

المؤتمر الوطني السادس للسكري والغدد الصماء

تُنظَّمه الجمعية الليبية للسكري والغدد الصماء برعاية مجلس التخصصات الطبية

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The Advance Abstracts Booklet

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من الثامن والعشرين إلى الثلاثين من إبريل لسنة 2008 بالقبة السماوية طرابلس ليبيا

April 28-30, 2008 Tripoli, Libya

LIBYAN ASSOCIATION FOR DIABETES AND ENDOCRINOLOGY

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The Sixth Libyan Diabetes and Endocrinology Conference

April 28-30, 2008, Skydome Tripoli, Libya.

Organized by

The Libyan Association for Diabetes and Endocrinology

and The Libyan Board for Medical Specialties

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سانوفي أفينتيس

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M1. IBN-SINA MEDAL LECTURE 2008:

THYROID AND THE HEART

Abdulfattah Ali LAKHDAR, Whipps Cross University Hospital, London, UK.

Thyroid hormones directly affect the heart and peripheral vascular system, increase myocardial inotropy and heart rate and dilate peripheral arteries to increase cardiac output and coronary circulation. Changes in cardiac function is mediated by T3 regulation of cardiac-specific genes. T3 increases the systolic depolarisation and diastolic repolarization rate and decreases the action potential duration and the refractory period of the atrial myocardium as well as the atrial/ventricular nodal refractory period. Thus atrial arrhythmias are frequent complications of overt hyperthyroidism especially in the elderly. Chronic hyperthyroidism induces cardiac hypertrophy and left ventricular mass leading to increased cardiovascular mortality and morbidity. Epidemiologically hyperthyroidism is associated with increased overall and cardiovascular mortality. Overt or subclinical hyperthyroidism warrants treatment.

In hypothyroidism the cardiac haemodynamics depend on the severity of thyroid hormone deficiency. Most frequently hypothyroid patients have increased vascular resistance, diastolic dysfunction, reduced systolic function and decreased cardiac preload increasing the risk of atherosclerosis in these patients that regresses with Thyroxine replacement therapy. Hypercholesterolaemia and marked increase in LDL is typical of this condition and may in part explain the frequently noted atherosclerosis. LDL increase in these patients is due a decrease in LDL receptor expression. Diastolic hypertension, arterial stiffness and endothelial dysfunction, altered coagulability may further contribute to the cardiovascular risk associated with overt and subclinical hypothyroidism. Morphologically the most consistent cardiac abnormality in hypothyroid patients is impaired left ventricular diastolic function. Hypertension due to increased arterial stiffness is common. Non-traditional risk factors for cardiovascular disease are common in overt hypothyroidism (homocysteine, CRP and alteration in coagulation parameters) but not consistent in subclinical disease. Congestive heart failure is increased in overt and subclinical hypothyroidism. Epidemiologically subclinical hypothyroidism has twice the risk of developing coronary heart disease. Thyroid replacement lowers cholesterol levels, reduces cardiovascular risk coronary artery disease progression and improves survival. Using Thyroxine in patients with ischaemic heart disease increases the risk of MI, aggravation of angina or cardiac arrhythmias. Such patients especially elderly need caution and starting Thyroxine at low dose. Asymptomatic patients with thyroid disease should be identified and offered treatment as they can benefit from therapy

M2. AL-FITURI MEDAL LECTURE 2008:

MUSCULOSKELETAL/RHEUMATIC COMPLICATIONS OF DIABETES MELLITUS: AN OVERVIEW. Rida Saleh BARUNI, Division of Physical Medicine, Rehabilitation and Pain, Department of Medicine, Sheikh Khalifa Medical City, Abu Dhabi, UAE.

A potpourri of musculoskeletal / rheumatic conditions associated with diabetes mellitus will be the scope of this presentation. In addition to micro- and macro-angiopathic complications, diabetes mellitus is also associated with a variety of rheumatic impairments that can be debilitating. These complications have not been as well recognized as the neurological, ophthalmic, cardiovascular, and renal complications of the disease. Patients with either type 1 or type 2 diabetes mellitus frequently have musculoskeletal complaints, such problems are commonly seen in subjects with a longstanding history of type 1 diabetes, but they are also seen in patients with type 2. Although very little is understood about the pathophysiologic consequences of hyperglycemia on bones, joints, tendons, ligaments, and muscles, there is well established association between diabetes and certain MSK syndromes. There is more than one way to categorize the MSK & Rheumatic complications of diabetes mellitus. A variety of suggested classifications will be discussed with emphasis on specific clinical entities from each group of these disorders. Early recognition and timely adequate therapeutic intervention/s may prevent profound disability.

M3. DR. SALEM SENUSSI MEMORIAL LECTURE:

THE INTERESTING FACE OF ENDOCRINOLOGY! Asma Ali DEEB, Imperial College London Diabetes Centre, Abu Dhabi, United Arab Emirates.

Putting aside all the advances in Genetics and technology which transformed Medicine, Endocrinology is interesting by nature. It is the branch of Medicine that displays a truly amazing human body. The concept of end organs being remotely controlled by the endocrine glands demonstrates a very sophisticated system. Moreover, the feedback mechanism relating these glands and their end organ provides a safety check for the control of various organ systems. The impact of advances in Genetic led to a revolution in Endocrinology which made the interesting area of Medicine even more exciting. Endocrine receptors are a main spot in the dynamics of the endocrine system. Their cross talks make endocrine disorders more challenging to endocrinologists. Various mutations of these receptors, activating and non activating, cause manifestations of the opposite ends of disease spectrum. These concepts enabled endocrinologists to treat diseases by manipulating the receptors in various modalities. Utilization of various knock out animal models was a key to understand the mechanism of many endocrine disorders. Technology has expanded the knowledge and the experience of Endocrinology. A clear example of this is the recent advances in the use of continuous subcutaneous insulin injections and real time sensing of glucose monitoring. Many models for the artificial pancreas are under trials nowadays which will eventually close the loop for diabetes treatment. The technology advances have been tailored to have direct clinical implications for patients' use. Beyond real time sensing transmitters for glucose monitoring, patients now have the option of checking their glucose level in tears by wearing special contact lenses. Moreover, dogs can now be trained to detect hypoglycemia of their diabetic owners! The lecture will cover some aspects of endocrine physiology, pathology, molecular genetics and the role of technology in endocrinology.

PLENARY LECTURE:

P1. KEY NOTE ADDRESS: PREVENTION IS BETTER THAN CURE: TAKE DIABETES FOR EXAMPLE!

Ahmed SWALEM, The Endocrine Unit, 7th October Hospital and Department of Medicine, Al-Arab Medical University, Benghazi, Libya.

Diabetes is a chronic disease whose incidence is increasing worldwide. The long term complications of diabetes place a large health and economic burden onto individuals, their families, and communities as a whole. Diabetes prevention has become a key target for clinicians, patients, and policy makers, as substantial evidence has accumulated that type 2 diabetes can be prevented or delayed in those at high risk by : life-style changes (e.g healthy diet) , weight loss through increasing physical activity , and smoking cessation. To date the evidence in favor of pharmacological methods is less robust , however encouraging results obtained so far suggest a promising future role for these agents. Several oral ant-hyperglycemic agents (e.g metformin) and the anti-obesity drug orlistat have been shown to significantly decrease progression to T2D. The role of other agents such as statins, estrogen, and anti-hypertensive agents remains to be clarified in additional well-controlled studies of diabetes prevention. Prevention of type 1 diabetes so far is still a research topic.

P2. THE FOOT IN DIABETES: PODIATRIST'S VIEW. Sami Hadi TABIB, Dubai Podiatry Center, Dubai and the Imperial College London Diabetes Centre, Abu Dhabi, UAE.

Diabetic foot disease has become a major medical, social and economic challenge worldwide. While 5% of patients with diabetes have a history of ulceration, the cumulative lifetime incidence is 15%. Of these, 20% will require amputation. In order to reduce the rates of lower extremity amputations amongst diabetics, a system of risk categorization and early intervention was advocated by The International Working Group on the Diabetic Foot. Recent studies have shown that early intervention, prior to developing diabetic foot complications, is the most effective method in reducing amputation rates. To achieve this, identification of the foot at risk should be the highest priority of any diabetic foot service. The risk factors to screen for are peripheral neuropathy, peripheral arterial disease, history of ulceration, amputation or neuroarthropathy, biomechanical dysfunction and inappropriate footwear. Ulceration is the pivotal event in the course of diabetic foot disease. The majority of these ulcers are neuropathic. Off-loading the ulcer area is the most critical and difficult aspect of ulcer management. Many modalities have been used to achieve complete off-loading but the most practical and effective method is a non-removable cast walker. In addition to proper wound care, infection control and off-loading, ulcer management should also focus on proper glycaemic control, patient and family education, depression, physical disability and obesity. Furthermore, a multidisciplinary approach to the management of the diabetic foot has been shown to

significantly reduce diabetes related lower extremity amputations. These teams should include a diabetologist, a vascular surgeon, a podiatrist, an orthopedic surgeon and an orthotist. Establishment of community based diabetic foot clinics is one way to provide the patient with easy access to a dedicated diabetic foot care team. In conclusion, routine foot assessment, early detection, education and a team approach can produce excellent results in the management of the diabetic foot.

P3. LADE ANNUAL LECTURE 2008: DIABETIC KETOACIDOSIS. Rafik Ramadan ELMEHDAWI. Department of Internal Medicine, Al-Arab Medical University, Benghazi, Libya.

Background: Diabetic ketoacidosis (DKA) is a common, serious and costly acute complication of diabetes. It is characterized by the triad of; hyperglycemia, anion gap metabolic acidosis, and ketonemia. The low insulin and high glucagon during DKA result in maximal gluconeogenesis and ketogenesis that lead to osmotic diuresis, dehydration, ketonemia and metabolic acidosis. DKA affects mainly type-1 DM patients but occasionally it also affects type-2 patients. It is more common in young women as compared to men and it carries a mortality rate between 2-10%. Precipitating factors: Insulin disruption and infection are the two most common precipitating factors of DKA worldwide. DKA as a first presentation of diabetes also contribute to a significant number of cases, while in some patient no obvious precipitating factor can be identified. Diagnosis and management: Diagnosis of DKA requires demonstration of the three components; hyperglycemia, metabolic acidosis and ketonemia. The severity of DKA is determined primarily by the pH level, and mental status, and not by the blood glucose measurement. For treatment of DKA the use of a standard protocol provides better and consistent results. Patients with severe DKA should be managed at Intensive Care Unit, while selected patients with mild DKA may be treated under observation and sent home without admission. Fluid, insulin and potassium replacement are the main parts of DKA management, as well as treating the precipitating factor, while bicarbonate replacement is rarely useful if ever. Prevention of another episode should be part of the treatment of DKA. Many problems may arise during DKA due either to disease itself or inappropriate management and they range from mild to life threatening complications. Mortality: With proper management the mortality rate should be less than 5%. Older age, co-morbidities, type-2 DM and decreased level of consciousness at presentation all might contribute to increased risk of mortality in individual patients. Delayed diagnosis and inappropriate management might also add to the mortality. National situation: In Libya the diagnosis and management of DKA is fragmented and not standardized and this contributes significantly to the considerably high mortality rate (9-10%) that is being reported over the last five years.

STATE OF THE ART LECTURES:

SA1. NEWER ANTI-DIABETIC AGENTS: INCRETIN-BASED THERAPIES IN TYPE 2 DIABETES. Amna Ali SALHIN, Diabetes and Glandular Disease Clinic, San Antonio, Texas USA.

Type 2 diabetes is a complex metabolic disease with long-term complications giving rise to significant morbidity and mortality. Diabetes is an epidemic health problem that is steadily increasing in prevalence for all age groups worldwide. Pivotal studies have established that intensive control substantially reduces both micro- and macrovascular complications associated with diabetes. Numerous strategies have been developed to achieve currently recommended treatment targets. Nonetheless, A1C and glycemic goals are not being met in a majority of patients. Insulin resistance and progressive decline in pancreatic beta cell function are the main pathogenic processes in Type 2 diabetes. Furthermore, patients with type 2 diabetes have impaired incretin action. Incretin hormones are intestinal peptides secreted in response to a meal and play an important role in glucose homeostasis. Glucagon like peptide-1 (GLP-1) and glucose dependent insulinotropic peptide (GIP) are the two major incretins that help regulate insulin secretion in glucose -dependent manner. Moreover, GLP-1 delays gastric emptying, suppresses post-meal glucagon level, and decreases food intake. They exhibit short half life as both are rapidly degraded by dipeptidyl peptidase-4 (DPP-4). Incretin-based therapies, also known as incretin mimetics (Exenatide) and incretin enhancers (Sitagliptin) that exploit the GLP-1 pathway are currently available to treat Type 2 diabetes; several other agents are still under investigation including exenatide LAR (long acting release) and liraglutide. Exenatide (Byetta) is a synthetic GLP-1 receptor agonist that is resistant to DPP-4 degradation and mimics the action of continuous GLP-1 infusion. As adjunctive therapy to oral agents, exenatide offers sustained A1C reduction with a secondary benefit of weight loss. Sitagliptin (Januvia) is an orally active inhibitor of DPP-4 enzyme, thereby promoting and prolonging the actions of active incretin hormones. It improves glycemic control and A1C without causing weight gain; indicated as monotherapy or in combination with metformin or thiazolidinediones. Given the recent development of these newer agents, their long-term benefits and safety have not been ascertained.

SA2. HYPERTENSION IN DIABETES: TRIALS, DRUGS AND TARGETS.

Mohsen S. ELEDRISI, Department of Medicine, Division of Endocrinology, National Guard Medical City, Eastern Province, Saudi Arabia.

Patients with diabetes carry a higher risk-up to 300 %- for the development of hypertension compared with people who do not have diabetes. The coexistence of diabetes and hypertension is common. About 60 % of patients with diabetes are diagnosed with hypertension. Hypertension works as a double hit with diabetes to further increase the risk of cardiovascular disease and renal disease in these patients. In addition, hypertension increases the risk of retinopathy and neuropathy. There is considerable evidence that control of blood pressure in patients with diabetes reduces cardiovascular events and microvascular complications. A target blood pressure of less than 130/80 mmHg in the diabetic population was endorsed by several professional organizations including the American Diabetes Association. Patients with chronic kidney disease or/and significant proteinuria (> 1 gram/day) require a more aggressive approach and a target of less than 125/75 mmHg is recommended. For patients with blood pressure levels of 130-139/80-89 mmHg, lifestyle changes including appropriate diet with salt restriction, achieving healthy weight and increased physical activity should be the initial line of management. Drug therapy should be considered if targets are not achieved after 3 months or if blood pressure levels are more than or equal 140/90 mmHg at diagnosis or follow up. An angiotensin converting-enzyme inhibitor or an angiotensin receptor blocker is recommended as a first line therapy. If one class is not tolerated, the other should be substituted. If target blood pressure is not attained, a thiazide diuretic is the next option. A loop diuretic can be used if the estimated glomerular filtration rate is less than 50/ml/min. Most patients require multiple drug therapy (two to more) to reach the desired target blood pressure. Because of the considerable risk of cardiovascular disease in patients with diabetes and hypertension, aspirin and a statin should be considered in all patients.

SA3. DIABETES AND HEART DISEASE: CARDIOLOGIST VIEW. Abdurrazzak A. GEHANI. Coronary Care Units, Hamad Medical Corporation and Cornell Medical College, Doha, Qatar

Diabetes is a major risk factor for heart disease. It affects every aspect of the practice of cardiology. Diabetics have higher incidence of all major cardiovascular events. Cardiovascular interventions are also associated with higher morbidity and mortality. Unlike in the general population, diabetic women have twice the mortality of diabetic men. While cardiovascular mortality is showing some decline, worldwide, diabetes seems to be on the increase. This is more so in some regions, including our Arab region. A diabetic man without previous myocardial infarction (MI) has similar the survival curve to a non-diabetic who already had an MI. If diabetes is added to a previous MI, the mortality is doubled in men and quadrupled in women. Despite these major adverse features of diabetes, there has been major understanding of the cardiovascular disease in diabetes. This lead to major preventative, pharmacological and interventional therapies with positive impact on management. The understanding of the crucial difference in the patho-physiology between ST Elevation MI (STEMI) with fibrin rich clot as opposed to the platelet-rich in Non-STEMI syndromes has given evidence-based therapy that translated into positive results. Dual anti-platelet therapy for Non STEMI syndromes and primary angioplasty for STEMI made a larger impact in diabetics than non-diabetics. The addition of GIIA/IIIB Receptor blockers has also added to this effect. Contrast nephropathy is a major determinant of post intervention morbidity and mortality. Several prophylactic regimens have been studied with variable results. Re-hydration and Sodium Bicarbonate infusion prior to the procedure appear to give the best results. Hyperglycemia and high HbA1c are independent risk factor for the long term prognosis for diabetic complications. Hyperglycemia on admission and during acute MI phase is also important determinants of prognosis. However, HbA1c is not as important as hyperglycemia in this acute setting. The DIGAMI-I trial suggested that insulin during acute MI improves survival; however, DIGAMI-II trial tested this conclusion in a three limb study and concluded that control of hyperglycemia rather than insulin which improved survival. Both trials and others agree that glycaemic and metabolic control during acute MI are important. In the long term, the target blood pressure and LDL-cholesterol levels are much lower than that desirable in non-diabetics. This has now been reflected in many international guidelines.

In conclusion: Diabetes affects every aspect of the patient's heart disease. It also affects every aspects of the cardiologist's practice. Improved understanding of the underlying pathology and evidence based prevention, pharmacological and interventional strategies have made a major positive impact on the management of diabetic patients.

ABSTRACTS OF CLINICAL SYMPOSIA:

SYMPOSIUM 1: MODERN MANAGEMENT OF DIABETES:

S1.1 WHAT DIABETES CARE TO EXPECT IN 2008? Tarek M. FIAD, Department of Endocrinology, Dudley Group of Hospitals, Pensnett Road, Dudley, West Midlands, DY1 2HQ, United Kingdom.

Over the last two decades diabetes emerged as a global epidemic with a considerable health, financial and social burden. To combat this epidemic, a concerted effort by all service providers and users is required. Available evidence suggests the presence of huge variation in diabetes care and failure to implement the evidence continues to be a major concern. Many models of service care have been promoted, and for such models to succeed, all key players should be involved in planning the service. These include health-care professionals, service users and their carers, managers and politicians. Successful implementation of agreed objectives requires clinical champions and team working. In developing the diabetes service, it is important to set agreed objectives and targets. A model of care, which meets specific needs of the local community, has to be agreed and sharing examples of good practice are often helpful. Given the unprecedented increase in the prevalence of diabetes, the number of specialists available has fallen short of the service demand and the case can be made to devolve the basic service to primary care physicians whilst allowing the diabetologists to focus on the specialists side of the service. Acknowledging the incremental cost of diabetes care, government initiatives to subsidise the cost of therapy and to promote a clinical cost-effective strategy are of paramount importance. From the healthcare professionals' perspective, resources for training and development should be made available to all members of the multidisciplinary team, and from the patients' perspective, easy access to a good service is needed. In conclusion, what diabetes care expects in 2008 is a partnership between key players, patients' empowerment, financial support based on cost-effective strategy, continuous education, and above all effective leadership.

S1.2 No Abstract Received.

S1.3 ORAL ANTI-DIABETIC MEDICATION. Kamal ABOUGLILA, Endocrine & Diabetes Unit, University Hospital North Durham,UK.

Diabetes mellitus (DM) is a chronic disease that is growing in prevalence worldwide. Type 2 DM is a complex disorder associated with significant health and economic burdens. Keeping blood glucose levels near the normal range lowers the risk of complications and is an important therapeutic goal. Several distinct oral drug classes are now available for the treatment of type 2 diabetes. Although nonpharmacologic therapy (e.g., diet, exercise and weight loss) remains a critical component in the treatment of diabetes, pharmacologic therapy is often necessary to achieve optimal glycemic control. Orally administered anti-hyperglycemic agents class (Biguanides, insulin secretagogues, insulin sensitizers, incretins and alpha-glucosidase inhibitors) can be used either alone or in combination with other oral hypoglycaemic agents or insulin. Most of these agents lower hemoglobin A1C levels approximately 1% to 2%. When they are used in combination, there are additional glycemic benefits. Aggressive glycemic control has been demonstrated to decrease microvascular and perhaps macrovascular complications. Given the multiple pathophysiological lesions in type 2 DM, combination therapy is a logical approach to its management because The UKPDS clearly demonstrated that type 2 DM is a progressive disease. Conclusion: With few exceptions, the available oral antihyperglycemic agents are equally effective at lowering glucose concentrations. Their mechanisms of action are different, however, and as a result they appear to have distinct metabolic effects. These are reflected in their adverse effect profiles and their effect on cardiovascular risk, which may influence drug choice.

S1.4 EFFECTIVE INSULIN THERAPY: Salem A BESHYAH, Center for Diabetes and Endocrinology, Sheikh Khalifa Medical City, Abu Dhabi, UAE.

The discovery of insulin 75 years ago was the most important event in the history of diabetes. The need to be treated with insulin for survival has for long defined type 1 diabetes even before the underlying distinct etiological basis was identified. Recognition of type 1 diabetes at the time of initial diagnosis is of paramount importance to avoid the risk of a potentially fatal diabetic ketoacidosis. If in doubt, insulin should be initiated and the decision may be reconsidered later. In addition, the role of insulin in the management of type 2 patients expanded too. Its early use has attracted particular interest. Over the last 75 years since its original discovery, insulin therapy advanced significantly by such changes such as purification, recognition of the human sequence and its modification to

produce the rapid and truly basal insulin analogues, unification of concentration as 100 units/ml, availability of fine, disposable needles and use of pen injectors. Insulins are best classed on bases of their action profiles. In practice, there are currently three different types short/rapid, intermediates and longer acting/basal insulin. At least four different regimens have been employed in adult practice. These include basal addition to oral agents, prandial addition to oral agents, convenient twice daily (usually using pre-mixed preparations) insulin with or without lunch time addition of rapid insulin and the intensive (basal-bolus) regimen. The intensified insulin therapy in type 1 patients gives the best results and should be the regimen of choices in adults and adolescents. It gives flexibility and the DCCT confirmed reduction in complications by its use. In type 2 diabetes, earlier use of insulin is being promoted more recently by major professional bodies such as ADA and EASD. However, insulin is surely indicated in patients not achieving targets of good glycaemic control on fairly advanced dose oral agents, or those with side effects or contraindications to oral agents. In addition, insulin is the preferred therapy in younger patients, those aiming to tight glycaemic control, those with complications and women who are planning pregnancy. Most patients who need insulin can nowadays be started easily and conveniently by addition of basal insulin to their oral agents. The initial dose may safely be empirical and can be easily adjusted by the patient himself guided by self blood glucose monitoring. However, advancing from basal insulin only could either employ a premixed insulin preparation taken twice daily or direct progression to full basal-bolus insulin regimen. Education of the patient and family regarding hypos, exercise, travel and the sick day rules is of paramount important importance to establish patients' autonomy and empowerment. Side effects are mainly those of hypos and weight gain. Use of the right therapeutic agents and regimens can help this cause. Employing newer insulins and modern technologies makes the life of both patients and clinicians easier and may make achieving targets more likely.

SYMPOSIUM 2: EFFECTIVE ORGANIZATION OF DIABETES CARE: LOCAL, REGIONAL AND NATIONAL PERSPECTIVES.

S2.1 No Abstract Received

S2.2 MANAGEMENT OF DIABETES AND HYPERGLYCAEMIA IN HOSPITAL.

Salem M. El-Habroush, Diabetes Centre, Tripoli, Libya.

Diabetes has reached epidemic proportions worldwide, affecting about 200 million individuals. There also is a disproportionate increase in the number of people with diabetes in the hospital. Furthermore, for every two patients in the hospital with known diabetes, there may be an additional one with newly observed hyperglycemia. Reasonable amount of evidence continues to accumulate to suggest that poorly controlled glucose levels are associated with increased morbidity and mortality, as well as with higher costs. Until recently, glycaemic control in hospitalized patients has not been a major therapeutic focus, partly because of a lack of published targets and guidelines for their care and partly because evidence demonstrating improved outcomes as the result of improved glycemia was only just emerging. In December 2003, the American Association of Clinical Endocrinologists (AACE) convened a two-day consensus conference, co-sponsored or supported by nine other professional organizations, to review results of recent clinical trials and to explore the relationship, if any, between inpatient glycaemic control and clinical outcomes. The conference brought together national and international experts, as well as several organizations concerned with clinical diabetes. Recommendations for the management of hyperglycemia were agreed upon and published. The American Diabetes Association (ADA) supported an extensive technical review evaluating the relationships between glycaemic control and its impact on hospital outcomes. This review became the basis for the 2005 ADA Clinical Practice Guidelines. Despite national and local efforts, widespread implementation of improved glycaemic control for inpatients has remained an important goal for many centers. Multiple institutional and attitudinal obstacles still exist to improved care; these barriers (organizational barrier) have created a significant and growing gap between what we know and what we do. For this reason, AACE and ADA have joined forces to plan and conduct a consensus conference (Inpatient Diabetes and Glycaemic Control: A Call to Action Conference) with the goal of identifying strategies to overcome barriers and facilitate improvements in patient care.

S2.3. THE DIABETIC PATIENT IN THE EMERGENCY DEPARTMENT. Salem A ELTABAL Endocrinology Division, Department of Medicine, Aljamahiriya Hospital and Department of Medicine Al-Arab Medical University, Benghazi, Libya.

Diabetes is a chronic illness that requires continuing medical care and patient self-management education to prevent acute complications and to reduce the risk of long-term complications. Several studies have suggested that individuals with diabetes are significantly more likely to use the accident and emergency (A&E) department than their nondiabetic counterparts. A substantial number of visits are for nonurgent problems, self-reported diagnosis of other comorbidities, and to assess presence or absence of diabetes-related complications. Diabetes care is complex and requires that many issues, beyond glycemic control, be addressed. Formulating an evaluation and management plan provide a basis for medical care for old and newly diagnosed diabetics. If the diagnosis of diabetes has already been made, the evaluation should review the previous treatment and the past and present degrees of glycemic control. Laboratory tests appropriate to the evaluation of each patient's general medical condition should be performed. The pattern, the most frequent reasons for attending the A&E department as well as a scheme for the medical evaluation of the diabetic patient in the A&E department with common emergencies will be discussed.

S2.4 OPTIMAL CARE OF THE DIABETIC PATIENT WITH KIDNEY DISEASE IN 2008. Abdulhafid SHEBANI, National Transplantation Programme, Tripoli Central Hospital The Renal Unit , Tripoli Medical Center, Tripoli, Libya.

Diabetic nephropathy (DN) is a major complication of diabetes, which affects up to a half of diabetics worldwide. It accounts for 10–30% of the causes of end-stage renal disease (ESRD) in Africa, while its contribution is even higher in more developed countries, reaching almost 50% in the United States. Diabetic nephropathy (DN) is a devastating disorder and is now worldwide the leading cause of end-stage renal failure. This diabetic complication is a complex disease, whereby various genetic and environmental factors determine susceptibility and progression to end-stage renal disease (ESRD). DN seems to occur as a result of an interaction between metabolic and haemodynamic factors, which activate common pathways that lead to renal damage. In addition, the renin–angiotensin system (RAS) is also an important target for both metabolic and haemodynamic derangements in DN. Despite the rapid research progress, ideal predictors to assess prospectively, and with high precision, the risk for DN in individuals with diabetes are still lacking. In screening for diabetic kidney disease we need to first identify those who have evidence of kidney damage, stage the level of kidney damage, and then determine whether that kidney damage is due to diabetes or to another kidney disease in a diabetic patient. Use of the albumin-to-creatinine ratio in an untimed urinary sample is recommended as the preferred screening strategy for all diabetic. Microalbuminuria appears to represent a stage of diabetic nephropathy at which treatment is often successful in preventing progressive renal disease. Glycemic and blood pressure control, particularly with angiotensin converting enzyme inhibitors or angiotensin receptor antagonists, may reduce microalbuminuria and progression to overt nephropathy. In management of hyperglycemia, The typical recommendation from the National Kidney Foundation is that we maximize our approach to lowering hyperglycemia and try to get the target hemoglobin A1c to less than 7.0 including in patients that have CKD. Management of hypertension in diabetes and CKD from stages I through IV, should be treated with an ACE inhibitor or an ARB, usually in combination with a diuretic because of the synergistic effect of these 2 agents on not only blood pressure but on reduction in protein excretion. On the basis of cardiovascular outcomes, it's recommended that we lower the LDL cholesterol concentration with the use of statins. Behavioral self-management is truly the cornerstone of all management of these patients. The patient needs to stop smoking, they need to exercise more.

In summary, we have a number of treatment modalities that have been shown to be beneficial in decreasing the rate of progression of underlying diabetic nephropathy control, with a goal of less than 130/80 and possibly 120/70, are clearly shown to be beneficial. ACE Inhibitors and possibly cardiovascular disease. Glucose control, with a goal HbA1c of less than 7%, and blood pressure and Angiotensin II receptor blockers have selective benefits for patients with underlying nephropathy and should be used as the first drugs for the treatment of hypertension and diabetic nephropathy.

S2.5 No Abstract Received.

SYMPOSIUM 3: DIABETES AND ENDOCRINOLOGY IN CHILDHOOD AND ADOLESCENCE:

S3.1 SIZE AT BIRTH AND RISK OF ENDOCRINOPATHIES. Abdel Hadi M. HABEEB, Paediatric Endocrine Unit, Women & Children Hospital, Al Median Al Monawara, KSA.

It is estimated that around 5–10 % of children are born outside the normal range for birth weight for gestational age and can be classified either as large (LGA) or small for gestational age (SGA). Although the majority of these children have normal life expectancy they are at a higher risk of developing various endocrine problems both during childhood and in later life. The influence of size at birth on endocrine system has been mainly seen in those born SGA. Contrary to the expectation that children born LGA will become obese as adults, the evidence indicate that birth weight is a weak predictor to adult weight and it is the SGA population, rather than LGA, who are at risk of obesity related illness in later life. Apart from neonatal hypoglycaemia the LGA infants appear to have no other significant endocrinopathies. During childhood, short stature is the most visible consequence of SGA. Despite the fact that the majority of SGA children are not growth hormone (GH) deficient they do respond well to GH treatment. In addition to short stature, SGA infants have higher risk of genital anomalies, early puberty and impaired reproductive function. The long-term effects of being born SGA remain the subject of intense interest following series of epidemiological studies linking small size at birth with increased prevalence of health problems in later life. There is now compelling evidence that individuals who were small at birth are at increased risk of metabolic syndrome in which hyperinsulinaemia and impaired glucose tolerance are associated with cardiovascular diseases, dyslipidemia, type 2 diabetes and central obesity. Recent data from clinical studies showed that some indicators of metabolic syndrome can be detected in SGA children as early as pre-school age, particularly in those with rapid catch-up in weight during infancy, suggesting that a window of opportunity for an early intervention may be feasible. The exact mechanism of metabolic consequences of SGA is not clearly understood however it appears that fetal programming in response to intrauterine malnutrition together with excessive weight gain during infancy play major role. The talk will discuss evidence from epidemiological and clinical data of the relationship between birth size and risk of early and late endocrinopathies and will also highlight the current understanding of the fetal origin of metabolic syndrome.

S3.2 AN INSIGHT INTO MONOGENIC DIABETES: MODY AND OTHERS. Abdel Hadi M. HABEEB, Paediatric Endocrine Unit, Women & Children Hospital, Al Median Al Monawara, KSA.

Monogenic diabetes (MGD) is a term used to describe subtype of diabetes resulting from single gene defect. These defects can be inherited as an autosomal dominant or recessive manner or it can develop as de novo mutation leading to a spontaneous case. It has been estimated that MGD account for 3-5% of diabetes case load in children and young adults however this can be an underestimate as the majority of genetically proven patients were initially mislabelled as either Type 1 or Type 2 diabetes. The importance of making the diagnosis of MGD goes beyond the scientific exercise as it has various clinical implications such as guiding the most appropriate management for the patient and allowing genetic counselling for family members. One of the major advances in diabetes in the last decade has been the defining of the molecular genetics of MGD. So far, mutations in more than 20 genes, that either control the pancreatic beta cell function or insulin receptor, have been associated with variable phenotypes of which maturity onset diabetes of the young (MODY) is the commonest. MODY is a clinically heterogeneous condition due to Beta cell defect characterized by autosomal dominant non-insulin dependent diabetes often present before 25 yrs of age. The condition is now classified according to aetiological mutations into either glucokinase (GCK) MODY or transcription factors MODY. Patients with GCK mutations have mild stable hyperglycaemia that rarely need treatment or cause complications while patients with transcription factor MODY have more aggressive disease that if not appropriately treated can lead to early microvascular complications. An example of the benefit of making the molecular diagnosis in patients with MGD is seen in adults with HNF-1 α mutations who showed better control when taken off insulin and put on sulphonylurea. Neonatal diabetes (NDM) is another form of MGD that has an aetiological link to MODY and recently has major advances in its diagnosis and management. The presentation will provide an update on the classification, pathophysiology, diagnosis and management of MGD with more emphasis on MODY.

S3.3 PERMANENT NEONATAL DIABETES MELLITUS AND ROLE OF SULFONYLUREA. Faten BEN RAJAB, Zienab HASHEIESHI and Ahmed Sassi SHAMEKH. The Tripoli Children Hospital, Omar Mokhtar Street, Tripoli, Libya.

Some rare forms of diabetes result from mutations in a single gene and are called monogenic, the gene mutation is inherited; in the remaining cases the gene mutation develops spontaneously. Neonatal DM is one main form of monogenic diabetes, onset of persistent type 1 DM before the age of six months is most unusual and very rare

before the age of three months, patients with permanent neonatal DM usually present within the first three months of life. 30 to 58% of cases due to missense mutation (R201H) in the KCNJ11 gene encoding

Kir 6.2 which is expressed in muscle, neuron and brain as well as the pancreatic beta cell, so patients with this mutation could have a neurological phenotype in addition to their diabetes. We report a 3 years boy who was presented at age of 6 weeks with lethargy unwell, he was born by normal delivery with birth weight 3.6 kg. He was the second baby of non consanguineous marriage; he had an elder healthy sibling and Family history of type 2 DM, on examination He was dehydrated, acidotic lost weight despite good intake (90 cc\2hr) & severe napkin dermatitis. The investigations revealed high blood sugar 980 mg % (54mmol/l), metabolic acidosis (pH 7.2 NaHCO₃ 3.8 PCO₂ 21) and ketonuria. He was commenced on soluble insulin at hospital for ten days then his insulin changed to isophan & soluble insulin at morning and soluble insulin at evening. At age of 10 months detected to have developmental delay and muscle weakness with no abnormal movements. At 2 years of age blood for molecular analysis showed mutation (R201H) in the KCNJ11 gene encoding Kir 6.2, so the diagnosis is Intermediate DEND syndrome (developmental delay, epilepsy & neonatal diabetes). We assess c-peptide & HbA1c before assessing insulin secretary response to oral glucose the results of C-peptide (< 100pmol/l) & insulin levels were low, HbA1c was 10%, his weight is 8 kg. The patient put on trial of sulfonylurea (Glibenclamide), he was started on dose of 0.1 mg \kg \day and was increased up to 1 mg \kg \day and insulin was concomitantly Tapered off. After 6 months the insulin secretary response to oral glucose revealed C-peptide (400pmol/l), insulin normal & HbA1c is 6.2%. His mother is very happy about his progress including his neurodevelopment. Our patient has been successfully transferred from insulin to Glibenclamide. He is asymptomatic gaining weight (11kg) and on regular neurodevelopment follow up.

ABSTRACTS OF FREE COMMUNICATIONS:

ORAL COMMUNICATIONS:

OC1. PRACTICES AND OUTCOMES OF DIABETIC PATIENTS DURING RAMADAN FAST IN ABU DHABI, UNITED ARAB EMIRATES. Salem A. BESHYAH, Mahmoud M. BENBARKA and Ali B. KHALIL. Center for Diabetes and Endocrinology, Sheikh Khalifa Medical City, Abu Dhabi, UAE

BACKGROUND: Managing individual patients with diabetes during Ramadan poses a challenge. Education of both patients and clinicians is essential to achieve good control. **METHODOLOGY:** Assessment was made by semi-structured interview using a proforma. Data collected included demographic data, diabetes details, medication and HbA1c level. Patients were specifically quizzed on fasting, changes in medication and outcome in terms of hypoglycaemia, hyperglycaemia and emergency hospital visits. **PATIENTS:** Three hundred and thirteen non-pregnant adult patients were surveyed in the 6 weeks after Ramadan. Their median age was 53 (range 11 to 87) years. One hundred and sixty nine patients (54%) were women and majority were UAE nationals (n=294; 94%). The median duration of known diabetes was 10 (range 1-4) years. **RESULTS:** The majority had type 2 diabetes (n= 276; 88%) and 37 patients had type 1 diabetes. Majority of the patients with type 1 diabetes (n=30/38) received intensive insulin regimens. Patient with type 2 patients were treated with intensive insulin regimen (n=28; 10%), twice daily insulin regimen (n=40; 14%) and basal insulin (n=52; 19%) with or without oral agents. Oral anti-diabetic therapy only was used in 156 (57%). The mean serum HbA1c was 8.7% with median (range) being 8.1(5.5-17.6)% measured a median of two months (range 1-12) before Ramadan. Fifteen patients did not observe the fast (4.8%) of whom four did not fast for other medical reasons than diabetes and of the total 5 had type 1 diabetes. Fasting was observed for the whole 258 patients (82%), for over 20 days by 31 patients (10%), between 10-20 days by 7 patients (2.2%) and for <10 days by two patients (0.6%). The total daily dose was unchanged in 209/298 (70%), was reduced by 83/298 (28%) and stopped completely by 5 patients (2%). Patients took their medication as three doses (6.4%), two doses (81%) or a single dose (12%). No hypoglycaemia was reported in 253 patients. However, in 26, 6, and 11 patients hypoglycaemia lead to breaking the fast in 1-3, 4-6 and >7 days respectively. Unusually high hyperglycaemia was reported by 33 patients with values around 200-400 mg/dl. Admission to hospital was needed by 3 patients for hypoglycaemia, dizzy spell and acute pulmonary oedema. **CONCLUSIONS:** Most patients with diabetes do fast during Ramadan with changes in their medications' total dose and frequency. Hypoglycaemia is the commonest complication in insulin treated patients.

OC2. CLINICAL USE OF THE DEPA SCORING SYSTEM FOR PREDICTION OF THE HEALING RATE OF DIABETIC FOOT ULCERS. Mohamed ALGABSI, Abubaker SUISSI and Hamad RAFAE, Surgery Department, Al Wahda Hospital, Derna and Faculty of Medicine, Omar Al Mukhtar University, Derna, Libya.

The aim of this study was to examine the use of recently described scoring system in predicting the outcome of diabetic foot ulcers in our patient population. The scoring system (DEPA score) depends on depth of the ulcer (D), the extent of bacterial colonization (E), the phase of ulcer healing (P) and the associated underlying etiology (A). The clinical outcome in terms of healing and lower-limb amputations was assessed against the DEPA scoring system. Sixty patients (40 males and 20 females) who attended the outpatient clinic in Al Wahda Hospital, Derna, Libya Between 1st September, 2005 to 31st March, 2006 were included in the study. Eleven patients (18.3%) had a DEPA score of 6 or less, 23 patients (38.4%) had a DEPA score of 7 to 9 and 26 patients (43.3%) had a DEPA score of 10 to 12. DEPA scoring system was accurate in predicting the outcome of management (Spearman nonparametric correlation coefficient was 0.86; $P < 0.001$) at a mean follow-up of 20 weeks. Excellent healing was observed in all patients with DEPA Score of 6 or lower. Only 67% of those with a score of 7-9 had good complete healing in <20 weeks. Poor healing or amputation was predicted in all patients with by a DEPA scores 10-12. In conclusion, our clinical experience concurs with the previous validation studies suggesting that higher DEPA score is associated with and an increased risk of amputation and poor healing. We recommend its wider use in clinical practice to select and intensify further the management of those at higher risk to salvage more diabetic feet.

OC3. PREVALENCE AND CHARACTERISTICS OF METABOLIC SYNDROME AMONG PATIENTS WITH TYPE-2 DIABETES MELLITUS IN BENGHAZI, LIBYA. Mabrouka Milad ELSHOUKRI and Rafik R ELMEHDAMI. Department of Internal Medicine, Arab Medical University, and Benghazi Centre for Diabetes and Endocrinology, Benghazi, Libya.

Background: Metabolic Syndrome is a constellation of three out of five biological entities that are due to hyperinsulinemia. These are abdominal obesity, atherogenic dyslipidemia (high triglycerides and/or low HDL), elevated blood pressure, and elevated plasma glucose. In 2001, the National Cholesterol Education Program Adult Treatment Panel NCEP ATP III proposed a set of easily applicable criteria to diagnose metabolic syndrome. The syndrome is highly prevalent in patients with type-2 DM and often precedes the onset of hyperglycemia. It has been shown that metabolic syndrome is an independent clinical indicator of macro- and microvascular complications in diabetics. **Objectives:** the aim of this study was to estimate the frequency (prevalence) and characteristics of metabolic syndrome among type-2 diabetics in Benghazi. **Subjects and Methods:** a cross sectional study involved 99 randomly selected adult patients with type-2 DM. The patients were interviewed and examined by the authors and their lipid profile was checked after 9-12 hours overnight fasting. Obesity was defined according to WHO ($\geq 30\text{kg/m}^2$) and metabolic syndrome was defined according to ATP III criteria. Data were expressed as mean \pm standard deviation and differences were considered statistically significant when $p\text{-value} \leq 0.05$. **Results:** about 92% of the studied patients had the metabolic syndrome according to ATP III criteria (96.7% of females and 84.2% of males) the mean age of the metabolic syndrome patients was 55.9 \pm 9 years and the mean duration of DM was 9.6 \pm 8 years. Around 77% of metabolic syndrome patients were obese with mean BMI 33.9 \pm 5.6, and 61.5% were hypertensive with mean BP 130.3/81.3mmHg. Males with metabolic syndrome were significantly older and females were significantly more obese, while there was no significant difference between males and females regarding waist circumference, HDL level and triglyceride levels. There was no significant difference between metabolic syndrome and non metabolic syndrome patients regarding age, disease duration, or waist circumference, while atherogenic dyslipidemia was significantly more prevalent in metabolic syndrome patients. The most common and most significantly important component of metabolic syndrome in the study group was low HDL (mean 37 \pm 13.5). **Conclusion:** metabolic syndrome is very common among Libyans with type-2 DM and it is much more common than obesity. It is significantly more common in females than males. While atherogenic dyslipidemia seems to be an important component of metabolic syndrome among Libyan diabetics, central obesity (does not look so) replace with (appears to be less prevalent). The most significant predictor of metabolic syndrome in type-2 diabetics in Benghazi is low HDL.

OC4. MENARCHEAL AGE IN LIBYAN GIRLS WITH TYPE 1 DIABETES MELLITUS. Ibtisam HADEED, A. GHAREBA, Mohamed KREASTA, Ahmed DHAEM, Mohamed. KABOUKA, Samira TARHUNI, Mohamed HWEDE, Om Elmir Elghadafi and Suliman ABUSREWIL. Department of Paediatric Endocrine and Diabetes Department, Tripoli Medical Centre, Tripoli, Libya

Menarche is one of most important biologic signals in the life of women. Timing of menarche is influenced by both genetic and environmental factors, especially nutritional status. Chronic illness such as diabetes may cause a delay in growth and pubertal development. Aim of the study. We aimed to study onset of menarche in adolescents girls with type 1 Diabetes and its relation to their Diabetic duration & control. Patients and methods: One hundred and forty three adolescent girls with type 1 Diabetes who have been attending the Paediatric Endocrine & Diabetic

Department at Tripoli Medical Centre between January - July 2007 were randomly selected for this study. One hundred and thirty one mothers and 169 non diabetic sisters were chosen as a control group. The participants were reviewed for their ages at onset of menarche, duration of diabetes before onset of menarche, mean insulin dose, their glycaemic control. (Mean HbA1c levels) over 1 year prior to menarche, their body mass index (BMI), any diabetic complications, and any associated autoimmune diseases with diabetes. Results: The mean age of menarche in Diabetic girls was 13.84 yrs, and 12.81 yrs for the control group. The mean duration of Diabetes in study group prior to onset of menarche was 5.37 yrs, all Diabetic girls were receiving insulin intensive therapy regime, the mean HbA1c over 1 year prior to the onset of menarche was 9.1%, and their mean BMI in the study group was 25.3 kg /m². Out of 143 girls, there were 4 Diabetic girls who have got associated coeliac disease & 2 had associated hypothyroidism. Conclusion: Significant delay in the menarcheal age especially in those with poor glycaemic control. An association with autoimmune diseases also affected the onset of menarche in the study group.

OC5. PATTERN OF CHILDHOOD HYPERTHYROIDISM IN TRIPOLI, LIBYA. Fathia BEN SALAH, Ahmed DHAEM, Mohamed KREASTA, Attalla GHAREBA, Mohamed KABOUKA, Ibtisam HADEED, Suliman ABUSREWIL. Paediatric Endocrine and Diabetes Department, Tripoli Medical Centre. Tripoli, Libya

Hyperthyroidism is an uncommon disorder in childhood. About 5% of patients are below 15 yrs of age, and about 95% are Grave's disease. This study included 28 patients, their ages ranged between 6 & 16 years, they were diagnosed to have hyperthyroidism at Paediatric Endocrine Department, Tripoli Medical Centre from 1st of Jan 1991 to 31 of Dec 2004. The main presenting symptom was thyroid swelling in 82%, mean symptom duration before diagnosis was 4.6 months, female were affected of 82.2%, and 68% of patients were more than 10 yrs old. T4 & TSH level at diagnosis was 315 nmol, 0.07 Miu respectively. 3 lines of therapy were used (medical, surgical and radiation), and these resulted in remission and off therapy in 53.5% of patients, adequate control in 21.4%, no response at all in 14.3% of patients, missed follow up before getting into remission in 3.7%, and missed follow up after recurrent relapses in 7.1% of patients. Conclusion: hyperthyroidism is uncommon in childhood, and its treatment is basically medical.

OC6. MICROALBUMINURIA AND NEPHROPATHY IN DIABETIC ADOLESCENTS IN TRIPOLI, LIBYA.

Om Elmir Elgadafi, Mohamed KREASTA, E. Elgadi, Ibtisam HADEED, Mohamed HWAEDE, Mohamed KABUKA, Ahmed DHAEM and Suliman ABUSREWIL. Paediatric Endocrine Diabetic & Department, Tripoli Medical Center, Tripoli Libya

Introduction: Diabetic nephropathy is a clinical syndrome characterized by an increased urinary albumin excretion rate 30-300mg/day (20-200ug/min). The risk of nephropathy increases with increased duration from onset of diabetes and poor glycaemic control. Patients & Methods: This study was carried out at Paediatric Endocrine Department, Tripoli Medical Center. 1209 patients with type I DM were screened by 24 hour urine collection to detect microalbuminuria on 2 successive occasions, 6 months apart. If urine contains more than 30 mg/day, it was considered positive. Results: Three hundred and seventy four patients (30.9%) were found positive for microalbuminuria; 194 (52%) were female and 180 patients (48%) were males. Most common age affected was 23-28 years old & microalbuminuria was seen maximally after 8 years of onset of diabetes. Their mean HbA1C over the last 3 years prior to microalbuminuria developed was 10%. All patients with microalbuminuria were put on angiotensin converting enzyme inhibitor drugs even in the absence of hypertension & all being followed up for annual microalbuminuria assessment after diagnosis. 52 patients with overt proteinuria were put on combination of ACEI & ARB drugs to slow the progress ESRD. Diabetic nephropathy is also a sign of worsening blood vessel disease throughout the body. Conclusion: Good glycaemic control can prevent the development and slow down the progress of diabetic nephropathy as well as other diabetic complications. HbA1C < 7% & screening for diabetic nephropathy in type 1 diabetes should start from 5 years post diagnosis & annually thereafter.

OC7. PREVALENCE OF COELIAC DISEASE AMONG TYPE 1 DIABETIC CHILDREN. Faten BEN RAJAB, Zienab HASHEISHU, Kalthum HIBA, Al Jala Children Hospital, Omar Mokhtar Street, Tripoli, Libya.

Background: Celiac disease (CD) is common among the children with type 1 diabetes mellitus (Type 1 DM). Its prevalence is higher in diabetic patients than that in normal population. Most cases are silent clinically and can be detected only by investigations. Aim of the study: To find out prevalence of CD among type 1 diabetic children. And the occurrence of the CD in relation to duration of diabetes mellitus. Patients and Methods: A retrospective study of

patients with CD among children with type 1 DM who were followed up at the endocrine clinic in Tripoli children's hospital during 6 years period (1-1-2002 to 31-12-2007). All patients investigated for CD by serological blood tests (Tissue transglutaminases IgA, IgG). The diagnosis was confirmed by jejunal biopsy. Data collected from patient's records analyzed in terms of age, gender and duration of diabetes mellitus at time of diagnosis of CD. Results: The medical files of 150 type 1 DM patients were studied. Their age ranged from 1 - 15 years (7.2 + 3.7 years). The female: to male ratio 1.3 to 1 The results showed, 15 out of 150 patients (10 %) diagnosed as celiac disease, their age ranged from 1-12 years (8.2 +3.6) .the female to male 1.1 to1. 135 patients (90%) were negative for celiac disease. and 12 out of 15 patients (80%) -diagnosed CD during the first year of their DM.. 2 patients developed CD after first year of DM one patient diagnosed celiac before onset of his DM. The majority of cases (80 %) of CD were asymptomatic in their presentation they have no signs of malnutrition. Conclusion: The prevalence of CD in patients with type 1 diabetes is 10 times higher than that in normal population. CD in these patients can develop at any time during the course of their diabetes, the age at onset of type 1 DM was not predictor of celiac disease development. Continuous screening for CD of all patients with type I DM.

POSTER PRESENTATIONS:

P1. ACUTE PITUITARY FAILURE DUE TO A NON-FUNCTIONING PITUITARY TUMOUR PRESENTING WITH INTRACTABLE POST-OPERATIVE VOMITING. Ali ABBARA and Abdulfattah A LAKHDAR. Department of Diabetes and Endocrinology. Whipps Cross University Hospital. London E11 1NR

A 51 year old male builder underwent an anterior cervical discectomy. Soon after surgery he started vomiting continuously, lost appetite and felt dizzy. There was a past history of asymptomatic hiatus hernia, asbestos exposure at 16, bilateral pneumothoraces and pleurodesis 8 years earlier. He smoked 20 cigarettes a day for 30 years and took little alcohol .Shortly after discharge he was readmitted to surgical ward with vomiting, headache and abdominal pain? Upper gut obstruction? Malignancy. Biochemistry was normal. He was treated with intravenous fluids. Upper GI endoscopy was normal. He continued to vomit. CT scan chest/abdomen and pelvis was normal, apart from changes in the chest compatible with his past history. Seen by a neurologist who suspected a CSF leak because of persistent headache and requested MRI brain which showed a pituitary mass. On endocrinology review, noted vomiting continuously since operation 13 days ago, complaining of headache, dizziness .abdominal pain, and lack of energy. No polyuria or polydipsia, his libido had been failing over the past two years and he was shaving less frequently. Postoperative notes review showed that his BP dropped transiently in the post-op recovery room? to 70/60 mm/Hg but improved spontaneously. On examination, he was unwell, pale looking, and had sunken eyes, BP 109/77. His skin was soft, and there was scanty beard, axillary and pubic hair .There was no visual field deficit. On IV fluids sodium was low at 130 mmol/l, potassium 4.8 mmol/l, chloride 104 mmol/l, urea 6.6 mmol/l and creatinine 115 umol/l. He was started on IV hydrocortisone. Within two hours he felt much improved and enjoyed a meal. Serum cortisol was 20 nmol/l at 2pm. Free T4 8.3pmol/l (9.4-24), TSH 2.0mu/l (0.49-4.4.67), Testosterone <0.1nmol/l (9.9-27.8), FSH 1.2IU/l (1-8), LH 0.8IU/l (2-12), Prolactin 67mu/l (86-324), IGF-1 <1 (7.5-30), ACTH 3 ng/l (10-80), SACE 38u/l (8-52), urine output 2.3 l/day, serum osmolality 297 mOsmol/kg (285-295), urine osmolality 900 mOsmol/kg (800-1200). Visual perimetry was normal. He was discharged on hydrocortisone 20 mg, 5 mg, 5 mg, Thyroxine 100 mcg and Sustanon 250. The pituitary mass/non-functioning adenoma was just over 1 cm with no evidence of chiasmal compression. Conservative management is planned. The pros and cons of this management approach will be discussed.

P2. THE LEVELS OF HbA1c AT THE TIME OF DIAGNOSIS IN LIBYAN DIABETIC CHILDREN AND ADOLESCENTS. Nadia ALGAZIR, Ibtisam ALKHAZMY, Atalla GAREBA, Mohmaed KRESTA, Ahmed. DAHEM, Mohamed KABOUKA and Suliman ABUSREWIL. Pediatric Endocrine and Diabetic Department Tripoli Medical Center, Tripoli, Libya

Childhood diabetes is common disease and it is increasing world wide. HbA1c remains the main test for glycaemic control in diabetics, its importance at time of diagnosis will be evaluated in this large cohort of 844 diabetic children and adolescent being diagnosed & treated during the period from the 1st Jan. 1999 to 30 June 2006 (7.5 years) . In this study we have looked at age, sex, residence, parent education, and family history of diabetes, presentation duration of sign and symptoms of diabetes. Data analyzed showed that mean age at diagnosis 8.9 years , equal sex incidence, 63 % of the patient had history of diabetes either type 1 or type 2 or both, 26.8 % present with ketosis , 95.6 % had a history of diabetic duration of 1 -3 wks. Mean HbA1c at diagnosis was 11.2 % for all age group, there

was no difference in HbA1c level at time of diagnosis between those presented preketotic and ketotic, there is no difference in HbA1c level at time of diagnosis between educated & non educated family. However presentation with preketotic and ketotic is affected by family education. between educated and non educated family. Conclusion: HbA1c level is significantly raised at time of diagnosis. HbA1c can be used as a test to confirm the diagnosis of diabetes.

P3. PREVALENCE OF HEPATITIS B & C AND HIV INFECTION IN DIABETIC CHILDREN & ADOLESCENT RECEIVING INSULIN IN TRIPOLI, LIBYA. Souad ELMEDDAH, Mohamed KRESTA, Ahmed DHAEM , A GAREBA, Mohamed KABOUKA, A. FRANKA, Fayza OSMAN, Ibtisam HADEED, Mohamed HWAEDE and Suliman ABUSREWIL. Paediatric Diabetes and Endocrinology Department, Tripoli Medical Center, Tripoli, Libya

This study was carried out during the period between 1996-2006 were 2100 children & adolescents with type 1 diabetes on multiple daily injections of insulin were screened for viral hepatitis B, C & HIV using ELISA & patients who were positive by ELISA were confirmed by PCR. Patients were found to be positive 15 for hepatitis C, 2 patients were positive for hepatitis B & none was positive for HIV. This study showed that hepatitis C was more common with the increasing age & the 2 cases of hepatitis B occurred in diabetic patients who were born before the introduction of hepatitis B vaccine & both had surgical interventions, however the prevalence of hepatitis B&C in this cohort of diabetic children & adolescents were less than the general population in Libya. Conclusion: diabetic children & adolescents are not at a high risk of hepatitis and HIV than the general population in this study.

P4. CHANGES IN SERUM LIPIDS AMONG DIABETICS ATTENDING ALWAHDA HOSPITAL, DERNA, LIBYA. Monsef ALOKALI*, Saleh EDRIS* and Omar EL-SHOUBAGY **. *Internal Medicine and ** Family & Community Medicine Departments. Faculty of Medicine, Omar Al-mukhtar University. Derna Libya.

Background: Lipid abnormalities are known of the major risk factors for atherosclerosis and ischemic heart disease patients. Lipoprotein disorders commonly accompany diabetic patients promote atherosclerotic process and represent cumulative risks for these patients. Objective. : To study the effects of diabetes mellitus on serum lipid profile, which constitute to major risk factors for coronary heart disease. Methodology: This case control study included 500 patients attending Alwahda Hospital (outpatient clinic departments) during 2007. Subjects with primary and/or secondary dyslipidemia -rather than diabetes mellitus- were excluded. Subjects were classified into two groups diabetics (no.=243) and non-diabetics (no.=257) groups. Complete medical history and examination and laboratory assessment of total cholesterol, triglycerides, LDL-C and HDL-C were done. Results: Mean serum values of TC, TG and LDL-C were significantly higher in diabetics (271, 246, 118 mg/dl, respectively) than non-diabetics (216, 140, 106 mg/dl, respectively) but HDL-C was significantly lower (30 mg/dl, 47 mg/dl, respectively). The mean values of serum TG, LDL-C and HDL-C were 241, 183, 115 and 43 mg/dl in males and were 200, 108 and 46 mg/dl, in females, respectively (P<0.01). Age was significantly positively correlated with TC (r=0.106, p<0.05). Conclusion: Management of dyslipidemia should be in conjunction with control of diabetes mellitus as a standard strategy for regression and control of IHD epidemics.

P5. PREVALENCE OF GALL BLADDER STONES AMONG TYPE-2 DIABETICS IN BENGHAZI. Rafik R ELMEHDAWI(1), S. ELMAJBERI (2), A. BEHIEH(3), A. ELRAMALI(3). Department of Internal Medicine, Al-Arab Medical University, Benghazi Centre for Diabetes and Endocrinology and Radiology Department, 7th of October hospital, Benghazi, Libya.

Background: Diabetes mellitus (DM) and gall bladder stones (GBS) both are common and costly diseases. Increasing age, female gender, overweight, familial history of the disease and type 2 DM are all associated with an increased risk of gallstones. Several studies from all over the world reported an increased prevalence of GBS in patients with diabetes mellitus. In Benghazi the prevalence of DM among cholecystectomized patients is 9.9%. Up to the best of our knowledge there is no data from Libya regarding the prevalence of GBS neither in general population nor in diabetic patients. **Aims and objectives:**The aim of this study was to define the frequency of GBS among Libyan diabetics and to evaluate the possible associated risk factors in these patients.**Patients and methods:** A prospective cross sectional clinic-based study, was performed during the year 2007 at Benghazi diabetes center, the study involved 161 randomly selected type-2 diabetic patients under regular follow up at the center. Patients were interviewed and a standard questionnaire was answered, the weight and height were measured and the body mass index (BMI) was calculated for each patient. Ultrasound assessment was performed by two radiologist who

employed real-time abdominal ultrasound to examine the abdomen after an over night fasting. Statistical analysis were performed using the Statistical Package for the Social Sciences (Windows version 11.0; SPSS Inc, Chicago [IL], US). Differences between groups were tested statistically using the Chi squared test and independent-samples t-test. Data were considered statistically significant when the *P-value* was 0.05 or less. **Results:** About 40% of the cohort had GBS. Females were significantly more affected than males (47% vs. 26%, *P-value*: 0.01). Patients with GBS were significantly older than those without GBS (55.5 years VS. 50.5 years, *P-value*: 0.007). Obesity was more common in GBS patients than non GBS patients and diabetics with GBS had a significantly higher BMI than those without GBS (34.78 Kg/m² VS. 32.2 Kg/m², *P-Value*: 0.027). The cut off BMI associated with significantly increased risk of GBS was 24 Kg/m² (*P-value*: 0.019). There was no significant difference between GBS and normal patients regarding neither duration of DM nor type of treatment (oral, insulin, *P-value* :> 0.05). Multiple GBS were the commonest type detected in 75% of the cases. The use of oral contraceptive pills did not increase the risk of GBS in diabetic women (44%VS. 42%, *P-value*: 0.84). **Conclusion:** The rate of GBS in Libyan diabetics is higher than the rates reported in diabetics from other parts of the world. Libyan diabetics with GBS tend to be older, and more obese than non GBS diabetics. Duration of DM and type of treatment does not seem to influence the frequency of GBS among Libyan diabetics.

P6. SEVERE ACTIVE THYROID EYE DISEASE AS THE PRESENTING FEATURE OF HASHI-TOXICOSIS. Helen COOPER, Kamal ABOUGLILA, Arif ULLAH, I. Mohammed IBRAHIM & Logan THIRUGNANASOTHY, University Hospital of North Durham, County Durham, UK.

Introduction: Patients suffering from autoimmune hypothyroidism can transform to hyperthyroidism and vice versa although in the majority these two conditions run distinct courses. The characteristics, course and outcome of an illustrative case of a patient with long standing autoimmune hypothyroidism presenting with active thyroid eye disease and subsequently diagnosed with Graves' disease is presented here. **Case history:** A 65-year-old female with history of autoimmune hypothyroidism for 15 years presented with increasing eye symptoms. She complained of prominent eyes and double vision. It had also been noted that her dose of thyroxin had been significantly decreasing. On examination, there was bilateral proptosis, restricted eye movement on upward gaze and palpable thyroid goiter and her clinical activity score was 3/7. Blood test results showed TSH binding inhibitor immunoglobulin (TBII) 20.3 (high), FT4 (13.4 pmol/l), FT3 (5.1 pmol/l) and TSH (0.14 mu/l), serial TFT's showed suppressed TSH and normal FT3 and FT4. MRI showed excess intraorbital fat. Isotope scan showed increased activity in thyroid. She was initially treated with a 3 day course of IV methylprednisolone followed by a reducing course of oral steroids and then another course of IV steroids. Her symptoms improved following the first course of IV steroids with clinical activity score of 1/7. **Comments:** This case illustrates that severe thyroid eye disease can present several years later from time of diagnosis of hypothyroidism and one suggested mechanism for transformation to Hashi toxicosis that the thyrotrophin receptor antibody has a heterogeneous function with stimulatory and inhibitory action.

P7: PRIMARY HYPOTHYROIDISM PRESENTING WITH HYPO-OSMOLAR HYPONATREMIA AND ORTHOSTATIC HYPOTENSION. Arif ULLAH, Kamal ABOUGLILA, Logan THIRUGNANASOTHY and Helen COOPER., University Hospital of North Durham, County Durham, UK.

Introduction: Postural hypotension is common in the elderly. Common causes include medication, fluid loss, adrenal insufficiency and autonomic dysfunction. Hyponatremia is not a disease in itself, but a manifestation of a variety of disorders and side-effects of diuretics; alternatively, it may be the only manifestation of certain disorders. We present a case of primary hypothyroidism presenting as collapse with postural hypotension and severe hyponatremia. **Case history:** A 75-year-old man presented with history of collapse. He was not taking any medications regularly. His blood pressure was found to be 140/80 mmHg supine and 114/70 mmHg on standing; thus fulfilling the criteria for orthostatic hypotension. Systemic examination was unremarkable. Laboratory tests showed severe hypotonic hyponatremia with normal urea and creatinine. Thyroid function test (TFT) showed a high serum TSH concentration (30.15 mu/l), low serum free T3 (3.8 pmol/l), low serum free T4 (10.7 pmol/l) and positive thyroid antibodies (1257). His short synacthen test, LH, FSH and serum prolactin were all normal. Low serum sodium level was corrected gradually by water restriction. He was started on Levothyroxine replacement. These two measures resulted in correction of the orthostatic hypotension and hyponatremia. **Comments:** Disorders of sodium and water metabolism are common in hospitalized patients. Hypothyroidism can sometime give rise to hyponatremia and hypotension (Nakando, *J Int Med* 2000;**39**:1075–1077). The potential mechanism, whereby hyponatremia develop is not entirely clear (Kimura, *J Int Med* 2000; **30**:1002–1003) but possible due to SIADH.

Treating hyponatremia can some time be challenging and this case illustrates the importance of checking thyroid status by measuring TFT rourinely.

P8 DISCREPANT RESULTS OF SERUM FREE THYROID HORMONES AND THYROTROPIN VALUES IN A PATIENT WITH HASHIMOTOS THYROIDITIS CAUSED BY INTERFERING T4 ANTIBODIES. Kamal ABOUGLILA, Arif ULLAH, Helen COOPER, Logan THIRUGNANASOTHY and Julie DAY, University Hospital of North Durham, County Durham, UK.

Introduction: Measurements of thyrotropin (TSH), free thyroxine (FT4) and triiodothyronine (FT3) are the three most commonly utilized diagnostic methods for evaluation of thyroid function status. However, some serum samples may demonstrate a nonspecific binding with assay reagents that can interfere with the measurement of these hormones. Few case reports of TSH interfering antibodies have described the presence of such interferences resulting in reported abnormal concentrations of thyroid hormones. Unusual combination of TSH and thyroid hormone results may have a pathological source, poor compliance or interfering antibodies. Interference from anti-thyroid hormone antibodies is method dependent. We report a case of interfering T4 antibodies giving falsely elevated FT4 result. **Case history:** A 39-year-old lady presented with symptoms of feeling tired, and lethargic. She had family history of hypothyroidism. On examination she was clinically hypothyroid and had diffuse smooth goitre. Thyroid function test (TFT) using Siemens competitive immunoassay revealed TSH of (92.35 mu/l), FT3 (2.2 pmol/l), FT4 (17.1 pmol/l) and a positive thyroid microsomal antibodies >1300. There is discrepancy between free FT4 and TSH values leads to suspicion of T4 interfering antibodies. Repeated of TFT using roche elecsys 2010 assay showed TSH (74.56 mu/l), FT4 (4.4 pmol/l), and FT3 (2.5 pmol/l) supporting the presence of T4 interfering antibodies. Symptoms resolved completely with levothyroxine replacement and here TFT were normalized. **Comments:** This case highlights the importance of considering interfering T4 antibodies when interpreting unusual TFT and importance of repeating TFT using different assay for confirmation.

P9.RISK OF ISCHAEMIC HEART AND CEREBROVASCULAR DISEASES IN PEOPLE WITH DIABETES ATTENDING ALWAHDA HOSPITAL, DERNA, LIBYA. Osama ALGADRA*, Monsef M ALOKALI, Abdelmonem GHIZAN* and Omar S EL SHOURBAGY. Departments of Internal Medicine* and Family and Community Medicine**, Faculty of Medicine, Omar Almkhtar University, Derna, Libya..**

Background: Several risk factors are involved in the etiological mechanisms of coronary artery disease and cerebrovascular disease. Many of these risk factors are modifiable. Objective: To assess frequency and risk of ischemic heart disease (IHD) or cerebrovascular diseases (CVD) in medical patients attending Alwahda hospital. The relationships to age, gender and presence or absence of diabetes mellitus were explored. Methodology: This prospective study included 347 patients (203 males and 144 females) attending in-patient internal medicine department at Al Wahda hospital from 1st January to 31 December 2006. There mean age was 53±17 years (23-95 years). They had a complete medical history and physical examination. Evidence of ischemia was assessed by 12 lead resting ECG. The presence of diabetes was documented by history of known diabetes and or fasting blood glucose level and HbA1c levels. Results: Diabetes was found in 295 /347 patients (85 %); being 130 men and 127 women. Therapy with oral glucose-lowering agents was employed by 81% of subjects; and 19% were treated with insulin and oral agents. The proportion of the study patients meeting the ADA recommended HbA1c goal of <7% was 30%. Seventy percent of study subjects had HbA1c levels greater than or equal to 7%. Coronary heart disease was present in 63/347 (18.2%). These were 47 males and 16 females. The frequency of IHD was 49.2% (31 / 63), 42.9% (27 / 63), 6.3% (4 /63) and 1.6% (1 /63) in age groups (60-79), (40-59), (20-39) and (>80), respectively (P <0.001). CVD was present in 27/347 (7.8%) of cases being 26 males and 1 female. Diabetes was a risk factor in 28 out of 63 patients with IHD (44.8%) and in the CVD patients was in 10 out of 27 CVD patients (37%). Of those diabetics, 26 patients were in the age group (40 to 59 years) and 9 patients were in the age group (60 to 79 years). Men with diabetes had significantly higher frequency of IHD or CVD (n=26; 64.4%) compared women with diabetes (n=12; 31.6%) (Chi-square=13.5, p<0.05). Conclusion: Management of ischemic heart and cerebrovascular diseases should be considered as regarding age, sex and diabetic state.

P10. RHEUMATOLOGICAL MANIFESTATIONS OF THYROID DISEASE. Fathia EHMODA, Adalia BESSAT and Mohammed ABDUL SALAM. Department of Rheumatology, 7th October Hospital and Faculty of Medicine Al-Arab Medical University, Benghazi, Libya.

Background: Thyroid diseases are chronic metabolic diseases, characterized by abnormal thyroid function tests. Thyroid diseases can result in musculoskeletal (MSK) symptoms that mimic connective tissue disorders. Some autoimmune disorders are associated with increased risk of thyroid disease. Method and Patients: 175 patients with thyroid diseases were studied for presence of MSK manifestation. Data were collected from Rheumatology and Endocrinology clinics during study period [2005]. Results: 113/175 (64.5%) had hypothyroidism; age range from (22-60 years), mean (41 19), sex (107) female (94%), (6) male (6%), disease duration (1-20 years) mean (9.5 10.5), out of which 101/113 (89%) with primary hypothyroidism, 13/113 (10.6%) with hashimoto's disease. 37/175 (21%) had thyrotoxicosis; age range from (22-55 years) mean (37 18), sex (30) female (81.1%), (7) male (18.9%), disease duration (4-48 months) mean (26 22m), out of which 23/37 (62.1%) with Grave's disease, 14/37 (37.8%) with hyperthyroidism. 25/175 (14.2%) had Subclinical hypothyroidism; age range from (23-60 years) mean (40 19), sex (24) female (96%), (1) male (4%), disease duration (6-60M), mean (39 26 months). Control group 50 patients; age range from (22-60 years) mean (41 19), sex (42) female (84%) and (8) male (16%). The MSK manifestation were seen in 66/113 (58.4%) of patients with hypothyroidism including myopathy in 33/66(53%), arthropathy in 18/66(27%), CTS and crystal arthritis in 3/66(4.5%), in 18/37 (48.6%) of patients with thyrotoxicosis; myopathy 4/18(22.2%), ophthalmopathy 6/18(33.3%) and thyroid acropachy1/18(5.5%), and in 18/25(72%) of patients with subclinical hypothyroidism; myopathy 8/18(44.4%), arthropathy 6/18(33.3%), CTS 6/18 (33.3%) and crystal arthritis 4/18(11.1%). Compared with control group; 8/50 (16%) had arthropathy, CTS 4/50(8%), crystal arthritis 2/50(4%). In patients with connective tissue disease and rheumatoid arthritis: 12(18%) had hypothyroidism, 4 (22.2%) subclinical hypothyroidism, and 4 (27.7%) with thyrotoxicosis. Patients with osteoarthritis: 10 (15%) had hypothyroidism, 4 (22.2%) subclinical hypothyroidism. SLE: 2 (3%) with hypothyroidism, 1 (5.5%) with subclinical hypothyroidism. Sjogren syndrome: 6 (9%) with hypothyroidism, 2(11.1%) with thyrotoxicosis, polymyositis 2(3%). Conclusion: Thyroid diseases are associated with musculoskeletal manifestations that mimic connective tissue diseases; appropriate treatment of thyroid diseases improves MSK symptoms of these diseases.

P11. CLINICAL PATTERN OF PREMATURE OVARIAN FAILURE IN PATIENTS ATTENDING ENDORINE CLINICS IN BENGHAZI LIBYA. Adela ELAMAMI, The Endocrine Unit, 7th of October Hospital and Department of Medicine, Faculty of Medicine, Al-Arab Medical University, Benghazi, Libya.

BACKGROUND: Premature ovarian failure (POF), defined as development of hypergonatropic hypogonadism before age of 40, was observed in 1% of women in one population-based sample. OBJECTIVES: To assess the clinical pattern and trends of POF in all new cases registered in endocrine clinics in Benghazi during the years 1995, 2000, 2005 and 2006. MATERIAL and METHODS: A retrospective study involving the files of all new cases of POF which were registered in endocrine clinics at 1995, 2000, 2005 and 2006. Data recorded included age of disease onset, marital state, age at menarche, number of children, associated autoimmune disease, chromosomal analyses, antibody testing, family history of POF or premature menopause, course of disease, history of coronary artery disease, osteoporotic fracture & abnormal DEXA scan. Data were analyzed using frequency tables, mean, t-tests. RESULTS: The estimated frequency of POF at 1995 was 0.7% (3/431), 2000 0.7% (9/1376), 2005 was 1.7(13/749), 2006 was 1.8(12/665). Out of 38 patients only one was a case of lymphoma who received chemotherapy and radiotherapy the others were spontaneous. The mean age in 1995 was 38.3+/-0.5 and in 2006 was 34.08+/-7.2 (p value<0.001). Thyroid disease was present in 1/3 in 1995, 6/9 in 2000, 6/13 in 2005, 2/12 in 2006. However, only 9 patients were tested without obvious thyroid disease. Frequency of diabetes mellitus, Addison disease or pernicious anemia were none out of 3 in 1995, 2 out of 9 in 2000, 1 out if 13 in 2005 7.6% (1/13), 2006 8.3% (1/12). Family history of POF or premature menopause was negative in 17 patients, positive in 3 patients and not documented in 17 patients. The age at menarche was not mentioned in 5 patients. Anti thyroid antibodies were requested in 2 patients and were negative. Anti-adrenal was not requested in any. Out of 6 patients whose disease start before age of 30, karyotyping was done in 3 patients only. 18 patients were married of whom 6 were nulliparaus, 7 had less than children and 5 had more than 3 children. 18 patients (49%) were lost to follow up. stop follow up after second or third visit and 3 were referred to gynecologist for fertility issue. In the remaining 16 patients who continued follow up, no history of premature cardiac events or osteoporotic fracture was found and DEXA was done in one patient. CONCLUSION: An

increased frequency of POF was seen which may reflect increased incidence of the condition and/or increased awareness of POF as an endocrine disease. Thyroid disease is underestimated by lack of routine screening. POF below age of 30 years, family history was not systematically elicited. The large number of patients which stop follow up may reflect low patients' satisfaction.

P12. PATTERN OF THYROID DISEASE AND THEIR IMPACT ON HEALTH RELATED QUALITY OF LIFE IN ALWAHDA HOSPITAL, DERNA, LIBYA. Hamad RAFE, Mohamed ALGABSI and Aubaker SUISSI. Department of Surgery Alwahda Hospital and Faculty of Medicine, Omar Al Mukhtar University, Derna, Libya,

Background: The importance of patient-reported outcomes such as health-related quality of life (HRQL) in clinical research is increasingly acknowledged. In order to yield valid results, the measurement properties of HRQL questionnaires must be thoroughly investigated. **Objectives:** To study the pattern of thyroid disorders in surgical department at Alwahda Hospital, Derna, Libya, 2004 - 2006 and their impact on HRQL. **Methods:** Two hundreds and ninety six (296) patients admitted to surgery department at Alwahda Hospital, Derna, Libya 2004 - 2006 were studied. Complete medical history, clinical examination and hormonal assays (T3, T4 and TSH) were done. On a subset of these patients, "Hyperthyroidism Complaint Questionnaire" was served to 57 patients (those showed hyperthyroidism by hormonal levels) and "Chronic Thyroid Questionnaire" was served to 46 patients (those showed hypothyroidism by hormonal levels). **Results:** Out of 296 patients with age ranging between 14 and 70 years with a mean value 36.3+11.9 years, 276 (93.2%) were females. Lobectomies were performed on 146 (49.3%), (65 cases were right, 35 cases were left and 46 cases were isthmusectomy). Near total thyroidectomy were done in 67 (22.6%), sub-total in 53 (17.9%), recurrence was observed in 13 cases and total thyroidectomy in 2 cases. About half of the patients (48% of hyperthyroid and 63% of hypothyroid subjects) had reduced overall quality of life and general health, limitations in usual activities as well as social and emotional problems. About two-thirds (60% of hyperthyroid and 68% of hypothyroid subjects) were fatigued and about one-third (32% of hyperthyroid and 39% of hypothyroid subjects) were anxious and had cognitive as well as sexual problems. **CONCLUSION:** It appears that persistent HRQL impairment is very frequent among patients with both hyper- and hypothyroidism.

P13. HYPERTHYROIDISM FROM HYDATIDIFORM MOLAR PREGNANCY: CASE STUDY AND REVIEW OF THE LITERATURE. Najat Eldressy, Endocrine and Diabetes Department, Eljamahyria Hospital and Al Arab Medical University, Benghazi, Libya.

Background: Hyperthyroidism in pregnancy has a prevalence of 0.1-0.4 %. Graves' disease accounts for 85% of cases. **Case presentation:** A 30 year patient was referred for endocrine assessment at the antenatal department. She has missed period for 1 month, presented with persistent vomiting, palpitation, bilateral hand tremor and weight loss. Physical examination revealed a sick patient with a pulse 120 per minute, clinically hyperthyroid with a diffusely enlarged thyroid gland (twice normal size) and a positional hand tremor. Per abdomen, a supra pubic mass just below the umbilicus was evident and pelvic ultrasonography revealed characteristic features of molar pregnancy. Biochemical investigations showed very high serum total T4 276.3 nmol/l, and serum T3 4.27 nmol/l, serum TSH 0.011 mIU/l, CA 125 114.2 u/l and serum beta HCG of 62981 mIU/l . She was started on Carbimazole, Propranolol 140 mg/day, Dexamethasone 8mg 8hourly IV, Lugol's solution and Meteclopramide prn. She underwent evacuation and curettage after 1 week without complications. Her repeat laboratory data markers total T4 195 nmol/l, T3 1.07 nmol/l. **Discussion:** Thyrotoxicosis complicating molar pregnancy is uncommon. It is caused by the high levels of beta-human chorionic gonadotrophin (HCG), a peptide with high homology to TSH. Thus, it posses thyroid stimulating activity and may cause biochemical and clinical hyperthyroidism. Symptoms of hyperthyroidism may mimicked by normal pregnancy. This cause illustrates the due care that obstetricians and endocrinologists need to exercise when dealing with abnormal thyroid function tests during pregnancy.

P14. WHAT ADVICE DO DIABETIC PATIENTS GET FOR RAMADAN FASTING? Salem A Beshyah. Centre for Diabetes and Endocrinology, Sheikh Khalifa Medical City, Abu Dhabi, UAE.

BACKGROUNDS: The management of diabetes during Ramadan fasting is a classical example for the collaborative relationship between patients and their diabetes care teams. Plans should be considered well in advance of the holy month. **OBJECTIVES:** To assess the sources of advice diabetic patients get to guide them through Ramadan, nature (if any) and the results of such advice on glycaemic control as recalled by patients. **PATIENTS AND METHODS:** Over a 6 weeks period immediately before the start of the month of Ramadan (2007), eligible patients attending one practitioner were surveyed “as part of their pre-Ramadan care”. Their previous practices, source of advice and outcome in terms of recalled hypoglycaemia or hyperglycaemia were recorded. **RESULTS:** They were 23 women and 25 men with mean age 50 years (range 17-72). Six patients had type 1 diabetes. The duration of diabetes was 34 (range 1-34) years. They were treated with insulin (n=14), combination oral therapy (n=25) or mono-therapy (n=6). Forty two patients observe the fast and only six do not (2 patients had type 1 diabetes). Two thirds reported that took their own decisions regarding the fasting and changes of medication and one third got some advice. Of these, many reported getting advice from non diabetic physicians. Majority of the patients described reduction in the medication during Ramadan but details could not be ascertained due to long duration. 17 patients described problems with blood glucose control (hypoglycaemia in 11, hyperglycaemia with and without symptoms in 4 and a mixed picture in 2). Of concern that many patients did not feel the need or relevance of consult their diabetes care team. **CONCLUSIONS:** Majority of Muslim diabetic patients do observe the fasting during Ramadan. Many do not seek professional opinion to inform their choice and to guide them manage their diabetes during Ramadan fast safely. These findings call to regular seasonal campaigns to increase awareness about appropriateness and availability of professional advice and support.