hormone:follicle stimulating hormone ratio, cessation of follicular maturation and the presence of polycystic ovaries on ultrasonographic scans.

The authors suggest that this subgroup of patients developed polycystic ovaries and hyperandrogenemia because GnRH therapy unmasked an underlying pituitary or ovarian defect; the authors favor the ovary as the causative site, because GnRH therapy can normalize pituitary gonadotropin secretion. They further suggest that study of patients with combined hypothalamic and hyperandrogenemic ovarian failure might help uncover the pathogenesis of hyperandrogenemia.

Original article Mattle V *et al.* (2008) Polycystic ovarian disease unmasked by pulsatile GnRH therapy in a subgroup of women with hypothalamic amenorrhea. *Fertil Steril* **89:** 404–409

Lanreotide injections can be successfully given at home to patients with acromegaly

Patients with acromegaly require fortnightly or monthly injections of somatostatin analogs during clinic visits. The introduction of lanreotide, in the form of Somatuline Autogel® (SCRAS, Paris, France)—which does not require reconstitution before injection and is available in ready-to-use, prefilled syringes—raises the possibility that patients could be treated at home. Bevan and colleagues tested the efficacy and safety of home injection of Somatuline Autogel® in this multicenter, open-label, nonrandomized, controlled study.

Patients (aged 29–86 years) with acromegaly who had been treated with a stable dose of Somatuline Autogel® (60, 90 or 120 mg) for at least 4 months elected to receive their monthly injections either from a health-care professional, as before (control group; $n = 15$), or at home, unsupervised (test group; $n = 15$). Monitoring of efficacy and tolerance was carried out for up to 40 weeks.

All injectors in the test group (12 of whom were the patients and 3 were other people) were successfully trained to inject without requiring supervision and all 30 patients received adequate treatment throughout the study. Efficacy was similarly high in both groups, as indicated by maintenance of growth hormone and insulin-like growth factor I levels in all but one patient in each group. In addition, there was no difference in injection tolerability between the groups.

Home administration of Somatuline Autogel® is effective and safe, and would benefit those patients who prefer its increased flexibility; home administration might also save health-care time and costs.

Original article Bevan JS *et al.* (2008) Home administration of lanreotide Autogel® by patients with acromegaly, or their partners, is safe and effective. *Clin Endocrinol* **68:** 343–349

Reduction in vertebral fracture risk persists after discontinuation of risedronate

Risedronate affects multiple factors that contribute to bone strength and, therefore, is commonly used to treat osteoporosis. The reduction in fracture risk observed with risedronate might only be partially explained by changes in BMD and bone turnover markers (BTM).

Watts *et al.* analyzed the changes in BMD and BTM and their effects on fracture risk after discontinuation of risedronate. They studied postmenopausal women with osteoporosis who had completed a 3-year, double-blind treatment period, during which they received either risedronate or placebo. At the end of this period women could choose to stay in the study for 1 year after treatment was discontinued. This extension year was completed by 599 women.

In the year following discontinuation of treatment, BMD at the lumbar spine, femur and trochanter decreased significantly in women who had previously received risedronate, although their BMD remained higher than that of women who formerly received placebo. In risedronate-treated women, urinary measurements of bone resorptive markers and serum bone-specific alkaline phosphatase had decreased significantly during the 3 years of treatment, but were not significantly different from those of placebo-treated women after 1 year off treatment. After the extension year, however, the relative risk of vertebral fracture in previously risedronate-treated women was still reduced by 46% compared with previously placebo-treated women.

The authors concluded that a reduced risk of new vertebral fractures persisted in the year following discontinuation of risedronate treatment, despite an apparent resolution of risedronate's effect on BMD and on BTM.

Original article Watts NB *et al.* (2008) Fracture risk remains reduced one year after discontinuation of risedronate. *Osteoporos Int* **19:** 365–372