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Editorial

Editor's page

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It gives us great satisfaction to launch this third issue of the journal. The first two issues were very well received, and we hope that the current issue will be equally well accepted. The number of submissions at our journal website has seen a significant climb and we may increase the number of manuscripts to be included in the forthcoming issues. It is our ardent hope that the members of our society Indian Society for Pediatric and Adolescent Endocrinology (ISPAE) and sister societies will continue patronizing us with the submission of more original research papers.

In this issue, we are focusing on two themes of significant concern to all pediatric endocrinologists and diabetologists. Hypothyroxinemia of prematurity is generally attributed to the immaturity of the hypothalamic-pituitary-thyroid axis and is largely believed to be transient. This leads to a blunted surge of the thyroid stimulating hormone (TSH) and low free thyroxine (FT4) levels. Generally considered benign, hypothyroxinemia in preterm needs to be differentiated from congenital hypothyroidism during newborn screening using current recommendations. *Seema Gaonkar and colleagues from Bengaluru, South India,* while analyzing their data recommend retesting FT4 levels at 2 weeks of life provided congenital hypothyroidism were ruled out by 3–4 days of life.

In an invited editorial on this topic, *K G Ravikumar from Chennai, South India,* cautions us to be careful about interpreting newborn thyroid screening data in preterm babies. He points out that there is no clear consensus regarding the timing of testing in babies with hypothyroxinemia of prematurity. While the American Academy of Pediatrics 2006 guidelines suggest serial measurements of T4 until they become normal, the European consensus guidelines recommend repeating thyroid tests at 10–14 days. "Newborn Screening Guidelines for Congenital Hypothyroidism in India" published by the ISPAE recommends routine screening for all preterm infants at 48–72 h of age, followed by a second screening test at 2–4 weeks of age for high-risk babies. Further long-term studies involving a larger number of patients are required to address this issue.

We also present another important aspect of managing acute emergencies, such as diabetic ketoacidosis (DKA) in limited resource setting (LRS). The mainstay of treatment for DKA is the correction of dehydration and hyperglycemia with intravenous (IV) fluids and IV insulin (IVI). Subcutaneous insulin (SCI) has been tried in a few centers in patients with DKA if the blood pH is >7. In general, IVI is preferred over SCI, or intramuscular insulin as its onset is rapid, and the dose can be titrated based on the patient's varying blood glucose levels. However, IVI is associated with a higher cost of hospitalizations and resource requirements. *Ahila Ayyavoo and colleagues from Coimbatore, South India,* suggest in an observational study that SCI could be an alternative to IVI infusion for DKA to reduce the costs and distress, in children during times of resource constraint such as the COVID-19 pandemic and in other resource-limited settings.

Leena Priyambada, Hyderabad, South India, has reviewed the management of DKA associated with type 1 diabetes (T1D) with special reference to LRS. The newly released T1D index shows that remaining life expectancy of T1D children in the LRs is significantly low due to a variety of reasons. The recently released guidelines by the International Society for Pediatric and Adolescent Diabetes have taken into account the evidence from the studies on the use of SCI in less severe and uncomplicated forms of T1D. There is no doubt that the need of the hour is a globally intensified effort to bring down the cost of insulin (and its analogs) and makes monitoring more available and affordable to reduce the incidence of this dreaded complication.

We have our usual section on interesting case reports. These include a case of *McCune-Albright syndrome* presenting with precocious puberty and growth hormone excess and asymptomatic fibrous dysplasia. Another interesting association of *neonatal diabetes mellitus with congenital hypothyroidism* due to *GLS3* mutation is presented. Yet, another case report presents a case of *Allan-Herndon-Dudley syndrome* due to a novel pathogenic variant in *MCT8* gene and the importance of free T3 assay in addition to TSH and FT4 in boys with severe developmental delay.

Continuing with the new series on "Genetics for the Pediatric Endocrinologists" *Neerja Gupta and Amit Kumar Gupta* discuss the diagnosis and management of primordial short stature. Good clinical observations can probably identify those children with genetic forms of primordial short stature from simple intrauterine growth restriction and small for gestational age. Characterizing the genotype will help the young endocrinologist choose appropriate treatment strategies.

Kriti Joshi has done commendable work once again to provide selected summaries of the recent publications in other journals, which are thought-provoking examples of advances in current research and state-of-the-art. I hope these will provide an impetus for young fellows and students alike.

The *interesting images section* features the importance of clinical examination in making a bedside diagnosis of pseudohypoparathyroidism.

A young trainee articulates vividly her experiences and joy in choosing a career in pediatric endocrinology. I am sure these experiences will provide exciting perspectives on the ever-changing state of clinical practice in the face of adversities.

I do hope these articles are stimulating. Happy reading!

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