after administration of CRH gave the highest diagnostic accuracy (99.7%). With a cut-off of 27 pg/ml (5.9 pmol/l), the sensitivity was 95% and the specificity was 97%. However, no significant differences were observed between the sensitivity and specificity of this test and other tests that measure post-CRH-stimulated ACTH levels or post-CRH cortisol levels at other time points.

In light of their findings, the authors conclude that suppression and stimulation tests must be interpreted with caution.

Original article Erickson D *et al.* (2007) Dexamethasone-suppressed corticotropin-releasing hormone stimulation test for diagnosis of mild hypercortisolism. *J Clin Endocrinol Metab* [doi: 10.1210/jc.2006-2662]

Increased risk of thyroid dysfunction in childhood cancer survivors

Cancer treatments have improved so much that doctors now need to plan how to handle the after-effects of the treatments themselves. One after-effect identified is hypothyroidism, which in children can have significant effects on growth and cognitive development, and can cause physical and mental fatigue and learning difficulties. It hasn't yet been clearly shown whether any particular cancer treatment is associated with a higher risk of developing hypothyroidism, (although radiotherapy to the head and neck is a known cause) because studies have varied over time frames as well as types of treatments and types of cancer. These authors retrospectively studied a group of pediatric cancer patients ($n = 291$) to determine the group at highest risk of consequent hypothyroidism and the optimal post-treatment endocrine surveillance program.

They found the quickest and most common development of hypothyroidism in patients with brain tumors or Hodgkin's disease, those who had undergone cerebrospinal or thyroid radiotherapy, and those who had undergone radiotherapy in general. Females were twice as likely as males to suffer postirradiation thyroid hypofunction.

Post-treatment endocrine surveillance thus needs to reflect not only the cancer diagnosis but also the location irradiated. Increased frequency of monitoring should apply to patients who have had brain tumors, leukemia or Hodgkin's disease treated with cerebrospinal or total-body irradiation, whereas surgical patients need not be monitored this way. The authors give some guidance for both frequency and duration of monitoring.

Original article Madanat LM *et al.* (2007) The natural history of thyroid function abnormalities after treatment for childhood cancer. *Eur J Cancer* **43:** 1161–1170

Patients with acromegaly who stop taking somatostatin analogs risk acute biliary problems

Gallstones are more common in patients with acromegaly than in the general population. Somatostatin analogs—the gold standard medical treatment for patients with acromegaly—are associated with a further increase in the incidence of gallstones. Although these gallstones are generally asymptomatic, there are concerns that withdrawal of somatostatin analog therapy precipitates acute biliary problems.

To determine the frequency of symptomatic biliary disease in patients who stop taking somatostatin analogs, Paisley *et al*. prospectively followed 50 patients (mean age 54 years; 30 were male) with acromegaly who were taking somatostatin analogs on 1 January 2003 in a single center. The number of years on and off treatment, the presence of gallstones, occurrence of cholecystectomy, and the reason for and timing of cholecystectomy in relation to SA therapy were noted.

Patients took somatostatin analogs for a mean 6.4 years. Fifteen patients discontinued somatostatin analog therapy (because of ineffective biochemical control, following curative surgery or biochemical remission post radiotherapy); five of these developed acute cholecystitis or biliary colic. The mean interval between discontinuation of therapy and the occurrence of symptoms was 3.6 months. Two patients continuing somatostatin analog therapy developed biliary colic. The seven symptomatic patients underwent cholecystectomy.

The authors conclude that there is a significantly increased risk of developing acute biliary problems following the withdrawal of somatostatin analog therapy (5 in 27.67 patient 'off-treatment' years vs 2 in 299 patient treatment years), and that patients should be forewarned of these symptoms.

Original article Paisley AN *et al.* (2007) Withdrawal of somatostatin analogue therapy in patients with acromegaly is associated with an increased risk of acute biliary problems. *Clin Endocrinol* **66:** 723–726