Editorials

Subclinical endocrinological disease

Diagnosis and treatment of endocrinological disturbances have improved considerably during the last decades. However, through ameliorated diagnostic tools – both biochemically and with respect to imaging techniques – the existence of subclinical endocrinological diseases has come to light. In the recent literature there are innumerable articles on this subject. It is not always easy for the practising clinician to decide whether or not to treat these patients or to monitor them closely. To help the practicing clinician, the *Postgraduate Medical Journal* will be publishing a series of five review articles on subclinical endocrinological disorders.

On p.67 of this issue, Heine and Mooy review the epidemiology of impaired glucose tolerance and undiagnosed non-insulin dependent diabetes mellitus (NIDDM) and address the implications for screening strategies. The prevalence of impaired glucose tolerance and NIDDM appears to be much higher (approximately double) than is known from diagnosed cases. Also chronic complications or risk factors for cardiovascular disease appear to be more prevalent in undiagnosed diabetes as compared to already known diabetics. Screening seems to be worthwhile. Many of the reported data come from their own investigations, known as the Hoorn study.

In the next issue, Elte, Mudde and Nieuwenhuijzen-Kruseman will report on subclinical thyroid disease. By definition there are no clinical signs or symptoms in patients with subclinical functional disorders. Cut-off points for the treatment of these subclinical thyroid diseases are arbitrary, but are given if data are available to support the use. This appears to be easier for subclinical hypothyroidism than for subclinical hyperthyroidism. Incidentally found thyroid nodules are prevalent and often have no clinical relevance.

The contribution of Newell-Price and Grossman will concern adrenal incidentaloma and subclinical Cushing's syndrome. The main questions here are whether there is

hormonal hypersecretion and whether malignancy can be excluded. A careful evaluation should be performed. However, even thereafter management is not always easy and recommendations may very well change with time. Nevertheless, the authors present some guidelines.

Soule and Jacobs will cover the evaluation and management of subclinical pituitary disease. Incidentalomas of the pituitary should be investigated with respect to the possible hypersecretion of adrenocorticotropin, growth hormone and prolactin (and thyroid-stimulating hormone); moreover, in macroadenomas hypopituitarism, compression of the optic chiasm and the potential for infarction should be examined. However, the natural history of most pituitary incidentalomas seems to be benign.

For a long time a controversy has existed on whether asymptomatic primary hyperparathyroidism needs treatment or only follow-up. Birkenhäger and Bouillon will summarise the literature and give their opinions. They state that hypercalcaemia always needs aetiological exploration and that successful correction of the primary disease is frequently possible and beneficial. Many 'asymptomatic' patients with primary hyperparathyroidism already have complications such as lowered bone mineral density, cardiovascular disease and/or (neuro)psychiatric symptoms. Surgery seems advisable if life expectancy exceeds 10 years and if there is no increased surgical risk.

The intention of the series on *Subclinical endocrinological disease* is to offer the practising clinician some help in situations in which decisions are not always easy. It is hoped that the readers of the *Postgraduate Medical Journal* will enjoy reading the articles as much as the series editor did.

JAN WILLEM F. ELTE
Department of Internal Medicine,
Sint Franciscus Gasthuis,
Rotterdam, The Netherlands