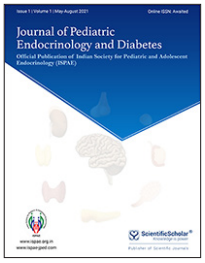
ScientificScholar®
Knowledge is power
Publisher of Scientific Journals

https://ispae-jped.com/

Journal of Pediatric Endocrinology and Diabetes



Editorial

Editor's page

P. S. N. Menon[1]

[1]Former Professor of Pediatrics and In-Charge, Division of Pediatric Endocrinology, All India Institute of Medical Sciences, New Delhi, India.

***Corresponding author:**
P. S. N. Menon,
EA8-3 Primanti Garden Estate, Sector 72, Southern Peripheral Road, Gurugram 122101, Haryana, India.

psnmenon@hotmail.com

Received: 13 March 2024
Accepted: 13 March 2024
Published: 05 April 2024

DOI
10.25259/JPED_9_2024

Quick Response Code:

We welcome you all to another interesting issue of our journal, covering a collection of original articles, case reports, images, reviews, and journal updates. We do hope these articles are academically stimulating to the readers, especially the postgraduate students and fellows in training. We had a stimulating biennial meeting of our society at Bengaluru in November 2023, preceded by the Fellow's School. The attendance was good and a number of original oral and poster presentations were made by budding talents during the meeting. We hope that some of them will get published in J Pediatr Endocrinol Diabetes in the near future. We also listened to quite a few thought-provoking talks from invited faculty from India and abroad on the current practice of clinical pediatric endocrinology and recent insights.

We look forward to the APPES meeting in New Delhi in October 2024.

Hypoglycemia is one of the most common presenting complaints in pediatric emergency departments. There are many distinct causes of hypoglycemia, ranging from nutritional insufficiency and infectious origins to metabolic disorders. Full clinical assessment and appropriate investigations can help differentiate the cause of hypoglycemia with subsequent tailored management. All patients with hypoglycemia should ideally have a full clinical assessment and a "hypoglycemia screen" if appropriate. In this issue, Chai *et al*. from Glasgow, Scotland, UK, describe a clinical review of investigations of hypoglycemia in young children below six years and whether the children received a subsequent diagnosis and adequate follow-up advice.[1] The authors noted that screening was not consistently performed for all patients presenting with hypoglycemia and that the great majority of children were not fully investigated or followed up. The authors have cautioned that children with moderate and severe hypoglycemia still require further investigations as they may lead to long-term consequences.

In an invited editorial commentary, Senniappan and Ramakrishnan from Liverpool, UK, note that the etiologies of hypoglycemia are different in neonatal and pediatric age groups.[2] They also point out that different cutoffs are used to define hypoglycemia, even in neonates the world over. Many patients with known risk factors are not evaluated unless they have refractory or persistent hypoglycemic episodes. The authors highlight that the adoption of the recently published National Health System Greater Glasgow and Clyde guidelines used in Scotland for evaluating neonatal hypoglycemia would have helped more neonates included in this study. Hypoglycemia in the postneonatal age group is different in presentation and etiology from those in neonates. A "hypoglycemia order set" on the electronic medical record system to facilitate completeness of testing and ease of requesting the tests during emergencies may be helpful. It is important that the hypoglycemia cutoffs and investigation list are shared and discussed widely with the neonatal and emergency teams to ensure adequate compliance with guidelines.

Bhardwaj from Jabalpur, Madhya Pradesh, India, discusses the Indian perspective in the evaluation of hypoglycemia in newborns and infants.[3] There is a lack of consensus on the diagnostic cutoff of low blood glucose (BG) in different age groups and the threshold for initiating treatment in children who are symptomatic vis-a-vis those who are asymptomatic. History of presenting illness, family history, and clinical findings can provide clues to the likely etiopathology. A low BG detected by a glucometer needs to be confirmed by parallel testing in the laboratory. A critical blood sample and first urine sample after the laboratory confirmed low BG should be collected for re-assessment. There is a need to sensitize pediatricians to endocrine disorders presenting as hypoglycemia regularly.

This issue also has some unusual yet noteworthy case reports. Mishra *et al*., from Kanpur, Uttar Pradesh, India, describe a family of two children and a mother with pseudohypoparathyroidism type 1A.[4] The proband, a 14-year-old boy, had short stature, obesity, skeletal anomalies, hypocalcemia, and hypothyroidism. His 12-year-old sister had bone pains and carpopedal spasms with hypocalcemia. The mother had short 3rd and 4th metacarpals with normal biochemical profiles. Clinical exome sequencing in the siblings revealed heterozygous inactivating mutations in the *GNAS* gene, highlighting the differences in phenotypes.

Chrisbina *et al*. from Chennai, Tamil Nadu, India, describes the details of twin neonates with hypoglycemia due to exogenous insulin administration by a mother suffering from postpartum psychosis and accidentally noted by the father.[5] During their neonatal intensive care unit stay, both the babies developed multiple episodes of symptomatic refractory hypoglycemia with seizures and were managed with intravenous dextrose boluses and infusion, glucagon infusion, octreotide, diazoxide, and glucocorticoids. The authors highlight the importance of history taking and physical examination for early diagnosis and appropriate management.

Boddu *et al*. from Hyderabad, Telangana, India, describe the case of an adolescent boy who presented with excessive hunger, poor weight gain, anasarca, hypoalbuminemia, and electrolyte imbalance.[6] Investigating the history of post-meal drowsiness showed postprandial hypoglycemia, which, on subsequent evaluation, revealed elevated fasting insulin and suppressed postprandial insulin levels. This eventually led to the uncovering of a deliberately and cleverly concealed purging behavior. A meticulous interview of the family and the child confirmed the diagnosis of anorexia nervosa, binge eating-purging type, and averted unnecessary further investigations into the cause of failure to thrive.

In the Letters to the Editor section, Kumar *et al*. from New Delhi, India, present an unusual case of Wolfram syndrome (WFS), who developed status epilepticus accompanied by an episode of hypoglycemia.[7] Neurological manifestations usually manifest in WFS after the second decade. Neuroimaging revealed brainstem and cerebellar hypoplasia. The child recovered with neuroprotective measures.

In the Images section, Banerjee *et al*. from Chandigarh, India, highlight the importance of limited joint mobility, a common manifestation of long-term suboptimal glycemic control in children with type 1 diabetes.[8] Tabletop test (putting the palm against a flat surface) and "Namaste" prayer position are standard clinical methods to detect the condition. Individual joint examination at the metacarpophalangeal joint, proximal and distal interphalangeal joint, or any other joint for a range of motion and resistance is also important.

In our regular feature on "Ped Endo Journal Scan," Joshi, Brisbane, Australia, discusses five recent publications on baricitinib and β-cell function in patients with new-onset type 1 diabetes, clinical characteristics, and outcomes of prolactinomas in children and adolescents: a large retrospective 1 cohort study, dasiglucagon for the treatment of congenital hyperinsulinism: a randomized phase 3 trial in infants and children, vitamin D supplements for fracture prevention in schoolchildren in Mongolia: analysis of secondary outcomes from a multicenter, double-blind, randomized, placebo-controlled trial, and incidence and risk factors for adrenal crisis in pediatric-onset adrenal insufficiency: a prospective study.[9] The editors felt that these new research articles would add new insights for better management of children with chronic endocrine disorders.

We have endeavored our best to present to you a variety of interesting clinical situations requiring astute observations, clinical acumen, and supportive laboratory in the diagnosis and management of common endocrine situations.

We look forward to your comments and suggestions and welcome contributions to the forthcoming issues of our journal.

Happy reading!

REFERENCES

1. Chai XY, Shaikh MG, McNeilly JD. Etiology and outcome of hypoglycemia in young children: A retrospective cohort study. J Pediatr Endocrinol Diabetes 2023;3:100-5.
2. Senniappan S, Ramakrishnan A. Evaluation of the etiology and outcome of hypoglycemia in young children - a challenging task. J Pediatr Endocrinol Diabetes 2023;3:95-6.
3. Bhardwaj VK. Etiology and outcome of hypoglycemia in young children: Indian perspective. J Pediatr Endocrinol Diabetes 2023;3:97-9.
4. Mishra A, Singh S, Mishra P. Pseudohypoparathyroidism type 1A and Albright hereditary osteodystrophy: A genetic conundrum of multiple hormonal resistances in a family. J Pediatr Endocrinol Diabetes 2023;3:106-9.
5. Chrisbina AJ, Krishnan BA, Prasad H. Acute insulin-induced hypoglycemia in twin neonates. J Pediatr Endocrinol Diabetes 2023;3:114-7.
6. Boddu SK, Koyalakonda CS, Murthy MN. Postprandial

hypoinsulinemic hypoglycemia as a clue to hidden purging behavior in an adolescent boy with disordered eating. J Pediatr Endocrinol Diabetes 2023;3:110-3.
7. Kumar K, Dabas A, Saxena R. Early neurological association in a young child with Wolfram syndrome. J Pediatr Endocrinol Diabetes 2023;3:118-9.
8. Banerjee S, Yadav J, Kumar R. A boy with type 1 diabetes who could not do 'Namaste'! J Pediatr Endocrinol Diabetes 2023;3:120-1.
9. Joshi K. Ped Endo journal scan. J Pediatr Endocrinol Diabetes 2023;3:122-5.

How to cite this article: Menon PS. Editor's page. J Pediatr Endocrinol Diabetes. 2023;3:92-4. doi: 10.25259/JPED_9_2024