

JUNE 2004 | VOLUME 29 | NUMBER 3

ENDOCRINE NEWS

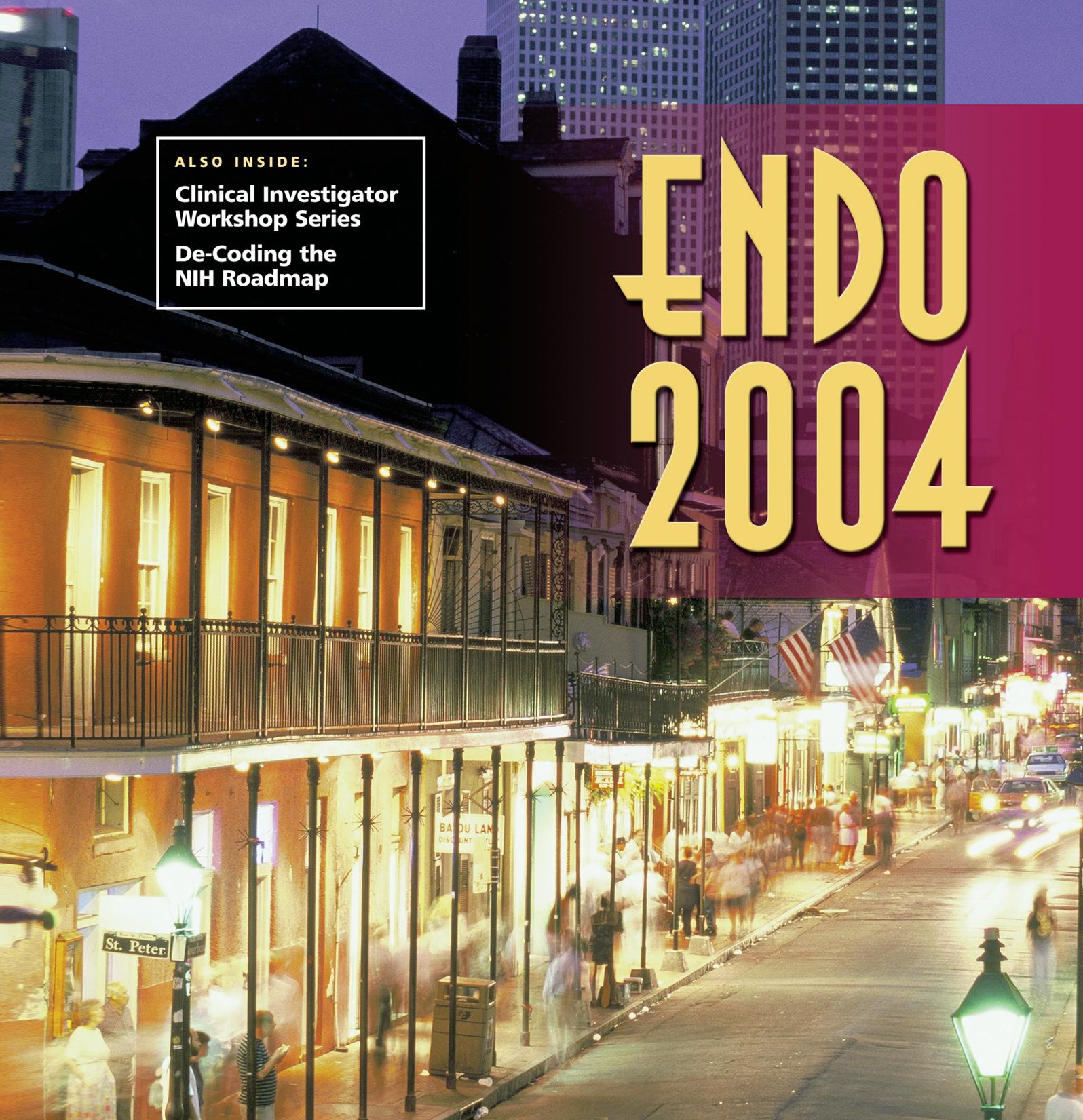
NEWS AND INFORMATION FOR THE ENDOCRINE COMMUNITY

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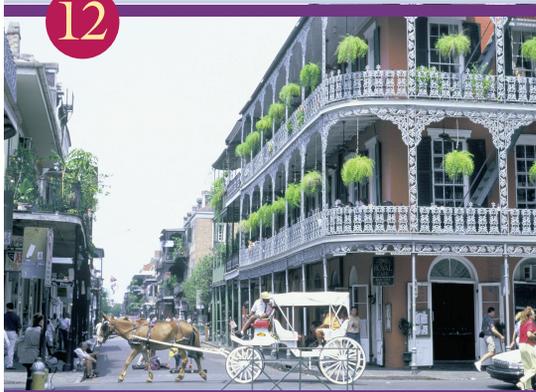
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Focus: Obesity, Endocrinology
and the Future

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Endocrine News is published by

THE ENDOCRINE SOCIETY

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Design: IconoGraph Designs, Inc. 1-301-590-2915



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- 2 As not-for-profit publishers, we reinvest all of the revenue from our journals in the direct support of science worldwide, including scholarships, scientific meetings, grants, educational outreach, advocacy for research funding, the free dissemination of information for the public, and improvements in scientific publishing.**
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- 5 We will continue to work with authors, peer-reviewers, and editors for the development of robust online and electronic tools to improve efficiency of their important intellectual endeavors.**
- 6 We strongly support the principle that publication fees should not be borne solely by researchers and their funding institutions, because the ability to publish in scientific journals should be available equally to all scientists worldwide, no matter what their economic circumstances.**
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The Washington DC Principles is a commitment from 50 (and growing) medical/scientific societies and publishers to provide free access and wide dissemination of published research findings.

The DC Principles provide what has been called the needed "middle ground" in the increasingly heated debate between those who advocate immediate unfettered online access to medical and scientific research findings and advocates of the current journal publishing system. The document was drafted in response to recent claims that these publishers' practices hinder the public's ability to access published scientific research.



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Congress Begins Appropriations Process

Society President Testifies in Support of NIH Budget Increase

Congress has taken the first step of the Fiscal Year (FY) 2005 federal appropriations process by addressing the FY 2005 Budget Resolution. Both the House and the Senate have passed their versions of the resolution. It now awaits agreement in a conference committee before final passage through Congress. During deliberations in the Senate, Senator Arlen Specter successfully passed an amendment to the budget resolution that would increase discretionary health funding by an additional two billion dollars. A similar effort failed in the House. Final spending limits, reportedly agreed to by the conference committee, hold total discretionary spending to \$821 billion for FY 2005. This is two billion dollars less than the President's budget request. While Congress can begin the appropriations process without passage of the budget resolution, a budget resolution would provide a framework for appropriators to abide by during the appropriations process. A budget resolution would also provide an automatic extension of the federal debt limit, which will be needed to pass this year's budget.

During the month of April, Society-supported legislation limiting the sales of steroid precursors, such as androstenedione, won approval by both the House Energy and Commerce and the House Judiciary Committees. The legislation now awaits a vote from the entire House body. This legislative action comes at the heels of The Food and Drug Administration's ban on all sales of androstenedione in early March. The legislation (HR 3866) would add several new substances to the list of banned substances and provide increased penalties for any individual who traffics in

steroids within 1,000 feet of an athletic facility. Additionally, the legislation was amended by the Subcommittee on Crime, Terrorism, and Homeland Security to include a requirement that the Department of Health and Human



Dr. Chip Ridgway, President, The Endocrine Society, meets with Congresswoman Diana DeGette, (D-CO) on Capitol Hill

Services (HHS) and the Department of Justice report to the House and Senate Committees on the Judiciary within two years regarding the need to add additional dangerous substances to the list.

Society President Takes to the Hill—Twice

On February 25, Society President Dr. Chip Ridgway traveled to Washington, to meet with Congressional leaders and the Department of HHS on federal funding issues and obesity. Dr. Ridgway's visit included a meeting with the office of Senate Majority Leader Bill Frist to gauge support for congressional initiatives to combat obesity. Dr. Ridgway's next stop was Senator Arlen Specter's office to discuss appropriations to the National Institutes of Health (NIH). A long time supporter of NIH, Senator Specter indicated that he would continue to fight for

increased levels of funding for NIH throughout the appropriations process. Dr. Ridgway then had the opportunity to personally thank Congresswoman Diana DeGette for her support of the Society's efforts on minority health disparities, obesity and endocrinologist workforce issues. As co-chair of the Congressional Diabetes Caucus, Rep. DeGette promised continued support for our joint efforts and our shared public health concerns. Finally, Dr. Ridgway met with the Office of Secretary Tommy Thompson (HHS) to discuss the Society's recently launched public awareness campaign regarding obesity. Discussions are now ongoing between the Society and HHS about how our two organizations can combine efforts to educate the public about the health concerns associated with obesity.

On April 27, Dr. Ridgway, was asked to testify before the House Appropriations Committee. The Appropriations Committee held hearings with limited opportunity for public testimony before deciding final appropriation recommendations to Congress. Dr. Ridgway testified on the importance of fully-funding the NIH and warned Congress about the dangers of a "soft landing" in the post doubling period (see full statement on page 9). Dr. Ridgway also expressed concerns about the need for NIH to address emerging public health concerns such as obesity and its related ailments, and that this is not the time to reduce our investment in medical research. **EN**

For more information about the society's legislative activities, please contact Chris Rorick, Government Relations Manager, at rorick@endo-society.org or 1-301-941-0254.

The following testimony was presented by The Endocrine Society's President E. Chester Ridgway, M.D., before the House Appropriations Subcommittee on Labor, Health and Human Services, and Education on April 27, 2004.

Mr. Chairman and members of the subcommittee, I would like to thank you for the opportunity to testify today before your committee. I am the Fredric C. Hamilton Professor of Medicine at the University of Colorado Health Science Center. In my professional career I see patients with Endocrine Disorders like thyroid disease, pituitary disease, diabetes, and obesity. I also do both clinical and basic science research in Endocrinology. I am here today as the current President of The Endocrine Society. The Endocrine Society is the world's largest and most active professional organization of endocrinologists representing over 12,000 members worldwide. Our organization is dedicated to promoting excellence in research, education and clinical practice in the field of endocrinology.

The Centers for Disease Control recently announced that obesity is now the number two preventable cause of death among Americans, trailing only tobacco use. More than 64 percent of Americans are overweight or obese. Most alarming is that childhood obesity has tripled since 1970. In addition, there is now clear and compelling evidence that racial and ethnic minorities, as well as those with lower socioeconomic status are disproportionately affected by obesity and related ailments such as diabetes.

Everyday we are bombarded by news accounts and newly released statistics that show obesity is becoming the number one health concern in the nation. We must now ask ourselves what role the government has in helping to stem the tide of obesity. The National Institutes of Health (NIH) asked itself this very same question in April 2003, when NIH Director, Dr. Elias Zerhouni, created the NIH Obesity Research Task Force. The goal of the task force was to

examine obesity as a public health concern and determine its relevance to NIH's mission. The task force released its draft Strategic Plan for Obesity Research in February of this year. In summary, the plan calls for NIH to undertake research that explores preventing and treating obesity through lifestyle modification; pharmacologic and surgical approaches and research that further examines the link between obesity and its associated health conditions.

After reviewing the draft plan I have faith in both the task force members and NIH leadership and believe they are on the right track to identifying the government's role in combating obesity. However, I am left asking the question: How will NIH fund these, and other, vital objectives with recent annual budget appropriations far below historical increases.

As this committee is aware, Congress made a strong commitment to NIH from 1998-2003 and sent a message that biomedical research was important to our country's future. Those at NIH and those who depend on NIH for research funding received this message loud and clear and responded in kind. There are multiple examples of real scientific breakthroughs and benefit to the people of the United States from NIH sponsored research in obesity related research. I will only mention two examples. First, the discovery of the hormone Leptin by Jeff Friedman at the Rockefeller Institute opened a whole new dimension to the field of Obesity. Leptin is a substance produced by our fat cells that travels in the bloodstream to the brain where it is one of the controls on appetite. This terrific discovery established the principal that fat cells can communicate with the brain and influence metabolic processes. Since this

discovery there have been many more NIH sponsored discoveries demonstrating that other organs like the pancreas, the GI tract, in addition to fat cells, can produce substances that control appetite and metabolism. We are right at the threshold of understanding how



Dr. Ridgway testifies on April 27, 2004 before the House Appropriations Committee.

our bodies control weight and how we might use this knowledge to cure obesity. As you may know there are currently only two FDA approved drugs for the long term treatment of obesity. Neither is fully effective. We, as doctors, and the American population, as patients, need better medications based on the knowledge we will gain from NIH sponsored research.

Second, one of the most devastating complications of Obesity is the development of Type 2 Diabetes Mellitus and the Metabolic Syndrome. The NIH sponsored Diabetes Prevention Program firmly established that a 7-8% drop in body weight can decrease the burden of Type 2 Diabetes Mellitus by more than 50%. One is left to wonder what would happen to the prevalence of Type 2 Diabetes if obese patients could be dropped all the way to ideal body weight. Not only do these break-

Continued on page 8.

Keeping you informed about endocrinology in the news

Almost everyday, new developments in endocrinology are featured in the news. In each issue of Endocrine News, Endocrine Edge will highlight some of the recent news stories.

Estrogen

The April issue of the *Journal of the American Medical Association* (JAMA) reported data from the estrogen-only arm of the Women's Health Initiative (WHI) study. The clinical trial, led by Dr. Heidi D. Nelson and researchers at the Oregon Health and Science University, revealed that, on average, the hormone caused 12 more strokes and six additional venous blood clots per 10,000 women each year. The findings also showed that estrogen therapy for post-menopausal women benefited

bone health, but did not provide protection against heart disease.

EN

For more information please visit <http://jama.ama-assn.org>

Prostate Cancer

Prostate cancer is the second most common cancer in men, after skin cancer, affecting one in six men. A recent study published in the *Journal of the American Medical Association* (JAMA) reports that frequent sexual activity does not increase the risk of developing prostate cancer and might even

reduce the danger. The study was led by Dr. Michael F. Leitzman and researchers at the National Institutes of Health (NIH). **EN**

For more information please visit <http://jama.ama-assn.org>

Osteoporosis

According to research published in *The Journal of Clinical Endocrinology & Metabolism* older women with low levels of vitamin B-12 are more likely to experience rapid bone loss. The new findings help to establish the importance of vitamin B-12 in the bone health of women as they age. The study was led by Dr. Katie Stone and researchers at the University of California—San Francisco. **EN**

For more information please visit <http://jcem.endojournals.org/>

Appropriations Testimony

Continued from page 7.

throughs save lives but they save taxpayer dollars as well.

As obesity looms on the horizon as our next great public health concern we need to provide NIH with the resources it needs to carry out, not only the objectives identified in its Obesity Research Strategic Plan, but other ongoing NIH projects and initiatives. To support these goals Congress must appropriate NIH with an 8-10 percent budget increase so that we can maintain the progress we have made in recent years. Congress has funded NIH at an average eight percent annual growth rate over the last 30 years—now is not the time to reduce that commitment.

The current Administration request of a 2.6 percent increase for NIH would translate into 640 fewer grants than in FY2004 after funding 258 fewer grants in 2004

than in 2003. In addition, NIH will be forced to reduce the cost of ongoing projects to only a 1.3 percent cost of living increase. According to the Biomedical Research & Development Index, the inflation rate for biomedical research for recent years has been 3.5 percent. In effect not only will a 2.6 percent increase nullify project growth, it will reduce funding to existing projects as well.

I am well aware of the budget constraints that this committee and Congress are under, but I ask that you consider appropriations to NIH as an investment in our nation's health and not as an expenditure. The Centers for Disease Control estimates that U.S. obesity-attributed medical expenditures reached \$75 billion in 2003 and that taxpayers financed about half of these costs through Medicare and Medicaid. Conversely, a recently released report by Advanced Medical Technology Association suggests that, in the past 20 years, each dollar spent on health

care services has produced health gains valued at \$2.40 to \$3.00—that's a 300 percent return on your investment. In addition, based on a study of claims data for Medicare patients with Type 2 Diabetes, every additional dollar spent on the overall treatment of this condition has produced health gains valued at \$1.49.

Mr. Chairman and members of the subcommittee, doubling of the NIH Budget between 1998 and 2003 was a noble effort. Completely sequencing the human genome was a marvelous downstream benefit. It is like our robotic space probes on Mars; it is but a beginning. All the downstream exploration and translation of the new knowledge is ahead of us. The promise and hope for alleviating the serious health burdens of our citizens, as illustrated by the problem of Obesity, is also ahead of us in our future. Thank you for inviting me to testify today and thank you for your past and future support for medical research. **EN**

Endocrine Society, Hormone Foundation Launch National Campaign on Endocrinology, Obesity

In January, The Endocrine Society and its patient education affiliate, The Hormone Foundation, launched a national campaign to educate the public, the media and Congress about endocrinology and obesity. With 30 percent of American's obese and another 64 percent overweight, the campaign, titled "America Weighs In," is designed to improve awareness, understanding and appreciation for the important role that endocrinology plays in obesity research, prevention, diagnosis and treatment. Staff from both organizations is working with an experienced team from Ketchum Public Relations in Washington, DC to carry out the campaign, which was initiated by the Society's Media Advisory Committee in June 2003.

"We are in the midst of an epidemic of obesity in adults and children. A good portion of the research on the metabolic and clinical consequences of obesity and their treatment has been performed by endocrinologists. Therefore, it is important that The Endocrine Society take a leadership role in educating the public about this issue," noted Dr. Braunstein, Chair of the Media Advisory Committee.

"America Weighs In" includes a variety of activities intended to familiarize the three audiences with endocrinology's role in researching and treating obesity. The campaign's programs include:

- **The Endocrine Society Weighs In**—The first stage of the campaign began in January with a survey of The Endocrine Society's clinician members to gather information about their

views on obesity. The findings, which will be used for public relations activities throughout the year, help to clearly demonstrate how obesity impacts clinical endocrinologists.

- **Weighing In Now (WIN)**—A "rapid response" system has been developed to help the Society and the Foundation respond to news trends on obesity. The WIN program also includes a speaker's bureau and proactive media outreach on obesity and endocrinology. Finally, the *WIN Award* will be established to recognize a reporter who has covered obesity with a fair and balanced story.

- **Obesity in America**—The centerpiece of "America Weighs In" is a resource guide for the media and Congress titled *The Endocrine Society Weighs In: A Handbook on Obesity in America*. The guide will include the latest statistics and facts about obesity along with information about the role of endocrinologists in treating obesity and related diseases as well as the latest endocrine research into obesity. The content of the guide will be directed by an advisory board of endocrine experts in obesity.

- **Patients Weigh In**—Pairs of endocrine patients and clinicians/researchers have been identified to help demonstrate the impact of endocrine research on patient care. These pairs will speak with

reporters throughout the year to put a "face" on the endocrine researchers, clinicians and patients who are battling the obesity epidemic.

- **Congress Weighs In**—During the past year, The Society has been extremely active on Capitol Hill on the issue of obesity. "Congress Weighs In" will build upon these successes and will help to raise the visibility of The Endocrine Society and endocrinologists among the nation's policy makers. Materials from the campaign, including *Obesity in America*, will be shared with the Society's lobbyists to support existing efforts on the Hill.

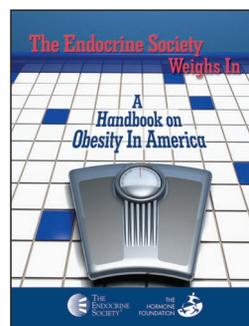
- **www.obesityinamerica.org**—Portions of the *Obesity in America* resource guide as well as other information on obesity will be compiled into a Web site: www.obesityinamerica.org The

Web site will be an excellent resource for patients, reporters and anyone else seeking information about obesity.

The *Obesity in America* guide as well as the campaign Web site, www.obesityinamerica.org will launch at ENDO 2004

in New Orleans. Look for information about the campaign's activities and successes in future issues of *Endocrine News*. **EN**

For more information about the Society's public relations activities, please contact Marisa Lavine, Associate Director, Public Relations, at mlavine@endo-society.org or 1-301-941-0255.



De-Coding The NIH Roadmap: New Opportunities for Endocrine Researchers

By: *Steven K. Grinspoon, M.D. and Kelly E. Mayo, Ph.D.*

Dr. Elias Zerhouni, Director of the National Institutes of Health (NIH), recently announced a new initiative—the NIH Roadmap for Medical Research. The Roadmap is a set of initiatives designed to foster interdisciplinary research that transcends usual institutional boundaries and bureaucratic barriers. It has the goal of accelerating fundamental discovery and translating that knowledge into effective prevention strategies and new treatments.



*Dr. Steven K. Grinspoon,
Co-Chair, Research
Affairs Committee*



*Dr. Kelly E. Mayo,
Co-Chair, Research
Affairs Committee*

The Roadmap was developed in a year-long process that involved extensive consultation with the scientific community, health care providers, and the public. The process represented a significant re-evaluation of the fundamental way that the NIH and its institutes operate. The set of initiatives that emerged were designed around the following criteria:

- To be transforming, in the sense of changing how biomedical research is conducted;
- To encourage synergism between various institutes and centers of the NIH;
- To be items the NIH could not afford not to do;
- To be compelling to all stakeholders, including the public;
- To uniquely position the NIH to carry out research that other entities cannot or will not undertake.

The Roadmap features new pathways, proposes new research teams and highlights the importance of training in a series of ongoing announcements and RFA's for research funding. Given the major role taken by Endocrine Society members in NIH research (there are more than 2500 NIH funded grants led by Endocrine Society members), this new initiative is of great importance to The Endocrine Society and its members. The Roadmap initiatives were recently discussed by the Research Affairs Committee at its March meeting. This article is the first installment of what we anticipate will be regular updates on the NIH Roadmap as it unfolds. The following is a brief summary of current Roadmap initiatives, which fall into three major thematic groupings.

New Pathways to Discovery

This theme focuses on the development of technologies to understand complex biological systems. Five implementation groups have thus far been designated. 1) Building Blocks, Pathways and Networks will include new National Technology Centers to investigate the proteome, protein interactions and the metabolome (metabolic components and how they network within the cell). 2) Molecular Libraries and Molecular Imaging will support new screening centers for bioactive small molecules (to identify targets for medicinal chemistry) with an aim toward development of a public database of cheminformatics of compounds with potential for use as biological, drug development and imaging probes. 3) Structural Biology will support interdisciplinary efforts to produce proteins, particu-

larly membrane proteins, for eventual structure determination. 4) Bioinformatics and Computational Biology will develop a set of National Centers for Biomedical Computing and will create a national software engineering system. 5) Nanomedicine will begin planning a series of Nanomedicine Centers to focus on how molecular machines are constructed and how synthetic biological devices at the nanoscale can be built.

Research Teams of the Future

The focus of this theme is on stimulating new ways of combining skills and disciplines in both the physical and biological sciences. Numerous initiatives in three implementation groups were announced. 1) High-Risk Research will fund NIH Director's Innovator awards to individuals who have the potential to make extraordinary contributions to medical research. 2) Interdisciplinary Research will forge the formation of new research teams by supporting the training of scientists in interdisciplinary strategies, by creating new Interdisciplinary Research Centers, and by initiating new conference formats to catalyze collaborations between groups that have historically had little interaction. 3) Public-Private Partnerships will facilitate collaboration between the NIH and the private sector by establishing a public-private liaison and coordinating committee for this purpose.

Re-engineering the Clinical Research Enterprise

This theme is designed to accelerate and strengthen the clinical research process, so that researchers are better poised to translate basic discov-

eries into improved health care. Seven implementation groups will work toward 1) harmonization of clinical research, including efforts to streamline the federal processes for research approval and oversight; 2) promotion of integrated clinical research networks; 3) enhancement of clinical research workforce training through the creation of a cadre of NIH National Clinical Research Associates; 4) establishment of a National Electronic Clinical Trials and Research Network (NECTAR); 5) creation of translational research core services; 6) establishment of regional translational research centers; and 7) development of enabling technologies for improved assessment of clinical outcomes.

Frequently Asked Questions

At this time, a number of important questions are being asked by Society members regarding the NIH Roadmap:

How is the Roadmap to work, and how will it affect existing research performed by Society members?

The full impact of the Roadmap for Endocrine Society members is not yet known, but in spirit, the initiative seems well suited for the research efforts of Society members. We are a Society that embraces multiple constituencies in our basic researchers, clinical investigators and physicians-in-practice, and thus have the ability and breadth to cover the spectrum of initiatives being developed in the Roadmap. The Roadmap will be funded by money that has been set aside in the amount of \$128 million/year initially, rising to \$507 million/year over five years. This represents a relatively small fraction of the overall NIH budget, but a large amount in terms of absolute dollars that may be diverted toward new research initiatives. To the extent that this money is used to enhance endocrine research initiatives, the overall funding earmarked for the Roadmap will help Society

members. To the extent that funds are diverted from existing projects to fund new Roadmap initiatives that are not taken advantage of by Society members, the Roadmap may squeeze funding for new and existing endocrine researchers. Current plans are that Roadmap initiatives will compliment, rather than replace, more traditional investigator-initiated research, but overall NIH funding levels are likely to impact the extent to which this can be accomplished. As the overall context of the Roadmap is to expand and streamline research, it is likely to have an overall beneficial effect on the research efforts of Society members.

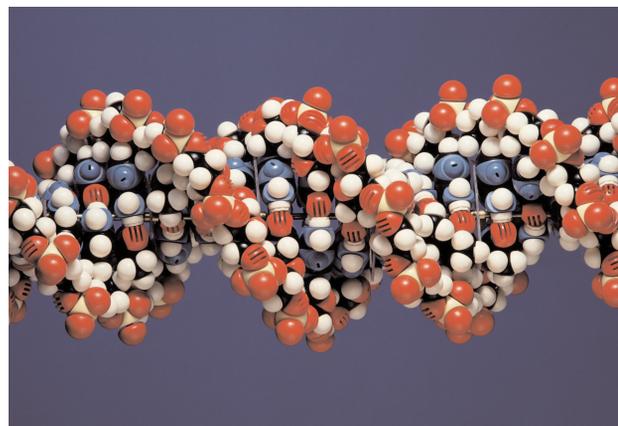
How do I become part of the Roadmap?

The best answer to this question is to be aware of the Roadmap initiatives through the Web site (listed below) or through NIH-sponsored meetings and symposia discussing the initiatives. Investigators should look at recently released Requests for Application (RFAs) to determine if any fit their research interests or needs. A number of the initial Roadmap RFA's for 2004 have already been released and submission deadlines have passed, but new funding opportunities are being announced all the time. In addition, talking to NIH program officers and looking at ways that the individual NIH institutes are accessing the Roadmap will likely be useful. For many members, it is also likely that your home institution is already initiating Roadmap-related activities in which you might participate.

How will the Roadmap affect my research career?

The Roadmap is designed to ultimately enhance research, and create new partnerships and teams of interdisciplinary researchers. Although many Society members form important collaborations and participate in center grants, many more lead their own individual research efforts through their own

R01 grants. Ultimately, the integrative nature of the research teams envisioned by the Roadmap may mean that more research is performed by large teams and networks rather than by individual researchers, which would represent a significant change in the scientific enterprise. It will be important for institutions and societies to lobby for recognition of the contributions made by individuals in the context of large integrated research teams, particularly with respect to the individual's professional advancement. The NIH is currently evaluating necessary strategies to encourage and recognize the important contributions of individuals in "team-based" research.



Where can I get more information?

An excellent overview article by NIH Director Dr. Elias Zerhouni was published in *Science* 302:63, 2003. The NIH also has a dedicated Roadmap Web site <http://nihroadmap.nih.gov/> that has substantial background information as well as a "What's New" section that lists RFA's as they are released and promotes Roadmap-related conferences. The Web site also has a link for joining the NIH Roadmap e-mail list, so subscribe now to get the latest Roadmap information. **EN**

For more information about the Research Affairs Committee activities please contact Janet Kreizman, Director of Program & Policy Affairs, at 1-301-941-0252 or email jkreizman@endo-society.org

Exciting Events Planned

JUNE 16–19, 2004 NEW ORLEANS, LOUISIANA

- Setting up a FREE practice Web site with MEDEM
- Accessing online patient information materials from The Hormone Foundation
- Preview the NEW Endocrine Society Web site—coming this fall (and receive a complimentary gift)

The Society Booth is also the place to find out how you can get involved in committee activities such as ethics, advocacy, Society elections and more. All ENDO 2004 attendees are encouraged to stop by!

Special ENDO 2004 Focus Events

Participate in these special activities planned in conjunction with the ENDO 2004 Focus on “Obesity, Endocrinology and the Future.”

- **Fit-for-Life Health Check**—How fit are you? Find out at this on-site health check center in the ENDO Exhibit Hall. The health check center will include several stations manned by experienced health care professionals. The following tests and activities have been planned to help you find out how fit you are:

- Height, weight, waist to hip ratio and
- body mass index (BMI)
- Blood pressure/stroke assessment
- Lipid panel and glucose testing
- Ankle-Brachial Index
- MedGem (measurement of resting
- metabolic rate-RMR)

- Computerized Nutrition Profile
- Ask the Registered Dietician

Supported by an unrestricted grant from Abbott Diagnostics.

- **ENDO Pedometers**—Keep track of the ground you cover in New Orleans with a clip-on pedometer. *Supported by an unrestricted grant from Takeda Pharmaceutical, North America, pedometers will be available at booth#1215 in the Exhibit Hall.*

- **Wake-up Walks**—The perfect way to put that pedometer to use! These free, professionally guided early morning walks are a great way to get exercise and see the historic neighborhoods of New Orleans. For schedule and details, visit www.endo-society.org/scimeetings/endo2004/tours.cfm

- **Special Sessions on Obesity Topics**—Select symposia, MTPs, and CME Sessions will focus on obesity-related issues, such as adipocyte biology, pediatric obesity, energy homeostasis, appetite regulation and the clinical management of obesity and related diseases. For a complete list of sessions, visit www.endo-society.org/scimeetings/endo2004

- **2004 Corporate Liaison Board Forum—Addressing the Obesity Epidemic: From Bench to Bedside to Market**—This special dinner forum will feature three topic areas with guest speakers presenting each sector’s own issues and perspectives on Obesity. From the FDA/Academia perspective, Dr. Robert Brackett

Stop by The Endocrine Society Booth at ENDO 2004

Visit The Endocrine Society Booth #921 at ENDO for the latest in membership and technology news. Become a member or update your Membership records; pick-up free copies of Society journals; and see this year’s History Exhibit. At the booth’s technology center, you can view Journals Online, ESAP and The Worldwide Endocrine Events Calendar as well as take in one of the live instructional presentations on these computer-related topics:

- Searching online using the High-Wire Library of The Sciences and Medicine

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ENDO 2004
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will discuss **Framing the Challenges in Obesity Research and Our Progress Toward Solution**. Dr. Allen Spiegel, Director, NIDDK (NIH Perspective), will address the topic **Impact of Obesity and Metabolic Syndrome on Human Health** and Dr. José Caro, Eli Lilly Research (Industry Perspective), will discuss **Emerging Concepts and Compounds in Obesity Therapeutics**. The evening will conclude with a question and answer session, moderated by CLB Co-Chair Dr. Andres Negro-Vilar, of Ligand Pharmaceuticals. This annual program furthers the CLB mission to maintain open dialogue among The Endocrine Society and industry by bringing topics of interest and opportunities for collaboration to the forefront, all benefiting endocrinology. To register, see the CMES Registration Form at www.endo-society.org/scimeetings/endo2004/ancillary.cfm

- **ENDO 2004 5K Run/ Walk**—This special 5K Run/ Walk (3.1 miles) benefiting The Hormone Foundation will be held in New Orleans scenic Audubon Park and is open to all ENDO attendees, friends and family. Water, juice and fruit will be provided for participants along with commemorative t-shirts. A small registration fee is required. For registration form and more information, visit www.endo-society.org/scimeetings/endo2004/special_run.cfm

Supported by an unrestricted grant from Glaxo Smith Kline.

Diversity Programs at ENDO 2004

- **Student Day Program** will take place on Wednesday, June 16, 2004 from 11:30 am to 3:30 pm at the New Orleans Marriott, La Galeries Room. Students who have attended short-courses in endocrinology will have an opportunity to hear an in depth endocrine presentation and an overview of the ENDO meeting.
- **Shortcourse Orientation Breakfast** will provide an overview of the undergraduate minority Shortcourse Program. The event will be held Thursday, June 17 from 7:00 am to 8:00 am at the Morial Convention Center, room 386. All members of the Society who are experienced educators with an interest in minority issues are encouraged to attend.
- **Minority Mentoring Reception** will provide an opportunity for minority students to network with Society mentors, faculty, post docs and fellows. This event will take place on Thursday, June 17, 2004 from 6:30 pm to 8:30 pm at the Sheraton New Orleans, Waterbury Room.

For more information, please visit the Web site at www.endo-society.org/diversity/activities.cfm or contact the Minority Affairs staff liaisons at mac@endo-society.org

For complete details on these and other ENDO activities, visit www.endo-society.org/scimeetings/endo2004

Stay Informed at ENDO 2004

Get the latest ENDO news with *ENDO Newslines* TV programming and the new *ENDO Daily* newspaper. Providing news coverage of ENDO events and interviews with key Society leadership, *ENDO Newslines* will air on monitors throughout the convention center and in most convention hotel rooms. Each day during the meeting, the *ENDO Daily* newsletter will print meeting updates and exciting information about events, activities and New Orleans attractions. *ENDO Daily* will be distributed at the convention center.

Don't Forget Your ENDO Gear!

Only at the ENDO Gear Stop (The Endocrine Society Store) can you find unique Endocrine Society items and special ENDO Gear for kids. Pick up your FREE ENDO 2005 luggage tag and browse among these great Society items:

- Special Publications: *RPHR, Vol. 59; 2003 CEU Syllabus*
- T-Shirts—Adult, Children, Toddlers
- CD holder
- Baby Bibs
- Denim Shirts
- Umbrellas
- Hats—Adult, Youth
- And More!

Learn about the beautiful city of San Diego



Pick up a free luggage tag and make program suggestions for next year's annual meeting at Booth# 1144 in the Exhibit Hall.

2004 Leadership Donors

In gratitude for their continued support of The Endocrine Society, the following 2004 Leadership Donors will be honored at a special Corporate Recognition Luncheon at ENDO 2004:

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Leadership Donors are companies who have contributed at least \$100,000 to the Society over the past year, with at least half being contributed towards educational activities.

Plan Ahead with ENDO Online Tools

- **Online Science/Itinerary Planner**—www.endo-society.org/scimeetings/index.cfm Access the full text of all accepted abstracts. Search through ENDO 2004 events and build a personalized schedule for the entire event. The Science/Itinerary Planner is also personal-desk-assistant (pda)-compatible. *This product is supported by an unrestricted grant from Eli Lilly & Company.*
- **Online Exhibit Planner**—www.endo-exhibitplanner.org/ Visit the exhibit database and interactive floor plan to create a customized exhibit planner that you can print out and bring with you to the ENDO 2004 Exhibit Hall. Browse through product descriptions and search by product category or company name and location. ■

Thank You ENDO 2004 Sponsors

Through their financial support of Plenary Sessions, Symposia, Meet-the-Professor Sessions, Awards, Travel Grants and other amenities, the following sponsors enable The Endocrine Society to provide accurate information and education to all ENDO 2004 attendees. Thank You!

Abbott Diagnostics ■ Abbott Laboratories ■ Abbott Renal Care ■ Paul F. Glenn Sponsorship Fund in cooperation with the American Federation for Aging Research ■ Amylin Pharmaceuticals ■ Astra Zeneca ■ Auxilium Pharmaceuticals, Inc. ■ Aventis Pharmaceuticals ■ Columbia Laboratories, Inc. ■ Diagnostic Products Corporation ■ Eli Lilly & Company ■ Genentech, Inc. ■ Genzyme Corporation ■ GlaxoSmithKline Pharmaceuticals ■ Ipsen Pharmaceuticals ■ King Pharmaceuticals ■ Merck & Co. ■ Merck Research Laboratories ■ NPS Pharmaceuticals ■ National Institutes of Health ■ Novartis Pharmaceuticals ■ Novo Nordisk Pharmaceuticals ■ Novo Nordisk/Novolog ■ Ortho-McNeil Pharmaceuticals, Inc. ■ Pfizer, Inc. ■ Procter & Gamble Pharmaceuticals ■ Quest Diagnostics ■ Sanofi Synthelabo Groupe ■ Serono ■ Solvay Pharmaceuticals, Inc. ■ Takeda Pharmaceuticals, North America ■ Yamanouchi Pharma America (*as of 4/7/04*)

CMES Symposia at ENDO 2004—Expanded Schedule of Programs Offered

The Special Programs Committee (SPC) of the Society has worked diligently since December 2003 to develop an outstanding selection of twenty-three breakfast and dinner symposia which will be presented during ENDO 2004 in New Orleans.

The CMES Symposia will present a diverse group of topics designed for clinical investigators and practitioners. Care has been given to minimize presentation overlap with the ENDO 2004 clinical symposia and to identify new speakers.

On Wednesday morning, June 16, CMES will also present "The Endocrinology of Pediatric Obesity," which is funded as one of the Society's Strategic Plan Initiatives and supports the meeting focus.

While many of the programs are supported by educational grants from industry, the program supporters are not involved with the development of the educational content. Each Program Director develops the educational content, which is reviewed and approved by both the SPC and the CME Advisory Committee.

As part of the evaluation process, each CMES program is evaluated by a CME Reviewer. These individuals are content experts who complete an expanded evaluation form that provides detailed information on the session. A summation of this information, as well as the general participant evaluations, is shared with the faculty and SPC members as well as the members of the CME Advisory Committee and the Meetings & Educational Programs Committee. CME Reviewers are recruited from these committees as well as the Trainee Development Committee, Clinical Affairs Committee and the Ethics Advisory Committee.

The list of CMES Symposia and registration information can be found on the Society's Web site at <http://www.endo-society.org/scimeetings/endo2004/ancillary.cfm> Advance registration is strongly encouraged.

If you are interested in serving as a CME Reviewer for a CMES Symposium, please contact Lisa Johnson, Associate Director, Education at ljohnson@endo-society.org prior to June 10 or see a Society staff person at the registration desk for the symposia.

SPOTLIGHT ON THE HISTORY PROJECT



The History Committee, chaired by Dr. Clark Sawin and staffed by Dr. Adolph Friedman, is pleased to present the 2004 History Exhibit at The Endocrine Society's Annual Meeting in New Orleans, Louisiana. The exhibit provides information to members and meeting attendees about major scientific discoveries and innovations that have shaped current endocrine research and treatment while adding a "human" element to the historical perspective via personal archives, photographs, scientific equipment and actual research from the pioneers behind the revolutionary work. The 2004 exhibit will showcase "The History of the Discovery and Production of Parathyroid Hormone (PTH)" and "Notable Women of The Endocrine Society."

Like many scientific breakthroughs, the discovery and production of PTH was not without its unique controversy. This year's exhibit focuses on Dr. Adolph M. Hanson and Dr. J.B. Collip, their ground-breaking work with parathyroid hormone in the early 1920's and the bitter conflict over discovery rights that arose between them. Personal letters, journal publications and photographs from Drs. Hanson and Collip will be on display. The History Committee chose to highlight this particular topic due to the discovery's significance in the 1920-1930 boom of hormone research as well as the vital role that PTH plays in the current treatment of endocrine conditions such as renal diseases and osteoporosis.

The 2004 History Exhibit will also honor notable women who have been instrumental in shaping not only The Endocrine Society but the field of endocrinology as a whole. The exhibit highlights these women, their leadership roles and the many honors and accolades that have been bestowed upon them for their exceptional work and dedication to science. Included are a Nobel prize winner and members of the National Academy of Sciences. Since the first woman joined The Endocrine Society in 1937, female membership has grown to 3,061. To further promote the professional development of female endocrinologists, Women in Endocrinology (WE) was formed as an affiliate of the Society in 1990. The History Committee expresses their gratitude to WE members and the many notable women who serve as exceptional role models for women and men alike.

The History Exhibit is just one part of the History Committee's overall commitment to educate members, physicians and students about the history of both the Society and endocrinology. The committee also aims to serve as a clearinghouse of information for all endocrinologists worldwide by compiling, researching and archiving past endocrine-related material for future use. Throughout the year, Dr. Adolph Friedman conducts interviews and collects memorabilia, photos and endocrine-related medical equipment in hopes of one day developing an Endocrine Society museum. Currently, the Society houses a display case of scientific artifacts, a library of donated books and a photo gallery of Society presidents. The committee also serves to preserve the history of its leadership by recording the personal interests and professional accomplishments of its past presidents with the intention that their anecdotes, historical artifacts and papers will generate a better understanding of endocrinology and inspire future leaders.

To find out more about the 2004 History Exhibit and the ongoing efforts of the History Committee, stop by and view the exhibit at The Endocrine Society Booth (#921) at ENDO 2004 or contact Dr. Adolph Friedman at afriedman@endo-society.org **EN**



Dr. J.B. Collip



Dr. Adolph M. Hanson

Help Shape the Future of Endocrinology by Preserving Its Past

In its ongoing efforts to enhance its archives and create more educational materials, the History Committee asks for your help! The Society is currently seeking donations of old texts, outdated endocrine-related medical equipment, personal documents and photographs. All contributions will be fully acknowledged and preserved at The Endocrine Society. If you have an item of interest, please contact Dr. Adolph Friedman at afriedman@endo-society.org or call 1-301-951-2607.

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Therapeutic equivalence among approved levothyroxine sodium tablets has not been established.

Levoxyl® is indicated for thyroid hormone replacement or supplemental therapy for hypothyroidism.

Levoxyl® is contraindicated in patients with untreated thyrotoxicosis, uncorrected adrenal insufficiency, or hypersensitivity to any of its inactive ingredients.

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**So give a little thought about *Levoxyl*[®]
for your new hypothyroid patients,
and give them that little bit more.**

WARNING: Thyroid hormones, including *Levoxyl*[®], either alone or together with other therapeutic agents, should not be used for the treatment of obesity. In euthyroid patients, doses within the range of daily hormonal requirements are ineffective for weight reduction. Larger doses may produce serious or even life-threatening manifestations of toxicity, particularly when given in association with sympathomimetic amines such as those used for anorectic effects.

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CONTRAINDICATIONS
Levothyroxine is contraindicated in patients with untreated subclinical (suppressed serum TSH level with normal T₄ and T₃ levels) or overt thyrotoxicosis of any etiology and in patients with acute myocardial infarction. Levothyroxine is contraindicated in patients with uncorrected adrenal insufficiency since thyroid hormones may precipitate an adrenal crisis by increasing the metabolic clearance of glucocorticoids (see **PRECAUTIONS**). LEVOXYL® is contraindicated in patients with hypersensitivity to any of the inactive ingredients in LEVOXYL® tablets (see **DESCRIPTION**, **Inactive Ingredients**).

WARNINGS
Warning: Thyroid hormones, including LEVOXYL®, either alone or with other therapeutic agents, should not be used for the treatment of obesity or weight loss. In euthyroid patients, doses within the range of daily hormonal requirements are ineffective for weight reduction. Larger doses may produce serious or even life threatening manifestations of toxicity, particularly when given in association with sympathomimetic amines such as those used for their anorectic effects.

Levothyroxine sodium should not be used in the treatment of male or female infertility unless this condition is associated with hypothyroidism.
In patients with nontoxic diffuse goiter or nodular thyroid disease, particularly the elderly or those with underlying cardiovascular disease, levothyroxine sodium therapy is contraindicated if the serum TSH level is already suppressed due to the risk of precipitating overt thyrotoxicosis (see **CONTRAINDICATIONS**). If the serum TSH level is not suppressed, LEVOXYL® should be used with caution in conjunction with careful monitoring of thyroid function for evidence of hyperthyroidism and clinical monitoring for potential associated adverse cardiovascular signs and symptoms of hyperthyroidism.

PRECAUTIONS
General
Levothyroxine has a narrow therapeutic index. Regardless of the indication for use, careful dosage titration is necessary to avoid the consequences of over- or under-treatment. These consequences include, among others, effects on growth and development, cardiovascular function, bone metabolism, reproductive function, cognitive function, emotional state, gastrointestinal function, and on glucose and lipid metabolism. Many drugs interact with levothyroxine sodium necessitating adjustments in dosing to maintain therapeutic response (see **Drug Interactions**).

Effects on bone mineral density – In women, long-term levothyroxine sodium therapy has been associated with decreased bone mineral density, especially in postmenopausal women on greater than replacement doses or in women with osteoporosis receiving replacement doses of levothyroxine sodium. Therefore, it is recommended that patients receiving levothyroxine sodium use the minimum dose necessary to achieve the desired clinical and biochemical response.
Patients with underlying cardiovascular disease – Exercise caution when administering levothyroxine to patients with cardiovascular disorders and to the elderly in whom there is an increased risk of occult cardiac disease. In these patients, levothyroxine therapy should be initiated at lower doses than those recommended in younger individuals. In patients without cardiac disease (see **WARNINGS**, **PRECAUTIONS**, **Geriatric Use**, and **DOSE AND ADMINISTRATION**), if cardiac symptoms develop or increase with levothyroxine dose should be reduced or withheld for one week and then cautiously restarted at a lower dose. Over-treatment with levothyroxine sodium may have adverse cardiovascular effects such as an increase in heart rate, cardiac thickness, and cardiac contractility and may precipitate angina or arrhythmias. Patients with coronary artery disease who are receiving levothyroxine therapy should be monitored closely during surgical procedures, since the possibility of precipitating cardiac arrhythmias may be greater in those treated with levothyroxine. Concomitant administration of levothyroxine and sympathomimetic agents to patients with coronary artery disease may precipitate coronary insufficiency.

Patients with nontoxic diffuse goiter or nodular thyroid disease – Exercise caution when administering levothyroxine to patients with nontoxic diffuse goiter or nodular thyroid disease in order to prevent precipitation of thyrotoxicosis (see **WARNINGS**). If the serum TSH is already suppressed, levothyroxine sodium should not be administered (see **CONTRAINDICATIONS**).

Associated endocrine disorders
Hypothalamic/pituitary hormone deficiencies – In patients with secondary or tertiary hypothyroidism, additional hypothalamic/pituitary hormone deficiencies should be considered, and, if diagnosed, treated (see **PRECAUTIONS**, **Adverse Reactions**, **Endocrine Disorders**, and **Drug Interactions**).
Autism spectrum disorders – Occasionally, chronic autoimmune thyroiditis may occur in association with other autoimmune disorders such as adrenal insufficiency, pernicious anemia, and insulin-dependent diabetes mellitus. Patients with concomitant adrenal insufficiency should be treated with glucocorticoid therapy prior to initiation of levothyroxine sodium. Failure to do so may precipitate an acute adrenal crisis when thyroid hormone therapy is initiated, due to increased metabolic clearance of glucocorticoids by thyroid hormone. Patients with diabetes mellitus may require upward adjustments of their antidiabetic therapeutic regimens when treated with levothyroxine (see **PRECAUTIONS**, **Drug Interactions**).

Other associated medical conditions
Infants with congenital hypothyroidism appear to be at increased risk for other congenital anomalies, with cardiovascular anomalies (pulmonary stenosis, atrial septal defect, and ventricular septal defect), being the most common association.

Information for Patients
Patients should be informed of the following information to aid in the safe and effective use of LEVOXYL®:

1. Notify your physician if you are allergic to any foods or medicines, are pregnant or intend to become pregnant, are breast-feeding or are taking any other medications, including prescription and over-the-counter preparations.
2. Notify your physician if any other medical conditions you may have, particularly heart disease, diabetes, clotting disorders, and adrenal or pituitary gland problems. Your dose of medications used to control these other conditions may need to be adjusted while you are taking LEVOXYL®. If you have diabetes, monitor your blood and/or urinary glucose levels as directed by your physician. Do so immediately report any changes to your physician. If you are taking anticoagulants (blood thinners), your clotting status may be affected by your physician.
3. Use LEVOXYL® only as prescribed by your physician. Do not discontinue or change the amount you take or how often you take it, unless directed to do so by your physician.
4. The levothyroxine in LEVOXYL® is intended to replace a hormone that is normally produced by your thyroid gland. Generally, replacement therapy is necessary in cases of permanent or transient hypothyroidism, which is usually associated with an inflammation of the thyroid gland (thyroiditis).
5. Take LEVOXYL® in the morning on an empty stomach, at least one-half hour before eating any food.
6. It may take several weeks before you notice an improvement in your symptoms.
7. Notify your physician if any of the following symptoms occur: rapid or irregular heartbeat, chest pain, shortness of breath, leg cramps, headache, nervousness, irritability, sleeplessness, tremors, change in appetite, weight gain or loss, vomiting, diarrhea, excessive sweating, heat intolerance, fever, changes in menstrual periods, rashes or skin rash, or any other unusual medical event.
8. Notify your physician if you become pregnant while taking LEVOXYL®. It is likely that your dose of LEVOXYL® will need to be increased during pregnancy.
9. Notify your physician or dentist that you are taking LEVOXYL® prior to any surgery.
10. Partial hair loss may occur rarely during the first few months of LEVOXYL® therapy, but this is usually temporary.
11. LEVOXYL® should not be used as a primary or adjunctive therapy in a weight control program.
12. Keep LEVOXYL® out of the reach of children. Store LEVOXYL® away from heat, moisture, and light.

Laboratory Tests
Serum TSH
The diagnosis of hypothyroidism is confirmed by measuring TSH levels using a sensitive assay (second generation assay sensitivity 0.1 mIU/L or third generation assay sensitivity 0.01 mIU/L) and measurement of free T₄.

The adequacy of therapy is determined by periodic assessment of appropriate laboratory tests and clinical evaluation. The choice of laboratory tests depends on various factors including the etiology of the underlying thyroid disease, the presence of concomitant medical conditions, including pregnancy, and the use of concomitant medications (see **PRECAUTIONS**, **Drug Interactions**, and **Drug-Laboratory Test Interactions**). Persistent clinical and laboratory evidence of hypothyroidism despite an apparent adequate replacement dose of LEVOXYL® may be evidence of inadequate absorption, poor compliance, drug interactions, or decreased T₄ potency of the drug product.

Adults
In adult patients with primary (thyroidal) hypothyroidism, serum TSH levels (using a sensitive assay) alone may be used to monitor therapy. The frequency of TSH monitoring during levothyroxine dose titration depends on the clinical situation and is generally recommended as 4-6 week intervals until normalization. For patients who have recently initiated levothyroxine therapy and whose serum TSH has normalized or in patients who have had their dosage or brand of levothyroxine changed, the serum TSH concentration should be measured after 8-12 weeks. When the optimum replacement dose has been attained, clinical (physical examination) and biochemical monitoring may be performed every 6-12 months, depending on the clinical situation, and whenever there is a change in the patient's status. It is recommended that a physical examination and a serum TSH measurement be performed annually in patients receiving LEVOXYL® (see **WARNINGS**, **PRECAUTIONS**, and **DOSE AND ADMINISTRATION**).

Pediatrics
In patients with congenital hypothyroidism, the adequacy of replacement therapy should be assessed by measuring both serum TSH (using a sensitive assay) and total- or free- T₄. During the first three years of life, the serum total- or free- T₄ should be maintained at all times in the upper half of the normal range. While the aim of therapy is to also normalize the serum TSH level, this is not always possible in a small percentage of patients, particularly in the first few months of therapy. TSH may not normalize due to a resetting of the pituitary-thyroid feedback threshold as a result of an *in utero* hypothyroidism. Failure of the serum T₄ to increase into the upper half of the normal range within 2 weeks of initiation of LEVOXYL® therapy and/or of the serum TSH to decrease below 20 mIU/L within 4 weeks should alert the physician to the possibility that the child is not receiving adequate therapy. Careful inquiry should then be made regarding compliance, dose of medication administered, and method of administration prior to raising the dose of LEVOXYL®.
The recommended frequency of monitoring of TSH and total- or free- T₄ in children is as follows: at 2 and 4 weeks after the initiation of treatment; every 1-2 months during the first year of life; every 2-3 months between 1 and 3 years of age; and every 3 to 12 months thereafter until growth is completed. More frequent intervals of monitoring are warranted if compliance is suspected or abnormal values are observed. It is recommended that TSH and T₄ levels, and a physical examination, if indicated, be performed 2 weeks after any change in LEVOXYL® drug. Routine clinical examination, including assessment of mental and physical growth and development, and bone maturation, should be performed at regular intervals (see **PRECAUTIONS**, **Pediatric Use** and **DOSE AND ADMINISTRATION**).

Secondary (pituitary) and tertiary (hypothalamic) hypothyroidism
Adequacy of therapy should be assessed by measuring serum free-T₄ levels, which should be maintained in the upper half of the normal range in these patients.

Drug Interactions
Many drugs affect thyroid hormone pharmacokinetics and metabolism (e.g., absorption, synthesis, secretion, catabolism, protein binding, and target tissue response) and may alter the therapeutic response to LEVOXYL®. In addition, thyroid hormones and thyroid status have varied effects on the pharmacokinetics and action of other drugs. A listing of drug-thyroid axis interactions is contained in Table 2.
The list of drug-thyroid axis interactions in Table 2 may not be comprehensive due to the introduction of new drugs that interact with the thyroidal axis or the discovery of previously unknown interactions. The prescriber should be aware of this fact and should consult appropriate reference sources (e.g., package inserts of newly approved drugs, medical literature) for additional information if a drug-drug interaction with levothyroxine is suspected.

Drugs that alter thyroid hormone secretion	
Drugs that may decrease thyroid hormone secretion, which may result in hypothyroidism	
Amiodolone Amiodolone Iodine (including iodine-containing contrast agents) Lithium Methazolamide Propylthiouracil (PTU) Sulfonamides Tolbutamide	Long-term lithium therapy can result in goiter in up to 50% of patients, and either subclinical or overt hypothyroidism, each in up to 20% of patients. The fetus, neonate, elderly and euthyroid patients with underlying thyroid disease (e.g., Hashimoto's thyroiditis or with Grave's disease previously treated with radioactive iodine or surgery) are among those individuals who are particularly susceptible to iodine-induced hypothyroidism. Amiodolone, a beta-adrenergic antagonist, and amiodolone are slowly excreted, producing more prolonged hypothyroidism than parenterally administered iodinated contrast agents. Amiodolone and amiodolone therapy may minimally decrease T ₄ and T ₃ levels and increase TSH, although all values remain within normal limits in most patients.
Drugs that may increase thyroid hormone secretion, which may result in hyperthyroidism	
Amiodolone Iodine (including iodine-containing contrast agents) Radioiodine contrast agents	Iodide and drugs that contain pharmacologic amounts of iodide may cause hyperthyroidism in euthyroid patients with Grave's disease previously treated with antithyroid drugs or in patients with thyroid autonomy (e.g., multinodular goiter or hyperfunctioning thyroid adenoma). Hyperthyroidism may develop over several weeks and may persist for several months after therapy discontinuation. Amiodolone may induce hyperthyroidism by causing thyrotoxicosis.
Drugs that may decrease T₄ absorption, which may result in hypothyroidism	
Antacid - Aluminum & Magnesium Hydroxides - Simethicone Bile Acid Sequestrants - Cholestyramine - Colestipol Calcium Carbonate Cation Exchange Resins - Kayexalate Ferrous Sulfate Sucralfate	Concurrent use may reduce the efficacy of levothyroxine by binding and delaying or preventing absorption, potentially resulting in hypothyroidism. Calcium carbonate may form an insoluble chelate with levothyroxine and ferrous sulfate likely forms a ferric-thyroxine complex. Administer levothyroxine at least 4 hours apart from these agents.
Drugs that may alter T₄ and T₃ serum transport – but FT₄ concentration remains normal; and, therefore, the patient remains euthyroid	
Drugs that may increase serum TBG concentration Drugs that may decrease serum TBG concentration	
Clofibrate Estrogen-containing oral contraceptives Estrogens (oral) Hercin / Methadone 5-Fluorouracil Mifentane Tamoxifen	Androgens / Anabolic Steroids Aparanazine Glucocorticoids Slow-Release Nicotinic Acid
Drugs that may cause protein-binding site displacement	
Furosemide (> 80 mg IV) Heparin Hydantoin Non Steroidal Anti-inflammatory Drugs - Fenamates - Phenytoin - Propylthiouracil Salicylates (> 2 g/day)	Administration of these agents with levothyroxine results in an initial transient increase in FT ₄ . Continued administration results in a decrease in serum T ₄ and normal FT ₄ and TSH concentrations and, therefore, patients remain euthyroid. Salicylates inhibit binding of T ₄ and T ₃ to TBG and thyroxine. An initial increase in serum FT ₄ is followed by return of FT ₄ to normal levels with sustained therapeutic serum salicylate concentrations, although total-T ₄ levels may decrease by as much as 30%.
Drugs that may alter T₄ and T₃ metabolism	
Drugs that may increase hepatic metabolism, which may result in hypothyroidism	
Carbamazepine Halothane Phenobarbital Rifampin	Stimulation of hepatic microsomal drug-metabolizing enzyme activity may cause increased hepatic degradation of levothyroxine, resulting in decreased levothyroxine requirements. Phenytoin and carbamazepine reduce serum protein binding of levothyroxine, and total- and free-T ₄ may be reduced. In children, 40% to 60% of most patients have normal serum TSH levels and are clinically euthyroid.
Drugs that may decrease T₄ 5'-deiodinase activity	
Amiodolone Beta-adrenergic antagonists - (e.g., Propranolol > 160 mg/day) Glucocorticoids - (e.g., Dexamethasone 4 mg/day) Propylthiouracil (PTU)	Administration of these enzyme inhibitors decreases the peripheral conversion of T ₄ to T ₃ , leading to decreased T ₃ levels. However, serum T ₄ levels are usually normal but may occasionally be slightly increased. In patients treated with large doses of propranolol (> 160 mg/day), T ₄ and T ₃ levels change slightly. TSH levels remain normal, and patients are clinically euthyroid. It should be noted that actions of particular beta-adrenergic antagonists may be impaired when the hypothyroid patient is administered to the euthyroid state. Short-term administration of large doses of glucocorticoids may decrease serum T ₄ concentrations by 30% with minimal change in serum T ₃ levels. However, long-term glucocorticoid therapy may result in slightly decreased T ₄ and T ₃ levels and increased decreased TBG production (see above).
Miscellaneous	
Anticoagulants (oral) - Coumatin Derivatives - Indandione Derivatives	Thyroid hormones appear to increase the catabolism of vitamin K-dependent clotting factors, thereby increasing the anticoagulant activity of oral anticoagulants. Concomitant use of these agents impairs the compensatory increases in clotting factor synthesis. Prothrombin time should be carefully monitored in patients taking levothyroxine and oral anticoagulants and the dose of anticoagulant therapy adjusted accordingly.
Antidepressants - Tricyclics (e.g., Amitriptyline) - Tetracyclics (e.g., Maprotiline) - Selective Serotonin Reuptake Inhibitors (SSRIs; (e.g., Sertraline))	Concurrent use of tricyclic antidepressants and levothyroxine may increase the therapeutic and toxic effects of both drugs, possibly due to increased receptor sensitivity to catecholamines. Toxic effects may include increased risk of cardiac arrhythmias and CNS stimulation; onset of action of tricyclics may be accelerated. Discontinuation of sertraline in patients stabilized on levothyroxine may result in increased levothyroxine requirements.
Antidiabetic Agents - Biguanides - Meglitinides - Sulfonylureas - Thiazolidinediones - Insulin	Addition of levothyroxine to antidiabetic or insulin therapy may result in increased antidiabetic agent or insulin requirements. Careful monitoring of diabetic control is recommended, especially when thyroid therapy is started, changed, or discontinued.
Cardiac Glucosides	Serum digitalis glycoside levels may be reduced in hypothyroidism or when the hypothyroid patient is converted to the euthyroid state. Therapeutic effect of digitalis glycosides may be reduced.
Oxytocins - Interferon-α - Interleukin-2	Therapy with interferon-α has been associated with the development of antithyroid microsomal antibodies in 20% of patients and some have transient hypothyroidism, hyperthyroidism, or both. Patients who have antithyroid antibodies before treatment are at higher risk for thyroid dysfunction during treatment. Interleukin-2 has been associated with transient painful thyroiditis in 20% of patients. Interleukin-2 and interferon-α have not been reported to cause thyroid dysfunction.
Growth Hormones - Somatrem - Somatropin	Excessive use of thyroid hormones with growth hormones may accelerate epiphyseal closure. However, untreated hypothyroidism may interfere with growth response to growth hormone.

Ketamine	Concurrent use may produce marked hypertension and tachycardia; cautious administration to patients receiving thyroid hormone therapy is recommended.
Methoxyanthine Bronchodilators (e.g., Theophylline)	Decreased theophylline clearance may occur in hypothyroid patients; clearance returns to normal when the euthyroid state is achieved.
Radiographic Agents	Thyroid hormones may reduce the uptake of ¹³¹ I, ¹²⁵ I, and ¹²³ I.
Sympathomimetics	Concurrent use may increase the effects of sympathomimetic or thyroid hormones. Thyroid hormones may increase the risk of coronary insufficiency when sympathomimetic agents are administered to patients with coronary artery disease.
Chloral Hydrate Diazepam Ethinamate Lorazepam Meclozamine 6-Mercaptopurine Nitroglycerin Paracetamol Perphenazine Resorcinol (excessive topical use) Thiazide Diuretics	These agents have been associated with thyroid hormone and/or TSH level alterations by various mechanisms.

Oral Anticoagulant Therapy – Levothyroxine increases the response to oral anticoagulant therapy. Therefore, a decrease in the dose of anticoagulant may be warranted with correction of the hypothyroid state or when the LEVOXYL® dose is increased. Prothrombin time should be closely monitored to permit appropriate and timely dosage adjustments (see **Table 2**).
Digitalis glycosides – The therapeutic effects of digitalis glycosides may be reduced by levothyroxine. Serum digitalis glycoside levels may be decreased when a hypothyroid patient becomes euthyroid, necessitating an increase in the dose of digitalis glycosides (see **Table 2**).
Drug-Food Interactions – Consumption of certain foods may affect levothyroxine absorption therapy necessitating adjustments in dosing. Soybean flour (infant formula), cotton seed meal, walnuts, and dietary fiber may decrease the absorption of levothyroxine sodium. Avoidance of these foods is recommended.
Drug-Laboratory Test Interactions – Changes in TBG concentration must be considered when interpreting T₄ and T₃ values, which necessitates measurement and evaluation of unbound (free) hormone and/or determination of the free T₄ index (FT₄). Pregnancy, infectious hepatitis, estrogens, estrogen-containing oral contraceptives, and acute intermittent porphyria increase TBG concentrations. Decreases in TBG concentrations are observed in nephrosis, severe hypothyroidism, severe liver disease, acromegaly, and after androgen or corticosteroid therapy (see also **Table 2**). Familial hypothyroidism or hypo-thyroidism binding globulins have been described, with the incidence of TBG deficiency approximating 1 in 9000.
Carcinogenesis, Mutagenesis, and Impairment of Fertility – Animal studies have not been performed to evaluate the carcinogenic potential, mutagenic potential or effects on fertility of levothyroxine. The synthetic T₄ LEVOXYL® is identical to that produced naturally by the human thyroid gland. Although there has been a reported association between prolonged thyroid hormone therapy and breast cancer, this has not been confirmed. Patients receiving LEVOXYL® for appropriate clinical indications should be titrated to the lowest effective replacement dose.
Pregnancy – Category A – Studies in women taking levothyroxine sodium during pregnancy have not shown an increased risk of congenital abnormalities. Therefore, the possibility of fetal harm appears remote. LEVOXYL® should be discontinued during pregnancy and hypothyroidism diagnosed during pregnancy should be promptly treated.
Hypothyroidism during pregnancy is associated with a higher rate of complications, including spontaneous abortion, pre-eclampsia, stillbirth and premature delivery. Maternal hypothyroidism may have an adverse effect on fetal and childhood growth and development. During pregnancy, serum T₄ levels may decrease and serum TSH levels increase to values above the normal range. Since elevations in serum TSH may occur as early as 4 weeks gestation, pregnant women taking LEVOXYL® should have their TSH measured during each trimester. An elevated serum TSH level should be corrected by an increase in the dose of LEVOXYL®. Since postpartum TSH levels are similar to preconception values, the LEVOXYL® dosage should return to the pre-pregnancy dose immediately after delivery. A serum TSH level should be obtained 6-8 weeks postpartum. Thyroid hormones do not readily cross the placental barrier; however, some transfer does occur as evidenced by levels in cord blood of athletic fetuses being approximately one-third maternal levels. Transfer of thyroid hormones to the fetus, however, may not be adequate to prevent in *utero* hypothyroidism.
Nursing Mothers – Although thyroid hormones are excreted only minimally in human milk, caution should be exercised when LEVOXYL® is administered to a nursing woman. However, adequate replacement doses of levothyroxine are generally needed to maintain normal lactation.

Pediatric Use
General
The goal of treatment in pediatric patients with hypothyroidism is to achieve and maintain normal intellectual and physical growth and development.
The initial dose of levothyroxine varies with age and body weight (see **DOSE AND ADMINISTRATION**, **Table 3**). Dosing adjustments are based on an assessment of the individual patient's clinical and laboratory parameters (see **PRECAUTIONS**, **Laboratory Tests**).
In children, in whom a diagnosis of permanent hypothyroidism has not been established, it is recommended that levothyroxine administration be discontinued for a 30-day trial period, but only after the child is at least 3 years of age. Serum T₄ and TSH levels should then be obtained. If the T₄ is low and the TSH high, the diagnosis of permanent hypothyroidism is established, and levothyroxine therapy should be restarted. If the T₄ and TSH levels are normal, euthyroidism may be assumed and, therefore, the hypothyroidism can be considered to have been transient. In this instance, however, the physician should carefully monitor the child and repeat the thyroid function tests if any signs or symptoms of hypothyroidism develop. In this setting, the clinician should have a high index of suspicion of relapse. If the results of the levothyroxine withdrawal test are inconclusive, careful follow-up and subsequent testing will be necessary.
If the diagnosis of permanent hypothyroidism is established, and levothyroxine therapy when treatment is discontinued for 30 days, an alternate approach is to reduce the replacement dose of levothyroxine by half during the 30-day trial period. If, after 30 days, the serum TSH is elevated above 20 mIU/L, the diagnosis of permanent hypothyroidism is established, and full replacement therapy should be resumed. However, if the serum TSH has not risen to greater than 20mIU/L, levothyroxine treatment should be discontinued for another 30-day trial period followed by repeat serum T₄ and TSH.
The presence of concomitant medical conditions should be considered in certain clinical circumstances and, if present, appropriately treated (see **PRECAUTIONS**, **Laboratory Tests** and **DOSE AND ADMINISTRATION**).
Congenital Hypothyroidism (see **PRECAUTIONS**, **Laboratory Tests** and **DOSE AND ADMINISTRATION**).
Rapid restoration of normal serum T₄ concentrations is essential for preventing the adverse effects of congenital hypothyroidism on intellectual development as well as on overall physical growth and maturation. Therefore, LEVOXYL® therapy should be initiated immediately upon diagnosis and is generally continued for life.
During the first 2 weeks of LEVOXYL® therapy, infants should be closely monitored for cardiac overload, arrhythmias, and aspiration from acid vomiting.
The patient should be monitored closely to avoid undertreatment or overtreatment. Undertreatment may have deleterious effects on intellectual development and linear growth. Overtreatment has been associated with craniosynostosis in infants, and may adversely affect the tempo of brain maturation and accelerate the bone age with resultant premature closure of the epiphyses and compromised adult stature.
Equated Hypothyroidism in Pediatric Patients
The patient should be monitored closely to avoid undertreatment and overtreatment. Undertreatment may result in poor school performance due to impaired concentration and slowed mental and in reduced adult height. Overtreatment may accelerate the bone age and result in premature epiphyseal closure and compromised adult stature.
Treated children may manifest a period of catch-up growth, which may be adequate in some cases to normalize adult height. In children with severe or prolonged hypothyroidism, catch-up growth may not be adequate to normalize adult height.

Geriatric Use
Because of the increased prevalence of cardiovascular disease among the elderly, levothyroxine therapy should not be initiated at the full replacement dose (see **WARNINGS**, **PRECAUTIONS**, and **DOSE AND ADMINISTRATION**).

ADVERSE REACTIONS
Adverse reactions associated with levothyroxine therapy are primarily those of hypothyroidism due to the therapeutic underdosage. They include the following:
General: fatigue, increased appetite, weight loss, heat intolerance, fever, excessive sweating;
Central nervous system: headache, hyperactivity, nervousness, anxiety, irritability, emotional lability, insomnia;
Musculoskeletal: tremors, muscle weakness;
Cardiac: palpitations, tachycardia, arrhythmias, increased pulse and blood pressure, heart failure, angina, myocardial infarction, cardiac arrest;
Pulmonary: dyspnea;
GI: diarrhea, vomiting, abdominal cramps;
Dermatologic: hair loss, flushing;
Reproductive: menstrual irregularities, impaired fertility.
Pseudotumor cerebri and slipped capital femoral epiphysis have been reported in children receiving levothyroxine therapy. Overtreatment may result in craniosynostosis in infants and premature closure of the epiphyses in children with resultant compromised adult height.
Seizures have been reported rarely with the institution of levothyroxine therapy.
Inadequate levothyroxine dosage will produce or fail to ameliorate the signs and symptoms of hypothyroidism.
Hypersensitivity reactions to inactive ingredients have occurred in patients treated with thyroid hormone products. These include urticaria, pruritus, skin rash, flushing, angioedema, various GI symptoms (abdominal pain, nausea, vomiting and diarrhea), hives, antralgia, glaucosclerosis and wheezing. Hypersensitivity to levothyroxine itself is not known to occur.

MANUFACTURER
JONES PHARMA INCORPORATED
(A wholly owned subsidiary of King Pharmaceuticals, Inc.)
St. Louis, MO 63146
Prescribing Information as of August 2003.

*Accudose® tablet design allows Levoxy® to be accurately divided into two segments
†The instantly identifiable thyroid shape is a registered trademark of Jones Pharma Incorporated™
‡LEVOXYL is protected by U.S. Patent Number 6,555,581
§Price-Check PC - January 2004.



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Drug or Drug Class	Effect
Drugs that may reduce TSH secretion – the reduction is not sustained; therefore, hypothyroidism does not occur	
Dopamine / Dopamine Agonists Glucocorticoids Octreotide	Use of these agents may result in a transient reduction in TSH secretion when administered at the following doses: Dopamine (> 1 mcg/kg/min); Glucocorticoids (hydrocortisone ≥ 100 mg/day or equivalent); Octreotide (> 100 mcg/day).

A Clinical Investigators Workshop Presentation for Everyone

How to Accomplish Your Goals It's As Easy As A-B-C

By: *Nicholas Mulcahy*

The following four-step exercise was conducted by Dr. Ora Pescovitz, during the first annual Clinical Investigators Workshop for Trainees in Boston, Massachusetts January 23-25, 2004. Currently, Dr. Pescovitz is the Executive Associate Dean for Research Affairs and Edwin Letzer Professor of Pediatrics at Indiana University School of Medicine.



Dr. Ora Pescovitz

The Clinical Investigator Workshop which was created by The Endocrine Society's Trainee Development Committee, is "one of the first professional society-sponsored courses in clinical research in the country" and uniquely emphasizes "both career development and methodological considerations," according to Program Co-Chair, Dr. Steven Grinspoon, Associate Professor of Medicine at Harvard Medical School and Director of the Program for Nutritional Metabolism at Massachusetts General Hospital.

The program, "addresses the mis-match between limited training opportunities and the growing interest among society members in clinical research. The Endocrine Society convened a panel of expert clinical researchers, National Institutes of Health and industry representatives to provide information on critical aspects of clinical research as well as feedback on proposed research projects to a select group of fellows," notes Dr. Grinspoon.

of Medicine (in her job as Executive Associate Director for Research Affairs). 4. Make the University of Indiana's pediatric endocrinology unit one of top three units in U.S. (in her job as department director) 5. Get a current grant funded.

If your lists are now complete, you are ready for the fourth and final step of the exercise: Look at the list of ten activities and compare them to the five goals and see if any or all of the "next week activities" are helping to get you to the "life goals."

"At least one of your life goals had better be on your list of activities for next week and it better start moving you toward that life goal," summarized Dr. Pescovitz.

"The exercise helped identify contradictions that arise in our lives as we pursue our goals, including being clinical researchers," said Dr. Naifa Busaidy, a fellow at Baylor College of Medicine and MD Anderson Cancer Center, Houston, TX.



Would you like to perform a five-minute exercise to refocus your life in general and career in endocrinology specifically?

Standing before a select audience of 15 clinical fellows chosen from an applicant pool of 52, Dr. Pescovitz began her workshop talk, "How to Accomplish Your Goals," by asking participants to take pen and paper in hand and execute the following:

1) List the ten things (not limited to work) that you need to do this week;

2) Grade each item as either: A (very important); B (important); or C (not as important as A or B);

3) List five things that are lifetime goals.

Dr. Pescovitz offered her current list of five lifetime goals to the audience as an example. 1. Have her three children be "healthy, productive, constructive people as they enter adulthood." 2. Sustain a "healthy marriage." 3. Double the size of the research budget by 2010 at Indiana University School

Workshop participant and University of Pittsburgh fellow, Rajib Bhattacharya was impressed by the session on goals and even more so by Dr. Pescovitz: "Her talk was a good place to refocus. It is really interesting that she is such an accomplished person but has had

"The fellows at the workshop were at all levels of training, but Dr. Pescovitz had everyone's attention equally. Everyone related to it," said Trainee Development Committee Chair and Clinical Investigators Program Co-chair Dr. Jane Lee.

sharpen your focus on career and life ambitions. "If these are your goals, are you taking the necessary steps to achieve those goals?" she asks.

Dr Pescovitz's talk was one of 13 presentations made to the fellows. "Selecting A Mentor: What to Look for and Avoid" (Dr. Andrea Dunaif, Northwestern Medical School), "Funding Options for Fellows" (Dr. James Hyde, National Institutes of Health), and "Career Pathways in Clinical Research: How to Get Started" (Dr. Kenneth Polonsky, Washington University) were among the other sessions.

Dr. Pescovitz's talk was intended to help fellows lay groundwork for accomplishing these major tasks. "You need to think clearly about what it is you want to accomplish and how to make sure you are doing things that will help you get there."

time to raise a family. So often we see people who have an imbalance and work takes over everything."

According to Dr. Pescovitz, the point of the exercise, which can be done periodically by anyone, is to

The Clinical Investigators Workshop was created at the behest of The Endocrine Society Past-President William Crowley, Jr. to partially address a lack in medical education, says Dr. Grinspoon. "Few options exist for comprehensive instruction in clinical research. Many institutions offer pieces—such as statistics and bioethics courses—but not the whole."

"Securing some fundamental education about clinical research is a key to succeeding in the field," says Dr. Grinspoon, "but is still secondary to finding a mentor and choosing a research project. Find a good mentor, learn by watching and get good advice on your experiments because you can easily waste four or five years on a bad one. Also, you need to find a good question that is close to other questions but provides you with your own niche," he summarized.

Dr. Pescovitz's talk was intended to help fellows lay groundwork for accomplishing these major tasks. "You need to think clearly about what it is you want to accomplish and how to make sure you are doing things that will help you get there."

A career in clinical research requires a wide variety of work and projects, some of which such as writing papers and research grants

Join Endocrine Trainees During ENDO 2004!

■ Career Development Workshop

Tuesday, June 15, 2004

New Orleans Marriott

7:00 a.m. – 5:00 p.m.

With over 100 trainees attending last year, the workshop continues to grow and attract trainees from all over the world. Register early! All Fellow/Student Associate members of the Society are invited to attend the full-day workshop free of charge. The non-member fee is \$40. Registration information can be found on the Society's Web site at www.endo-society.org/students/endo_activities.cfm

■ Fellow and Student Reception

Tuesday, June 15, 2004

Sheraton New Orleans

6:30 p.m. – 7:30 p.m.

All fellows and students attending ENDO 2004 are invited to this event. To register, check the appropriate box on the ENDO 2004 registration form.

■ Fellow and Student Lounge

June 16-18, 2004

Morial Convention Center

8:00 a.m. – 6:00 p.m.

All Fellow/Student Associates of The Endocrine Society are welcome to work and relax in this special lounge created just for them.

The Endocrine Society's Trainee Development Committee's mission is to represent, serve and advocate for undergraduates, graduates and postgraduates in basic science and clinical endocrinology with regard to their professional development.

For more information please contact Colleen Gorman at cgorman@endo-society.org or 1-301-951-2611.

or creating talks and presentations are more demanding than others, observed Dr. Pescovitz.

Successful execution of the most challenging and pivotal work of a scientist requires “‘A’ time,” said Dr. Pescovitz, referring back to the exercise that opened the “How to Accomplish Your Goals” talk.

“When is your most productive time in the day? My ‘A’ time is in the morning, that’s when I am the most creative and productive,” she said.

“I get 150 emails a day. I have to read email every day, but that is a ‘C’ activity. Reading journals is a ‘C’ activity. Reviewing patient charts is ‘C’ activity. Signing off on administrative matters is a ‘C’ activity. I can do all of those when I am tired and hungry, but I can’t write a paper or grant when I am tired and hungry. They need ‘A’ time,” she explained.

“If you don’t set aside ‘A’ time for those ‘A’ activities, then those ‘A’ activities will never happen,” she advised the fellows.

Furthermore, while the need to “set a course” is highly important, the value of “making a contribution” is greater. “I followed my husband, who is a transplant surgeon, around the country as his career in academia developed. Each place that I landed, I pursued goals but each time I also asked myself, ‘What can I contribute here?’” she said.

However, the “biggest trap” in any work life is being “consumed by the minutia,” said Dr. Pescovitz. “There is satisfaction in checking off activities on a to-do list. But they may be dis-synchronous with your big goals,” she said.

Another trap is to get stuck in disappointment. “I have files full of rejected grants. To this day, I am inconsolable about a grant rejection—you invest your heart and

soul in writing a grant. I allow myself 24 hours to grieve and I move on.”

Sometimes even the best-laid plans (and ‘A’ activities) do not land an ambitious scientist at the door of complete success. “No matter,” says Dr. Pescovitz. “Shoot for the stars but settle for the moon. And make everyone think that you were aiming at the moon.”

Calling all fellows! You may want to add the next clinical investigators workshop to your ‘A’ list. **EN**

Look for information about future Clinical Investigator Workshops in upcoming issues of Endocrine News. For more information on the Clinical Investigators Workshop or other programs for all trainees please visit the Societies Web site at www.endo-society.org/students/ciworkshop.cfm or contact Colleen Gorman, Manager, Membership & Professional Affairs at cgorman@endo-society.org or 1-301-951-2611.

Don't Miss This Exciting Meeting after ENDO 2004 in Bethesda, MD

9th International Workshop on Multiple Endocrine Neoplasias

MEN 2004

June 20-23, 2004

**Hyatt Regency Bethesda Hotel
Bethesda, MD**

www.MEN2004.org

MEN 2004 will showcase new data and discussion on MENs including important syndromes, genes and gene function, improvements in diagnosis and management of a chronic condition.

Sponsored by National Institute of Child Health & Human Development, National Institute of Diabetes & Digestive & Kidney Diseases, Offices of Rare Diseases, and National Institutes of Health.

For more information, please visit www.MEN2004.org or email MEN2004@air.org

A Heartfelt "Thanks" from The Hormone Foundation to Member Volunteers

The Hormone Foundation would like to thank and recognize members of The Endocrine Society who have helped the Foundation become a patient education leader in the prevention, treatment and cure of hormone-related conditions.

Since its inception in 1997, The Hormone Foundation has developed programs in a variety of endocrine-related conditions. These programs have been implemented through public education forums, media roundtables, poster sessions, brochures, fact sheets, the Web site, and media outreach.

Regardless of the form in which the messages from the Foundation have been disseminated, the one

steady factor behind the quality of its materials is the volunteer members.

The Hormone Foundation would like to thank and recognize the members who have contributed their time and expertise to Foundation programs by serving on the Foundation's Board and Advisory Councils, participating as panelists in public forums, contributing as editors for our publications, and more.

We look forward to your continued leadership and support as we update and expand the Foundation's programs. **EN**

For more information about the Foundation visit www.hormone.org or call 1-800-HORMONE.

The Hormone Foundation would like thank the following Endocrine Society members:

Wayne Barden
Elizabeth Barrett-Connor
John Baxter
Daniel Bessesen
George Blackburn
George Bray
Henry Burger
Gerard Burrow
Robert Carey
William Chin
Michael Conn
Glenn Cunningham
Daisy De Leon
Adrian Dobs
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Len Wartofsky
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Holly Wyatt
William Young

Check out the Hormone Foundation Web site!

Visit www.hormone.org for the most up-to-date information on hormone-related conditions.

**Menopause • Obesity • Diabetes • Osteoporosis
Thyroid Disease • Growth Disorders • Hormone Abuse
Pituitary Imbalances • Low Testosterone • PCOS**

Featuring unique resources for patients.

The Hormone Foundation, the public education affiliate of The Endocrine Society, is dedicated to serving as a resource for the public by promoting the prevention, treatment and cure of hormone-related conditions.

For more information about The Hormone Foundation, please call 1-800-HORMONE.



THE HORMONE FOUNDATION



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HORMONES & YOU

Patient Information Page

Hormones and Obesity

What is obesity?

Obesity is a chronic medical condition characterized by too much body fat. Obesity is diagnosed by a number called the Body Mass Index (BMI), which calculates the amount of body fat. Your BMI is calculated from your current height and weight. The higher the BMI the more body fat a person has.

BMI	Weight Status
Below 18.5	Underweight
18.5 – 24.9	Normal
25.0 – 29.9	Overweight
30.0 and above	Obese

Source: Centers for Disease Control.

Why care about obesity?

Both overweight and obesity can make it more likely that you will develop serious diseases, such as diabetes, high blood pressure, heart disease, stroke, gallstones, high cholesterol, gout, most types of cancer, and even early death. Obesity can also make many other medical conditions more difficult to treat. Each year about 300,000 adult Americans die of causes related to their obesity.

What causes obesity?

Obesity is very complex and not just a simple problem of willpower or self-control. In general, it is caused by a combination of eating too much

and exercising too little, and genetics. Overweight or obesity occurs when, over time, the body takes in more calories than it burns. However, some people do gain weight more easily than others.

Obesity can also be caused by a hormonal imbalance, as in hypothyroidism or Cushing's disease, but this is rare. Our understanding of obesity is growing rapidly. For example, we now know that fat cells produce many hormones that play an important role in how much you eat, how much energy you spend and how much you will weigh.

How is obesity treated?

There is no simple solution or a pill to cure obesity but there are effective treatments to help manage the condition. Obesity needs to be managed long-term with a combination of diet, increased activity and lifestyle changes. Some obese patients may also benefit from weight loss medication or even surgery.

Ask your doctor what weight-loss treatment options are best for you. Some people with conditions such as diabetes may need to be monitored while they lose weight. Endocrinologists, specialists in hormones and metabolism, can help assess the cause of your obesity and the possible complications, direct how you should be treated, and prescribe and monitor your medications.

What should I do with this information?

Ask your doctor about your specific weight loss needs and goals. The following lifestyle changes are a good place to start:

- Reduce portions of foods that are high in fat or sugar
- Eat more fruits, vegetables, and whole grains
- Spend 30 minutes a day in moderate physical activity (e.g., brisk walking)
- Eat three meals every day, including breakfast
- Find opportunities to be more physically active (e.g., take the stairs whenever possible, park your car farther out in the parking lot, etc.)

Don't expect overnight results. There are no quick fixes. Aim for a 5–10% weight reduction to start. Weight loss takes time and changes in diet and activity will need to continue for the rest of your life.

Resources

- To calculate your BMI:
<http://www.cdc.gov/nccdphp/dnpa/bmi/calc-bmi.htm>
- American Diabetes Association:
<http://diabetes.org/homepage.jsp>
- American Dietetic Association:
<http://www.eatright.org/Public/>
- American Obesity Association:
<http://www.obesity.org/>
- Weight-control Information Network:
<http://www.niddk.nih.gov/health/nutrit/win.htm>

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April 2004

For more information on how to find an endocrinologist, download free publications, translate this fact sheet into other languages, or make a contribution to The Hormone Foundation, visit www.hormone.org/bilingual or call 1-800-HORMONE. The Hormone Foundation, the public education affiliate of The Endocrine Society (www.endo-society.org), serves as a resource for the public by promoting the prevention, treatment, and cure of hormone-related conditions. This page may be reproduced non-commercially by health care professionals to share with patients. Translation by MEDI-FLAG Corp.

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OBESITY



THE HORMONE
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Las hormonas y la obesidad

¿Qué es la obesidad?

La obesidad es una condición crónica que se caracteriza por un exceso de grasa en el cuerpo. Se diagnostica por medio de un número llamado el Índice de Masa Corporal (IMC), el cual calcula la cantidad de grasa en el cuerpo. Para calcular su IMC, usted tiene que multiplicar su peso (en libras) por 703 y luego dividir el resultado por su altura en pulgadas y, cuando obtenga ese resultado, vévalo a dividir por su altura en pulgadas. *(También puede calcularlo en kilos si divide su peso en kilogramos por su estatura en metros y cuando obtenga el resultado, vuelve a dividirlo por su estatura en metros.)*

IMC Clasificación

Menos de 18.5Bajo de peso
18.5 – 24.9Normal
25.0 – 29.9Pasado de peso
Más de 30.0Obesidad

Origen: Centros para Control de Enfermedades.

¿Por qué debe uno preocuparse por la obesidad?

Tanto el sobrepeso como la obesidad pueden aumentar la posibilidad de que sufra enfermedades serias, tales como la diabetes, la presión arterial alta, derrames, cálculos en la vesícula, colesterol alto, gota, casi todos los tipos de cáncer y hasta una muerte prematura. La obesidad también puede complicar el tratamiento de otras condiciones médicas. En los Estados Unidos, hay 300,000 personas adultas que fallecen por causas asociadas a la obesidad.

¿Qué causa la obesidad?

La obesidad es sumamente compleja y no es tan solo un problema de fuerza de voluntad o de autocontrol. En general, es causada por una combinación de comer en exceso, hacer poco ejercicio y por factores genéticos hereditarios. El sobrepeso o la obesidad ocurren cuando, a lo largo del tiempo, el cuerpo ingiere más calorías de las que consume. Sin embargo, sí hay unas personas que aumentan de peso con más facilidad que otras.

La obesidad también puede ser causada por un desequilibrio hormonal; por ejemplo, el hipotiroidismo o la enfermedad de Cushing, aunque esto es raro. Nuestra comprensión de la obesidad está aumentando aceleradamente. Por ejemplo, ahora sabemos que las células de grasa producen muchas hormonas que desempeñan un papel importante en determinar la cantidad que la persona come, cuánta energía utiliza y cuánto habrá de pesar.

¿Cómo se trata la obesidad?

No hay una solución sencilla ni una píldora que cure la obesidad pero sí hay tratamientos eficaces que le ayudan a conllevar esa condición. La obesidad tiene que ser tratada a largo plazo con una combinación de dieta, mayor actividad y cambios en el estilo de vida. Hay algunos pacientes obesos que también se benefician de los medicamentos para perder peso o, incluso, hasta de la cirugía.

Pregúntele a su médico cuáles son las opciones de tratamiento para perder peso que son más adecuadas para usted. Algunas personas que padecen de condiciones como la diabetes pueden necesitar supervisión mientras pierden peso. Los endocrinólogos, que

son los especialistas en las hormonas y el metabolismo, pueden ayudarle a evaluar la causa de su obesidad y las complicaciones posibles, indicarle cómo debe tratarse, y recetarle medicamentos y supervisar su administración.

¿Qué debo hacer con esta información?

Pregúntele a su médico sobre sus requisitos y objetivos específicos para perder peso. Los siguientes cambios en el estilo de vida son un buen comienzo:

- Reduzca las porciones de las comidas que tienen un alto contenido de grasa o azúcar
- Coma más frutas y vegetales, y granos integrales
- Durante 30 minutos diarios practique una actividad física moderada (por ej., caminar rápidamente)
- Coma tres comidas al día, incluso desayuno
- Busque la oportunidad de actividad física (por ej., subir y bajar por las escaleras siempre que sea posible)

No espere resultados de un día para el otro. No hay soluciones instantáneas. Propóngase una reducción de peso de un 5 a 10% para comenzar. Perder peso toma tiempo y los cambios de dieta y nivel de actividad tendrán que continuar por el resto de su vida.

Recursos

Para calcular su IMC:

<http://www.cdc.gov/nccdphp/dnpa/bmi/calc-bmi.htm>

Medline Plus: <http://www.nlm.nih.gov/medlineplus/spanish/obesity.html>

Asociación Americana de Diabetes:

<http://diabetes.org/enespanol/spanish.jsp>

Instituto Nacional de Diabetes y Enfermedades Digestivas y Renales:

<http://www.niddk.nih.gov/health/spanish.htm#dia>

EDITORES:

Daniel Bessesen, MD
James Hill, MD
Holly Wyatt, MD

Abril 2004

Para más información sobre cómo encontrar un endocrinólogo, obtener publicaciones de la Internet, traducir esta hoja de datos a otros idiomas, o hacer una contribución monetaria a la Fundación de Hormonas, visite a www.hormone.org/bilingual o llame al 1-800-HORMONE (1-800-467-6663). La Fundación de Hormonas, la filial de enseñanza pública de la Sociedad de Endocrinología (www.endo-society.org), sirve de recurso al público para promover la prevención, tratamiento y cura de condiciones hormonales. Esta página puede ser reproducida por los profesionales médicos que deseen compartirla con sus pacientes, pero no para fines comerciales. Traducción hecha por MEDI-FLAG Corp.

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Roundtable Forum on Endocrine, Metabolic, and Reproductive Issues in Neurology and Psychiatry

By: Patricia A. Stephens, Ph.D.

There is growing confusion and concern regarding the management of endocrine, metabolic, and reproductive side effects that may be associated with antiseizure and mood stabilizing agents. Late last year, Endocrine Society member, Andrea Dunaif, MD, approached the Society with a proposal to convene a roundtable of experts to address these issues. Dr. Dunaif, an endocrinologist at the Feinberg School of Medicine at Northwestern University, asked Martha J. Morrell, MD, a neurologist at the Columbia University College of Physicians & Surgeons, to join in this endeavor. Together, Drs. Dunaif and Morrell identified the key topics and enlisted a group of recognized thought leaders in psychiatry, neurology, and endocrinology to serve on the multidisciplinary panel. The resulting meeting, the *Roundtable Forum on Endocrine, Metabolic, and Reproductive Issues in Neurology and Psychiatry*, convened on January 16-18, 2004, in New Orleans. Financial support for the *Roundtable Forum* was provided through unrestricted educational grants from Abbott Laboratories and GlaxoSmithKline.

From its inception, the *Roundtable Forum* had three goals. Panelists first reviewed the evidence related to the endocrine, metabolic, and reproductive side effects that may be associated with anti-seizure and mood stabilizing agents. A list of the presentation and discussion topics is provided in the accompanying table. After distilling this information they next defined the issues concerning treatment of patients on currently available therapies. Finally, they developed strategies and recommendations for practicing physicians.

Recommendations centered on the detection and management of disorders such as the following:

- obesity, insulin resistance, and metabolic syndrome
- polycystic ovaries and polycystic ovary syndrome
- menstrual irregularities including amenorrhea
- reproductive disturbances affecting pregnancy
- long-term birth defects
- pediatric disorders
- bone loss

An Executive Summary of the *Roundtable Forum* is now in press and will soon be distributed widely

to endocrinologists, neurologists, psychiatrists, and other practicing physicians concerned with the endocrine, metabolic, and reproductive effects of antiseizure and antipsychotic medications. Further information on the Executive Summary, the CME-accredited monograph, and other future live CME-accredited programs related to these important issues will be available on the Endocrine Society's CMES webpage. **EN**

If you have questions about the Roundtable Forum or the services provided by the Meetings and Education Department, please contact Lisa Johnson, Associate Director, Education at ljohnson@endo-society.org

ROUNDTABLE PRESENTATIONS

Endocrine, Metabolic, and Reproductive Issues in Neurology and Psychiatry—

Andrea E. Dunaif, MD, Feinberg School of Medicine, Northwestern University

Polycystic Ovary Syndrome: Epidemiology and Reproductive Aspects—

Richard S. Legro, MD, Pennsylvania State University

An Overview: Metabolic Effects of Polycystic Ovary Syndrome—

Andrea E. Dunaif, MD, Feinberg School of Medicine, Northwestern University

Effects of AEDs on Steroidogenesis: An Explanation for Drug-induced

PCOS?—Jerome F. Strauss, III, MD, PhD, University of Pennsylvania Medical Center

Reproductive Disorders in Women with Epilepsy—

Andrew G. Herzog, MD, MSc, Beth Israel Deaconess Medical Center

Reproductive Disorders in Women with Affective Disorders—

Natalie Rasgon, MD, PhD, Stanford University

Effects of AEDs on Bone Health—

Elizabeth Shane, MD, Columbia University College of Physicians & Surgeons

The Regulation of Energy Balance by the CNS—

Randy J. Seeley, PhD, University of Cincinnati

Metabolic Effects of Atypical Antipsychotics—

Richard N. Bergman, PhD, University of Southern California

Weight Change and AED Treatment—

Barry E. Gidal, PharmD, University of Wisconsin Madison

Teratogenicity of AEDs and Psychiatric Medications—

Lewis B. Holmes, MD, Massachusetts General Hospital

Neurodevelopmental Effects of AED Exposure In Utero—

Naghme Adab, MB, ChB, Walton Centre for Neurology & Neurosurgery, UK

Diagnosis and Treatment of Bipolar Disorder—

Natalie Rasgon, MD, PhD, Stanford University

Epilepsy in Women: Endocrine, Metabolic, and Reproductive Health Consid-

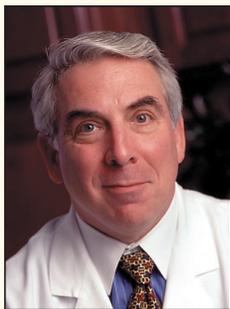
erations—Martha J. Morrell, MD, Columbia University College of Physicians & Surgeons

**Paul W. Ladenson
Named Editor-in-Chief
of *The Journal of
Clinical Endocrinology
& Metabolism (JCE&M)***

The Endocrine Society Publications Committee recommended, and Council approved the appointment of Paul W. Ladenson, M. D. as Editor-in-Chief of *The Journal of Clinical Endocrinology & Metabolism (JCE&M)*, 2005-2009. Dr. Ladenson is Director of the Division of Endocrinology and Metabolism at The Johns Hopkins University School of Medicine, where he is the John Eager Howard Professor of Endocrinology, and Professor of Medicine, Pathology, Oncology, and Internal Health. He is also Director of the Johns Hopkins Thyroid Tumor Center. Dr. Ladenson brings much experience to the position of Editor-in-Chief, having served on the editorial board from 1990-1993 and as an associate editor of the journal since 2000.

JCE&M is The Endocrine Society's flagship clinical journal with an impact factor of 5.199 that ranks it in the top four percent of all 5,876 scientific journals in ISI's Science Citation Index. It was also ranked 53rd overall in citations and 1st of the 88 endocrinology and metabolism journals.

Dr. Ladenson will work with Dr. John Bilezikian, the current editor-in-chief of *JCE&M*, to ensure a smooth transition of editorship. Dr. Ladenson will formally assume responsibility for the journal on January 1, 2005. The editorial office will be centralized at The Endocrine Society's offices in Chevy Chase, Maryland. **EN**



Paul W. Ladenson

**Women in
Endocrinology**

The Women in Endocrinology (WE) Annual Dinner will be held at 6:30 p.m. on Wednesday June 16, 2004 at the Sheraton New Orleans Hotel. Dr. Kathie Olsen, Associate Director for Science, Office of Science and Technology Policy (OSTP) will be the featured speaker. In this position, she advises the President and others within the Executive Office to implement sound scientific and educational policy in the areas of the life sciences, physical sciences, environmental science, behavioral and social sciences. Please visit http://www.ostp.gov/html/_aboutostp.html#olsen for Dr. Olsen's brief biosketch. Please plan on joining us for her presentation.

Also featured at the annual dinner is presentation of the **WE Mentor Award**, which is made possible by a grant from Pfizer, Inc. The Mentor Award is given annually to a woman or man whose outstanding scientific achievements are coupled with a record of support for women in academics and for mentoring women in their scientific careers.

WE is delighted to announce that this year's recipient is Dr. Jo Anne Brasel, Joseph W. St. Geme Chair of Pediatrics at UCLA School of Medicine, Program Director of the General Clinical Research Center

and Chief of the Division of Pediatric Endocrinology at the Harbor-UCLA Medical Center.

The WE on-line mentoring program continues to be a success. The goal of the mentoring program is to provide a resource to match mentees with mentors who have expertise in a variety of areas specific to endocrine careers in academics, industry and private practice. This innovative and important program has been made possible through the very generous support of Procter and Gamble. WE encourages mentors and mentees to go to the WE Web site <http://www.women-in-endo.org> and follow the instructions to access this mentoring program. **EN**

**2004 Journal Student
Award Winners**

The Endocrine Society is pleased to announce the award winners for outstanding first authored student papers published in *Endocrinology* and *Molecular Endocrinology*. The awards are designed to encourage and recognize student contributions to the study of endocrinology. The student awardees have been selected by the Editors and Student Affairs Committee of The Endocrine Society and are restricted to trainees (students, fellows). Awardees will receive a \$1,000 award and free registration to ENDO 2004 the 86th annual meeting of The Endocrine Society held in New Orleans, Louisiana, June 16-19, 2004. Awardees were

IMPORTANT NOTICE!!!

Your specialty and Society need your help. Members who are interested in helping with the coding or reimbursement advocacy program and representation of the Society and endocrinology are invited to contact Dr. Richard Dickey at mdrad@charter.net or 1-828-327-7269 or Janet Kreizman at jkreizman@endo-society.org or 1-301-941-0252 to discuss this opportunity.

selected from papers accepted for publication from January 1 to December 31 of the previous year.

Endocrinology Student Award Winners:

Suzanne Appleyard

Vollum Institute, Oregon Health & Science University, Portland, OR

“A Role for the Endogenous Opioid β -Endorphin in Energy Homeostasis”

Robert Robitaille

Department of Biochemistry, Maisonneuve-Rosemont Hospital, Montréal, Québec, Canada

“Insulin-Like Growth Factor II Allows Prolonged Blood Glucose Normalization with a Reduced Islet Cell Mass Transplantation”

Molecular Endocrinology Student Award Winners:

Zvi Granot

Department of Biological Chemistry, The Alexander Silberman Institute of Life Sciences, The Hebrew University of Jerusalem, Israel

“Proteolysis of normal and mutated steroidogenic acute regulatory (StAR) proteins in the mitochondria: the fate of unwanted proteins”

Bo Chen

Department of Biological Sciences

DONATE YOUR JOURNALS NOW!

This month we are highlighting three journals that are needed to pursue our online Legacy Data Project. We are seeking donations for the following journals:

- *Endocrinology*, Volume 129, July-September, 1991
- *Endocrinology*, Volume 125, September-December, 1989
- *Endocrine Reviews*, Volume 10, August issue, 1989

If you have and are willing to donate the requested issues or volumes please review the complete list at www.endo-society.org/journals/legacy.pdf

If you or a colleague has one of the highlighted journals, please contact Adrienne Weber, Journals Publications Coordinator, at 301-941-0238 or ship them to: Adrienne Weber, The Endocrine Society, 8401 Connecticut Avenue, Suite 900, Chevy Chase, MD 20815-5817 **EN**



and Biotechnology; Tsinghua University; Beijing, China

“Cyclin D2 compensates for the loss of cyclin D1 in estrogen induced mouse uterine epithelial cell proliferation” **EN**

For more information please contact the managing editors at Endocrinology endocrinology@endo-society.org or Molecular Endocrinology molendo@endo-society.org

National Academy of Sciences Elects John T. Potts, Jr., M.D.

Congratulations to John T. Potts, Jr., M.D., Director of Research and Physician-in-Chief Emeritus at Massachusetts General Hospital and

the Jackson Distinguished Professor of Clinical Medicine, Harvard School of Medicine, for his recent election to the National Academy of Science (NAS). Established in 1863, NAS includes the National Research Council, National Academy of Engineering and the Institute of Medicine. NAS members are elected in recognition of their distinguished and continuing achievements in original research. Election to the NAS is considered one of the highest honors a scientist or engineer can receive. **EN**

2004 Election Results



Andrea E. Dunaif, M.D., President Elect (Clinical Scientist)



Kelly E. Mayo, Ph.D., Council (Basic Scientist)



Daisy Delgado De Leon, Ph.D., Council (At-Large)



Martin I. Surks, M.D., Council (At-Large)



2005 ENDOCRINE SOCIETY ELECTION

The Nominating Committee is soliciting suggestions for candidates for the 2005 Election. This is your opportunity to make the Nominating Committee aware of members who would be outstanding leaders of the Society. Use the online Call for Nominations form now available in the Nominating Committee section of the Web site at:

http://www.endo-society.org/membersonly/committees/nominating/call_for_nomination.cfm

The deadline to submit your nominations is July 23, 2004.



Winners of Society Travel Grants, Fellowships and Abstract Awards

The Endocrine Society Student Affairs Committee is pleased to announce the winners of its 2004 travel grants, fellowships and abstract awards. The Committee will present over 350 awards this year totaling more than \$450,000. Please join the Society in congratulating the following winners:

Lilly Endocrine Scholars Award

L. Elizabeth Bernstein, M.D. won the **Lilly Endocrine Scholars Award**. This fellowship will provide Dr. Bernstein with up to two years of funding for her project "The Effect of TNF-alpha Antagonism in Patients with Metabolic Syndrome." Dr. Bernstein will conduct her research under the mentorship of Dr. Steven K. Grinspoon at Massachusetts General Hospital in Boston. Supported by a grant from Eli Lilly and Company.

Pfizer Postgraduate Course Travel Grants

Five individuals won a travel grant to attend the **Postgraduate Course on GH and Growth Factors—Metabolic Disorders**, which was held in Gothenburg, Sweden, May 3-7. These recipients are U.S. based, clinical endocrinologists who are in-training or recently completed their training, and who are interested in research and clinical practice in the areas of growth, growth hormone and metabolism. The Society provided each winner with airfare, registration, lodging and meals. Supported by an educational grant from Pfizer Endocrine Care.

Omar Ali, M.D.

Romy Jill Block, M.D.

Ali Ashgar Jawa, M.D.

Mahmood Kazemi, M.D.

Andrea Utz, M.D., Ph.D.

ENDO Abstract Awards

Six individuals won an **Abbott Thyroid Research Clinical Fellowship Award** for their outstanding ENDO abstracts, which were based on their research as major investigators in clinically relevant aspects of thyroid disease. The Society will present each winner with \$1,000 at the annual Awards Dinner at ENDO. All six winners will compete in an oral competition at ENDO 2004, and the mentor of the winning presentation will receive \$30,000 to continue training fellows in thyroid research. Supported by Abbott Laboratories.

Brian K. Golden, M.D.

Yasuhito Kato, M.D., Ph.D.

Caroline S. Kim, M.D.

Jordan E. Pinsker, M.D.

Nikolaos Stathatos, M.D.

Dany H. Zayour, M.D.

Five individuals won an **AstraZeneca Diabetes & Metabolism Research Fellow Award** for their outstanding ENDO abstracts on clinically relevant aspects of diabetes, lipids and metabolism. The Society will present each winner with \$2,000 at the annual Awards Dinner at ENDO. Supported by AstraZeneca.

Constanze Banz, M.D.

Florian Blaschke, M.D.

Magdalena Uhart, M.D.

Sophie Vallette-Kasic, M.D., Ph.D.

Nicolas R. Vulliemoz, M.D.

Four individuals won a **Glenn Foundation Endocrinology and Aging Award** for their outstanding ENDO abstracts that dealt with areas of basic biology closely related to problems of aging and endocrinology. The Society will present each winner with \$750 at the annual Awards Dinner at ENDO. Supported by the Paul F. Glenn Sponsorship Fund in cooperation with the American Federation for Aging Research.

Jorge N. Artaza, Ph.D.

Lynnette M. Gerhold

Adam R. Kennedy

Loretta P. Mayer, Ph.D.

Five individuals won a **Merck Senior Fellows Award** for their outstanding ENDO abstracts that investigate the endocrinology of reproduction, cytokines & growth factors, growth and aging, brain and behavior, cancer, or stress, energy, water, electrolytes and metabolism. The Society will present each winner with \$2,000 at the annual Awards Dinner at ENDO. Supported by Merck & Company, Inc.

Maria Alba, M.D.

Hiroko Furumoto, M.D., Ph.D.

Reiko Hanada, M.D., Ph.D.

Libuse Tauchmanova, M.D., Ph.D.

Michael Zitzmann, M.D.

ENDO Abstract Travel Grants

The following abstract authors won a travel grant to attend ENDO 2004. These authors are in-training post-doctoral fellows, new faculty, or graduate students. The Society will honor them at the Fellow and Student Reception at ENDO.

Quest Diagnostics Young Investigator Travel Grants (\$1,000 each supported by Quest Diagnostics)

Shaun P. Brothers
 Junny C.Y. Chan, M.D.
 Cecilia Garcia-Rudaz, M.D.
 John C. Gill
 Derek Haas
 Vincent R. Harley, Ph.D.
 Siwanon Jirawatnotai
 Xue-feng Liu, Ph.D.
 James A. McCormick, Ph.D.
 Louise A. Metherell
 Sommer L. Miller
 Houg-Wei Tsai, Ph.D.

Mara E. Lieberman Memorial Travel Grants (\$500 each supported by the Mara E. Lieberman Memorial Fund)

Kathryn J. MacLean
 GyunJee Song, Ph.D.

Ira M. Rosenthal Memorial Travel Grant (\$1,500 supported by the Ira M. Rosenthal Memorial Fund)

Vijay Yechoor, M.D.

The Endocrine Society Travel Grants (\$500 each funded by The Endocrine Society)

Tamara N. Alliston, Ph.D.
 Jorge Aranda
 Frank Barletta, Ph.D.
 Daniel H. Barnett
 Alicia Belgorosky, M.D., Ph.D.
 Nicholas B. Berry
 Mihaela C. Blendea, M.D., Ph.D.
 Cary Boyd
 Kara L. Britt
 Winnifred M. Bryant, Ph.D.
 Davide Calebiro, M.D.
 Ignacio G. Camarillo, Ph.D.
 Deborah J. Clegg, Ph.D.
 Laurence Clement, Ph.D.
 Ethel Codner, M.D.
 Ginevra Corneli, M.D., Ph.D.
 Andrea D. Coviello, M.D.
 Amy L. Creekmore
 Raymundo Cruz, Ms.Sci.
 Pablo G. Damian-Matsumura, Ph.D.
 Sandrine De Seranno
 Ignacio A. Demarco
 Xuesen Dong
 Andrea Dovio, M.D.
 Nicole Draper, Ph.D.
 Renea R. Eason
 Cem Elbi, M.D., Ph.D.

Kate L.J. Ellacott, Ph.D.
 Peng Fang, Ph.D.
 Ningping Feng, Ph.D.
 Shu Feng, Ph.D.
 Monica G. Ferrini, Ph.D.
 Amy M. Fowler
 Bethany D. Freedman
 Mario D. Galigniana, Ph.D.
 Michael A. Gentile
 Nicolas Gevry, Ph.D.
 Dimitris K. Grammatopoulos, Ph.D., MRCP
 Kurt J. Griffin, M.D., Ph.D.
 Lionel Groussin, M.D.
 Feifan Guo, Ph.D.
 Julia Halperin, Ph.D.
 Caroline E. Harbeson
 Daniel B. Hardy, Ph.D.
 William R. Harrington
 Lorin M. Henrich
 Rachel A. Hill
 Yasushi Hirota
 Jing Huang
 Wenyu Huang, M.D.
 Yao Huang, Ph.D.
 Jeffrey S. Huo
 Keiji Iida, M.D.
 Michael S. Irwig, M.D.
 Hitoshi Ishimoto, M.D., Ph.D.
 Michelle Jamnongjit
 Renea A. Jarred, Ph.D.
 Brian W. Jones
 Zhigang Kang, M.D.
 Catherine E. Keegan, M.D., Ph.D.
 Akira Kohsaka
 Natallia Kremianeuskaya, M.D.
 Charlemagne T. Lacza
 Christopher R. LaPensee
 Jennifer H. Lee, M.D.
 Sok-hyong Lee
 Quanxi Li, Ph.D.
 Xiaodong Li
 John R. Lindsay, M.D.
 Jeffrey C. Liu
 Fiona A. Lovett
 Yazmin Macotela
 Natalia A. Makhanova, Ph.D.
 Ryan Matika
 Christopher M. Mayer
 Allison T. McElvaine
 Maria Veronica Mericq, M.D.
 Madhusmita Misra, M.D.
 Abir Mukherjee, Ph.D.
 Jacqueline L. Naffin, Ph.D.
 Angele Nalbandian
 Andrew W. Norris, M.D., Ph.D.
 Joy K. Osafo
 J. Carl Pallais, M.D.

Seongeun Park
 Daniela Parodi, M.Sc.
 Graciela Piwien-Pilipuk, Ph.D.
 Marcus Quinkler
 Annaswamy Raji, M.D.
 Melissa A. Rasar
 Khurram S. Rehman, M.D.
 Jose Carlos Rivera, M.Sc.
 Audrey J. Robinson-White, Ph.D.
 Palma Rocchi, Ph.D.
 Buel D. Rodgers, Ph.D.
 Rossana Roman, M.D.
 Susan Sam, M.D.
 Melanie Sanchez
 Tamar D. Schirman-Hildesheim, M.Sc.
 Jennifer R. Schultz
 Josef V. Silha, M.D.
 Rajan Singh, Ph.D.
 Venkataraman Sriraman, Ph.D.
 Akiyo Tanabe, M.D.
 Danny Titolo
 Gyanendra Tripathi, Ph.D.
 Vien H. Vanderhoof
 Sheelu Varghese, Ph.D.
 Mark H. Vickers, M.Sc., Ph.D.
 Elizabeth A. Walker
 Yuhong Wei, M.D.
 Bryan M. Wittmann, Ph.D.
 Antony W. Wood, Ph.D.
 Elizabeth A. Wooddy
 Katie A. Woods, M.D.
 Debra Wright
 Mingzhao Xing, M.D., Ph.D.
 Paul M. Yen, M.D.
 Ping Yin, M.D., Ph.D.
 Yuan-Shan Zhu, M.D., Ph.D.

Genentech Clinical Fellows Travel Grants

80 clinical fellows received a \$1250 travel grant to attend ENDO 2004. They were nominated by their program director and are actively enrolled in an accredited fellowship training program in either adult or pediatric endocrinology. The Society will honor them at the Fellow and Student Reception at ENDO. Supported by Genentech, Inc.

Siham D. Accacha, M.D.
 Tyler F. Aguinaldo, M.D.
 Rehan Ahmad, D.O.
 Omar Ali, M.D.
 Laleh Ardeshirpour, M.D.
 Ambika P. Ashraf, M.D.
 Angela Badaru, MBBS

Shichun Bao, M.D., Ph.D.
 Sabreena M. Basu, M.D.
 Dalia Batista, M.D.
 Andrew P. Cagle, M.D.
 John D. Carmichael, M.D.
 Dennis J. Chia, M.D.
 Harvey K. Chiu, M.D.
 Bassem H. Dekelbab, M.D.
 Alejandro Diaz, M.D.
 Sara A. DiVall, M.D.
 Qing Dong, M.D., Ph.D.
 Stephanie Drobac, M.D.
 Rachel C. Edelen, M.D.
 Daniel D. Elsholz, M.D.
 Berrin Ergun-Longmire, M.D.
 Amy D. Fleischman, M.D.
 Armando Flor-Cisneros, M.D.
 Laura M. Gandrud, M.D.
 Mireya H. Garcia, M.D.
 Michael D. Goldberg, M.D.
 Niyaz Gosmanov, M.D.
 Ashutosh Gupta, M.D.
 Isil Halac, M.D.
 Joan Han, M.D.
 Molly H. Harrington, M.D.
 Abeer Hassoun, M.D.
 Maria J. Henwood, D.O.
 Stephanie C. Hsu, M.D., Ph.D.
 Eric A. Huang, M.D.
 Camilo Jimenez, M.D.
 Dyron Juc, M.D.
 Matthew F. Kamil, M.D.
 Ana H. De Luca Karabell, M.D.
 Maria V. Karantza, M.D.
 Thomas G. Kelly, M.D.
 Janice Kerr, M.D.
 Hootan Khatami, M.D.
 Jaime Kim, M.D.
 Renee A. Kinman, M.D., Ph.D.
 Polyxeni D. Koutkia, M.D.
 Natasha Leibel, M.D.
 Jefferson P. Lomenick, M.D.
 David M. Maahs, M.D.
 Aristides K. Maniatis, M.D.
 Nicole A.V. Matthews, M.D.
 Arlene B. Mercado, M.D.
 Ryan S. Miller, M.D.
 Roshanak Monzavi, M.D.
 Elaine C. Moreland, M.D.
 Pablito G. Nagpala, M.D., Ph.D.
 Ralf M. Nass, M.D.
 Karen S. Penko, M.D.
 Priya Phulwani, M.D.
 Grazyna Piekos-Sobczak, M.D.
 David C. Plache, M.D.
 Xiaodan Qu, M.D.
 Vanessa Rodriguez, M.D.

Archana R. Sadhu, M.D.
 William T. Scouten, M.D.
 Jill H. Simmons, M.D.
 Jessica R. Smith, M.D.
 Michael S. Stalvey, M.D.
 Sumana Sundararajan, MBBS
 Elena Sutu, M.D.
 Denise A. Teves, M.D.
 Aysin Uckun-Kitapci, M.D.
 Priya Vaidyanathan, M.D.
 Moshe Weiss, M.D.
 Kupper A. Wintergerst, M.D.
 Catherine M. Yates, M.D.
 Sung-Eun Yoo, M.D.
 Christine H. Yu, M.D.
 Ping Zhou, M.D.

Summer Research Fellowships

25 students won a Summer Research Fellowship. The Society awards these fellowships to promising undergraduate students, medical students, and students entering graduate school to encourage them to pursue careers in endocrinology. The Society will provide each student with a \$4,000 stipend to participate in research projects under the guidance of a Society member for eight to ten weeks during the summer. Supported by The Endocrine Society.

Student: Kim Natasha Berg
Mentor: Judith Luborsky, Ph.D.

Student: Vance Broach
Mentor: Roy Weiss, M.D. Ph.D.

Student: Varun Chowdhry*
Mentor: Patricia Hinkle, Ph.D.

Student: Selina A. Estwick
Mentor: Michael Econs, M.D.

Student: Flavia Fedeles
Mentor: Andrew Arnold, M.D.

Student: Manuel David Gahete-Ortiz
Mentor: Rhonda Kineman, Ph.D.

Student: Daniel G. Gebremedhin
Mentor: Dimitris Papanicolaou, M.D.

Student: Jennifer E. Griffin
Mentor: Deborah Good, Ph.D.

Student: Melissa Jenny Ho
Mentor: Mladen Vranic, M.D.

Student: Ryan Holly
Mentor: Beatrice Darimont, Ph.D.

Student: Sonya Marie Hughes
Mentor: Andrea Gore, Ph.D.

Student: Jennifer Hunnicutt
Mentor: Pamela Mellon, Ph.D.

Student: Dandan Liu
Mentor: Stephen Rosenthal, M.D.

Student: Sara Murray
Mentor: Gerard Elberg, Ph.D.

Student: Rebecca Ohman
Mentor: Jane Reusch, M.D.

Student: Eric Joseph Palfreyman
Mentor: E. Dale Abel, M.D., Ph.D.

Student: Simina Popa
Mentor: Robert Steiner, Ph.D.

Student: Madeeha Saeed
Mentor: Agnes Schonbrunal, Ph.D.

Student: Michael J. Sanderson
Mentor: Donald McClain, M.D., Ph.D.

Student: Maia Schoonmaker
Mentor: Joan Jorgensen, DVM, Ph.D.

Student: Brandon Stone
Mentor: Sally Camper, Ph.D.

Student: Robert Hill Thiele
Mentor: Sudhansu Dey, Ph.D.

Student: Roberto Treviño
Mentor: Eric Widmaier, Ph.D.

Student: Kay Waud
Mentor: Denis Magoffin, Ph.D.

Student: Lena Webb
Mentor: Marc Tetel, Ph.D.

*`Designated as the recipient of the Maurice Raben Summer Research Fellowship for research related to thyroid disease.

The Endocrine Society extends a special thanks to the Student Affairs Committee and other individuals who volunteered to review the applications for these prestigious awards. Without their participation and dedication to the Society, these awards would not be possible. **EN**



Important Diagnosis (ICD-9-CM) Coding Changes for 2004

Richard A Dickey, MD, FACP, FACE

Chair, Clinical Affairs Committee; Endocrine Society's CPT advisor, RUC advisor, and member AMA Practice Expense Advisory Committee (PEAC)

The last issue of *Endocrine News* featured endocrinology-pertinent code changes for 2004 in the Healthcare Common Procedure Coding System (HCPCS) Medicare National Level II code system of over 4,000 codes. In this issue of *Endocrine News*, Coding News will cover new and changed codes in the diagnosis coding system (ICD-9-CM).

The International Classification of Diagnosis codes (ICD-9-CM) are primarily diagnosis/numeric codes (three numbers followed by

a period after which there may be up to two additional numbers); V codes (for Supplementary Classification of Factors Influencing Health Status and Contact with Health Services) consisting of V followed by two or three numbers and a period, followed by one or two additional numbers; and E codes (Supplementary Classification of External Causes of Injury and Poisoning) consisting of an E followed by three numbers which may be followed by a period followed by one additional number.

Listed below are the important code changes for 2004. There are no important changes for the E codes.

Should you be aware of any additional changes for 2004, please advise Janet Kreizman, Director of Programs & Policy Affairs, at 1-301-941-0252 or jkreizman@endo-society.org



Richard A Dickey, MD, FACP, FACE

ICD CODE	DESCRIPTOR	TYPE OF CHANGE	NOTE
255.1	Hyperaldosteronism	Revised code title	Use one of the five new codes below instead of this code
255.10	Primary aldosteronism	New code	
255.11	Glucocorticoid-remediable aldosteronism	New code	
255.12	Conn's syndrome	New code	
255.13	Bartter's syndrome	New code	
255.14	Other secondary aldosteronism	New code	
277.8	Other specified disorders of metabolism	Revised code title	Use one of the five new codes below instead of this code
277.81	Primary carnitine deficiency	New code	
277.82	Carnitine deficiency due to inborn errors of metabolism	New code	
277.83	Iatrogenic carnitine deficiency	New code	
277.84	Other secondary carnitine deficiency	New code	
277.89	Other specified disorders of metabolism	New code	

Continued.



ICD CODE	DESCRIPTOR	TYPE OF CHANGE	NOTE
625.4	Premenstrual tension syndrome	Revised text to address coding premenstrual dysphoric disorder (PMDD)	
752.8	Other specified anomalies of genital organs	Revised code title	Use one of the two new codes below instead of this code
752.81	Scrotal transposition	New code	
752.89	Other specified anomalies of genital organs	New code	
780.93	Memory loss	New code	
780.94	Early satiety	New code	
790.2	Abnormal glucose	Revised code title. The three new codes below exclude diabetes mellitus (250.00-250.93), dysmetabolic syndrome X (277.7), gestational diabetes (648.8), glycosuria (791.5), hypoglycemia (251.2), abnormal glucose complicating pregnancy, childbirth, or puerperium (648.8)	Use one of the three new codes below instead of this code
790.21	Impaired fasting glucose	New code	
790.22	Abnormal glucose tolerance test (oral)	New code	
790.29	Other abnormal glucose	New code	
799.81	Decreased libido	New code. Excludes psychosexual dysfunction with inhibited sexual desire (302.71)	
V25.03	Encounter for emergency contraceptive counseling and prescription (postcoital)	New code	
V45.85	Insulin pump status	New code	
V53.9	Fitting and adjustment of other and unspecified device	Revised code title	Use one of the three new codes below instead of this code
V53.90	Fitting and adjustment of unspecified device	New code	
V53.91	Fitting and adjustment of insulin pump	New code	
V53.99	Fitting and adjustment of other device	New code	
V65.46	Encounter for insulin pump training	New code	

References:

1. International Classification of Diseases ICD-9-CM 2004. *Available from the AMA (discount for AMA member) or other suppliers.*
2. HCPCS Level II Codes 2004 *Available from the AMA (discount for AMA member) or other suppliers.*

BECOME A MEMBER OF THE ENDOCRINE SOCIETY

The Endocrine Society welcomes you to apply for membership if you have a commitment to endocrine research, practice and/or education. Membership in the Society will provide you with an extraordinary opportunity to network with more than 11,000 scientists and clinicians worldwide who are involved in all disciplines of endocrinology. You will also benefit from the variety of programs and services that the Society offers to foster and enhance your professional development, including:

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- Discounted subscription rates to the Society journals: *The Journal of Clinical Endocrinology and Metabolism*, *Endocrinology*, *Molecular Endocrinology*, *Endocrine Reviews*
- Eligibility to sponsor abstracts that are submitted for ENDO
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JULY

July 3-8, 2004: 2004 FASEB Summer Research Conferences - Virus Assembly, Saxton's River, VT. For more information please visit www.src.faseb.org

July 4-7, 2004: Human Growth in Sickness and in Health, Florence, Italy. For more information please visit <http://www.auxologia.org> or contact Centro Studi Auxologici by phone +39 55 290932 fax +39 55 290932 or email congress@auxologia.org

July 5-9, 2004: Summer Neuropeptide 2004 Conference, Miami Beach, FL. For more information please email meetings@unitours.co.il

July 10-14, 2004: 4th Forum of European Neuroscience, Lisbon, Portugal. For more information please visit <http://www.fens.org/fens2004.org/>

July 11-13, 2004: Bangalore Bio 2004, Bangalore, Karnataka, India. For more information please visit <http://www.bangalorebio2004.com> call + 91 - 80 - 51131912/13/15 fax + 91 - 80 - 51131914 or email info@bangalorebio2004.com

July 14-18, 2004: 1st Annual Symposium of the American Heart Association's Council on Basic Cardiovascular Sciences: Stress Signals, Molecular Targets, and the Genome, Stevenson, WA. For more information please visit <http://www.americanheart.org> or email scientificconferences@heart.org

July 14-15, 2004: IBC's Cardiovascular Research & Therapeutic Development, Cambridge, MA. For more information please visit <http://www.LifeSciencesInfo.com/cardio/?source=3066-47> or email reg@ibcusa.com

July 14-17, 2004: Summer Conference on OB/GYN, Yosemite, CA. For more information please visit <http://www.symposiamedicus.org/calendar.asp>

July 17-22, 2004: 2004 FASEB Summer Research Conferences—Retinal Neurobiology and Visual Processing, Saxton's River, VT. For more information please visit <http://src.faseb.org>

July 17-22, 2004: 2004 FASEB Summer Research Conferences—Modern Scientific Approaches to Drug Addiction: Relationship with Behavior, Tucson, AZ. For more information please visit <http://src.faseb.org>

July 17-22, 2004: 2004 FASEB Summer Research Conferences—Protein Phosphatases, Snowmass Village, CO. For more information please visit <http://src.faseb.org>

July 17-22, 2004: 2004 FASEB Summer Research Conferences—Phospholipases, Pine Mountain, GA. For more information please visit <http://src.faseb.org>

July 18-30, 2004: 30th Ten-Day Seminar on the Epidemiology and Prevention of Cardiovascular Disease, Tahoe City, CA. For more information please visit <http://www.americanheart.org> or email scientificconferences@heart.org

July 18-23, 2004: Seventh International Symposium on Neurobiology and Neuroendocrinology of Aging, Bregenz, Austria. For more information please visit <http://www.neurobiology-and-neuroendocrinology-of-aging.org/> or email Dr. Andrez Bartke at abartke@siumed.edu

July 18-30, 2004: 45th Annual Short Course in Medical and Experimental Mammalian Genetics, Bar Harbor, ME. For more information please visit <http://www.jax.org/courses/events/course/details.do?id=31> or contact Ms. Judi Alexander by phone 207-288-6326 or email judih@jax.org

July 20-24, 2004: Seattle Internal Medicine Board Review Course, Seattle, WA. For more information please visit <http://www.acponline.org/cme/courses.htm>

July 24-30, 2004: Disparities In Health In America: Working Towards Social Justice, Houston, TX. For more information please contact Ms. Anissa Lewis by phone 713-563-4006 or email ajlewis@mdanderson.org

July 31 – August 05, 2004: National Medical Association (NMA) 2004 Annual Convention, San Diego, CA. For more information please visit <http://www.nmanet.org> **EN**

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October 3-6, 2004

Hyatt Regency Baltimore • Baltimore, MD

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- Refresh your knowledge in endocrinology
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- Prepare for Board Exams
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Focus on Diagnosis and Management of Endocrine Disorders

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- Cutting-edge plenary lectures
- Taught by experts
- Format offers opportunity to interact with faculty and ask questions on case management
- Covers major endocrine areas: diabetes, lipids/cardiovascular, pituitary, adrenal/hypertension, thyroid, reproduction, bone mineral

Board Review Session • October 1-2

This unique, interactive workshop preceding CEU 2004 provides an intensive review of the eight key areas of endocrinology: thyroid, adrenal/hypertension, pituitary, calcium/bone, reproduction, lipids/obesity, diabetes/obesity, and pediatrics.

Special Thyroid Sonography Hands-On Workshop • October 6

For more information, visit
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