

CONSENSUS STATEMENT

Consensus statement on the management of the GH-treated adolescent in the transition to adult care

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Abstract

The European Society for Paediatric Endocrinology held a consensus workshop in Manchester, UK in December 2003 to discuss issues relating to the care of GH-treated patients in the transition from paediatric to adult life. Clinicians experienced in the care of paediatric and adult patients on GH treatment, from a wide range of countries, as well as medical representatives from the pharmaceutical manufacturers of GH participated.

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Introduction

Growth hormone (GH) has multiple beneficial effects in addition to its promotion of linear growth. These include maintenance of normal body composition and metabolism through adult life. Therefore, in GH-deficient individuals replacement throughout the life cycle is indicated. However, up until recently, insufficient evidence was available to determine if GH treatment should continue seamlessly or could be interrupted for a period of time at the end of growth without incurring disadvantage to the adolescent. Equally, information on GH dose requirement has only now become available. Thus the European Society for Paediatric Endocrinology judged that this was an appropriate time to provide some guidance on the assessment of those completing treatment with GH for growth promotion, not only for GH deficiency (GHD) but also for other causes of short stature.

Clinical programmes need to be developed for these young people to facilitate the orderly transfer of their care from paediatric to adult endocrine services, to optimise compliance and patient acceptance and to minimise interruption of care. This transfer of care occurs during a developmental stage referred to as the transitional period, during which important issues relating to post-pubertal maturation require consideration.

Definition of transition

Transition refers to a broad set of physical and psychosocial changes, arbitrarily defined as starting in late

puberty and ending with full adult maturation. This usually implies a period from mid to late teens until 6–7 years after achievement of final height.

The aims of management in the transition period for the GH-treated adolescent include the following: (a) reassessment of aetiology and disease-specific management; (b) reassessment of the GH treatment regimen to mimic the diminishing production of endogenous GH secretion; (c) achievement of full adult somatic development including lean body mass and bone mineral accrual; (d) completion of pubertal, sexual and reproductive maturation; (e) reduction of metabolic and cardiovascular risks; (f) attainment of adult psychosocial development; and (g) education to ensure that patients have an understanding of their disease to develop autonomy in health care decision making.

Delivery of transition care

Clinics in the transition period have been seen to be effective in a number of chronic disease states, such as diabetes mellitus, chronic renal failure and cystic fibrosis, in terms of improving compliance during the hand-over to adult services, and aiding patient acceptance of adult services. Transition care requires a dedicated service with contributions from paediatric and adult endocrinology. Local resources will determine the precise format of the service.

Paediatric and adult endocrinologists participating in a transition programme should be experienced in the management of hypopituitarism and GHD. The multidisciplinary approach should include the support of