presented a discussion on continuing care of growth hormone deficient (GHD) patients who have attained final adult height and have low bone mineral density, abnormal lipids, and impaired cardiac function. Radovick and DiVall delineated when to retest, how to test, when to treat, and how to treat. In their conclusion they recommended the establishment of specialized clinics "to improve compliance and follow-up during the transition to adult services."

Radovick S, DiVall S. Approach to the growth hormone deficient child during transition to adulthood. *J Clin Endocrinol Metab.* 2007;92:1195-200.

Editor's Comment: *This is an extremely detailed article addressing the important issues of transitional care of the GHD deficient patient following completion of linear growth. I cannot fault the careful objective analysis of the published literature and the recommendations are sensible and logically argued. However, this article emphasizes the very wide transatlantic divide in the approach to this subject.*

The authors described the clinical situation of the care of a GHD 17-year-old patient as being "relatively new to pediatric endocrinologists." The entity of the adult GHD syndrome and evidence of beneficial GH replacement therapy in adult hypopituitary patients was established in the late 1980s. That is nearly 20 years ago. Active transitional care programs have been operating in Europe, admittedly more so in northern rather than

southern parts of the continent, for at least 10 years.

The challenge is to get pediatric and adult endocrinologists to work together to improve care of the patient with hypopituitarism who has completed growth. With this aim, a consensus meeting, organized jointly by ESPE, LWPES, and the GRS (Manchester, UK, December 2003) and its consensus statement¹ was published in 2005. This statement, authored by an equal number of pediatric and adult endocrinologists discussed all the questions raised in the present review. However the Clayton et al paper is not even referenced!

The Radovick and DiVall review is written very much for the practicing pediatric endocrinologist. This again points to a difference in approach to the care of the young adult with GHD. The consensus view, as previously published,¹ is that care should be transferred, ie, the patient should be transitioned to the adult endocrine service. In this way, GH retesting using an insulin tolerance test (ITT), which is recognized to be the best test of adult GHD, can be performed in a safe adult environment and the decision whether to continue GH therapy in a young adult, can be taken, logically, by an adult endocrinologist.

I make a plea for transatlantic co-operation. We have a great deal to learn from each other.

Martin O. Savage, MD

Reference

1. Clayton PE, Cuneo RC, Juul A, et al. *Eur J Endocrinol.* 2005;152:165-70.

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Fima Lifshitz, MD
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