reported to decrease secretion of glycoprotein hormone subunits but rarely affect tumour size.

Incidentalomas

The sensitivity of computed tomography and magnetic resonance imaging has largely been responsible for establishing the "incidentaloma" as a new clinical entity. Occult microadenomas or macroadenomas have been found in as many as one in five of sequential necropsies of patients dying from unrelated causes. Incidental identification of a pituitary mass is said to occur in over 10% of patients undergoing cranial imaging for unrelated reasons (patients' mean age 69 years). Focal hypodensities are present in one third of normal women undergoing computed tomography, and a partially empty sella is present in 18%. The natural history of incidentalomas, particularly those less than 10 mm in diameter, is benign, but they do need occasional follow up.

Box 7—Unresolved issues in diagnosis and management of pituitary adenoma

- Cost effectiveness of surgery compared with long term bromocriptine treatment for microprolactinomas
- First line use of long lasting somatostatin analogues in acromegaly
- Role of growth hormone replacement in adults with panhypopituitarism
- Long term secondary effects of radiotherapy
- Use of α particle treatment instead of conventional radiotherapy
- Use of indium labelled somatostatin and somatostatin receptor analogues in diagnosis

Follow up

At one month or more after an operation, further glucocorticoid replacement is unnecessary in the short term if circulating cortisol concentration increases to over 495 nmol/l in response to an intravenous bolus of 250 μg tetracosactrin—given 24 hours after stopping hydrocortisone (typically 15 mg in the morning and 5-10 mg in the evening). If a patient has had radiotherapy the tetracosactrin test will need to be repeated every one to two years initially as a yearly reduction in hormone release of 15-20% can be expected.

A low concentration of free thyroxine indicates the need for thyroid hormone replacement. A low testosterone concentration associated with sexual dysfunction is treated with intramuscular testosterone (100 mg every two weeks or 250 mg every three to four weeks) as oral supplements are poorly absorbed and transdermal testosterone replacement is not yet available in Britain. Women are given conventional sex hormone replacement. When fertility is required both sexes require parenteral gonadotrophins.

Frequency of follow up depends on the size of the residual tumour, the presence or absence of residual visual field defects, and the possibility of further endocrine loss following radiotherapy. If there are no changes in pituitary imaging, hormonal status, or visual fields in the first two to three years after the operation magnetic resonance imaging can eventually be limited to once every three to five years.

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Correction

Impotence: diagnosis and management of male erectile dysfunction

A printer's error occurred in this article by Roger S Kirby (9 April, pp 957-61). In the second paragraph on p 960 the dose of prostaglandin E1 should be 20-40 μg [not 20-40 mg).

A PATIENT WHO CHANGED MY PARISH

An instant conversion

The church to which I had been appointed to serve my title as a curate was an ancient parish church in a village which had been swallowed up by a large housing estate. Although most of the population lived on the estate, the congregation attracted several well to do people who remembered the village as it had been years ago. On the first Sunday after my ordination I was instructed by the vicar to stand by the main door at the end of the service and to introduce myself to the congregation. A tall elderly lady bore down on me. As I shook her hand I noticed that her fingers were covered with bandages. "Yes," she said, "My doctor says it's septic arthritis." I glanced at her face. Beneath the expensive hat and above the gold earring there was a tiny white nodule on the pinna of her ear. "I wonder," I remarked, "whether it could be gout?"

I realised immediately that this was injudicious. Clearly, gout for Mrs C implied a life of dissipation. She drew herself up to her full height and stalked off down the church path. On my first Sunday I had succeeded in alienating an influential parishioner. But her doctor must have thought enough of my diagnosis to arrange a blood test, for by the following Friday I received a telephone call from the lady herself: "I've got gout. I've got gout." With appropriate treatment her tophi vanished quickly. From that time on I had no warmer supporter in the parish and no more active unlocker of doors than Mrs C.—KEITH LEIPER *was a general practitioner and is now a clergyman in Lancashire*