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Preference is given to the letters commenting on contributions published recently in the *JRSM*. They should not exceed 300 words and should be typed double spaced.

## Who needs growth hormone?

I read with interest the Editorial by Drs Stirling and Kelnar (September 1994 *JRSM*, pp 497–8). I write because I am amazed that the authors did not address the issue of continuing growth hormone treatment in children after achieving final height. It is now 5 years since the first two reports of double-blind placebo-controlled trials of growth hormone replacement showed unequivocal and substantial benefits in adults with growth hormone deficiency[1,2]. This is a rapidly moving field in adult endocrinology and there are now numerous papers confirming and extending these original reports.

The considerable benefits (very briefly) are in three main areas:

1 Body composition: increased lean tissues, reduced body fat (particularly central)
2 Metabolism: increased metabolic rate, increased protein synthesis, increased strength and work capacity and improved lipid profile
3 Quality of life: improved mood, increased energy, reduced social isolation

The latter points are particularly impressive and important and cast doubt on the previous view that 'social isolation' in children with growth hormone deficiency was secondary to short stature. The same symptoms are present in adults (of normal stature) with growth hormone deficiency and are completely cured by growth hormone replacement under strict double-blind placebo-controlled conditions[3].

The continuation of lifelong growth hormone replacement in children with growth hormone deficiency after longitudinal growth has ceased is an important issue that paediatric endocrinologists are considering world-wide.

Although growth hormone treatment is expensive and growth hormone itself does not yet have a product licence for 'hormone replacement' in adults, it can be prescribed on the NHS by general practitioners on the advice of a specialist.

One must ask why it now takes so long to get a product licence for replacement therapy with an essential and 'natural' hormone? Would the same problems arise now with cortisol and thyroxine if they were only recently shown to be needed?

**Peter Sönksen**
Division of Medicine, St Thomas's Hospital, Lambeth Palace Road, London SE1 7EH, UK

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2 Salomon F, Cuneo RC, Hesp R, Sönksen PH. The effects of treatment with recombinant growth hormone on body composition and metabolism in adults with growth hormone deficiency. *N Engl J Med* 1989;**321**:1789–803
3 McGauley GA, Cuneo RC, Salomon F, Soünksen PH. Psychological well-being before and after growth hormone treatment in adults with growth hormone deficiency. *Horm Res* 1990;**33**(suppl 4):52–4

## The first medical publication

Perhaps Nicholas Culpeper's *The English Physitian*, Boston 1708, was the first medical *book* to appear in America as Olav Thulesius says (September 1994 *JRSM*, pp 552–6), but it was certainly not the first medical publication. Thomas Thacher's *A Brief Rule to Guide the Common-People of New-England How to Order Themselves and Theirs in the Small Pocks* appeared in Boston in 1677, and was reprinted there in 1702 and 1721.

Before 1677 any North American physician seeking advice about a disease that had already been epidemic for 40 years could only turn to the Latin editions of Rhazes' (ninth century) or Sydenham's (1666 *et seq.*) texts. Thacher seems to have drawn on both in producing his English language *Guide*. As can be seen from its printing history, it was widely read.

Facsimile reproductions of the three editions, with an introductory essay by Henry R Viets, were published by The Johns Hopkins Press, Baltimore, USA in 1937.

**Ross Kessel**
Shute Hill, Malborough, Devon TQ7 3SF, UK

## Sheehan's syndrome

I note that post-partum pituitary haemorrhagic infarction, leading to hypopituitarism, is nowadays referred to as Sheehan's syndrome in the British endocrine literature. But Harold L Sheehan of Liverpool published his paper under the heading of 'Simmonds' disease due to postpartum necrosis of the anterior pituitary following postpartum haemorrhage'[1], because it was Morris Simmonds (1855–1925) of Hamburg who gave, what was thought to be, the first clinical account of the result of atrophy of the anterior lobe due to septic puerperal infection of it, in 1914[2]. The name of 'Simmonds' disease was introduced in 1922 by L Lichtwitz[3]. Simmonds thought that the arteries of the anterior lobe are endarteries, which would explain the risks in the case of puerperal sepsis, syphilis, tuberculosis, but there were patients where the anterior lobe was destroyed by a cyst or a tumour. Later it was found that L K Glinski of Cracow had published a case history of postpartum necrosis of the anterior lobe of the pituitary a year before Simmonds (in 1913), but, unfortunately, in the Polish language, which was, therefore, overlooked[4,5]. Simmonds' 'syndrome' was described as severe panhypopituitarism in the absence of a pituitary tumour and *not* a sequence of childbirth.

**V C Medvei**
38 Westmoreland Terrace, London SW1V 3HL, UK

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1 Sheenan HC. Simmonds disease due to postpartum necrosis of the anterior pituitary