DHEA therapy could reduce GH dose requirement in hypopituitary women

Growth hormone (GH) has been implicated in regulation of the adrenal androgen dehydroepiandrosterone (DHEA). Brooke *et al.* hypothesized that DHEA supplements might increase insulin-like growth factor 1 (IGF1) production, despite use of constant GH doses.

Their single-center trial enrolled 30 female and 21 male (26 and 18 of whom completed the study, respectively) hypopituitary patients aged 18–64 years, who were treated with full pituitary hormone-replacement therapy, including GH. In the initial, double-blind phase, patients were randomly allocated to receive either 50 mg DHEA or placebo daily for 6 months. Subsequently, all patients received open-label DHEA for 6 months, followed by a 2-month washout period. Patients were evaluated monthly during the study; if serum IGF1 levels showed a >15% change from baseline, the dose of GH was adjusted to maintain constant serum IGF1 levels.

All patients had subnormal DHEA sulfate levels at baseline that became normalized in those who received DHEA supplementation. In both the placebo-controlled and open-label phases of the trial, GH dose requirements were reduced by 15.3% on average (SD 3.6%) in DHEA-treated women, whereas GH doses increased by 2.7% (SD 4.8%) in placebo-treated women—a statistically significant difference (P<0.01). There was no change in GH dose requirements of male patients, perhaps because they were all taking testosterone-replacement therapy.

Brooke *et al.* concluded that close monitoring of serum IGF1 in GH-treated hypopituitary women who start DHEA-replacement therapy is necessary, as GH dose reductions might be achievable.

Original article Brooke AM *et al.* (2006) Dehydroepiandrosterone (DHEA) replacement reduces growth hormone (GH) dose requirement in female hypopituitary patients on GH replacement *Clin Endocrinol* [doi: 10.1111/j.1365–2265]

Sibutramine can cause bruising

Sibutramine is a selective serotonin reuptake inhibitor used to treat obesity. Such agents have been associated with bleeding events; the product information for Meridia® (sibutramine, Abbot Laboratories, IL, USA) states that bruising occurred in 0.7% of sibutramine-treated patients compared with 0.2% for placebo. A causal relationship had not, however, been proven.

The New Zealand Intensive Medicines Monitoring Programme included postmarketing prescription data and adverse-event reports from all 9,532 patients prescribed sibutramine between February 2001 and November 2002. Harrison-Woolrych *et al.* identified five cases of sibutramine-associated bruising in the New Zealand cohort, three of which resolved when sibutramine was withdrawn (two unknown); one patient experienced recurrence of bruising on sibutramine reintroduction—indicative of a causal relationship.

The authors also identified 39 reports of sibutramine-associated bruising notified to the WHO Uppsala Collaborating Centre for International Drug Monitoring. Of these, 31 had sufficient information for causality assessment; in 11 patients, bruising improved when sibutramine was withdrawn, and it recurred in one patient when sibutramine was reintroduced. In two WHO cases, however, sibutramine was not the sole drug that could cause bruising, because either aspirin or co-trimoxazole had been coadministered.

The overall risk of bruising when taking sibutramine was <1%. The authors suggest that sibutramine might reduce the amount of serotonin available for release by platelets, which could impair platelet aggregation. They advise caution in prescribing sibutramine to patients predisposed to bleeding complications, or who are on medicines that affect hemostasis or platelet function.

Original article Harrison-Woolrych M *et al.* (2006) Bruising associated with sibutramine: results from postmarketing surveillance in New Zealand. *Int J Obes (Lond)* **30:** 1315–1317

Successful oral sulfonylurea treatment for diabetes caused by Kir6.2 mutations

KCNJ11 encodes the Kir6.2 subunit of the ATP-sensitive inward-rectifier potassium channel (IK_{ATP}). Patients with *KCNJ11* mutations exhibit marked hyperglycemia within the first 6 months of life, because their β-cell IK_{ATP} channels do not close when intracellular ATP levels rise in response to glucose metabolism.