Experience with growth hormone treatment in Great Britain

The Medical Research Council working party which has been studying the clinical use of human growth hormone (hGH) in the treatment of children with short stature has recently published its final report.1 Patients treated in the trial included children with idiopathic hGH deficiency, some others with intracranial disorders with hGH deficiency, and a third group with a variety of miscellaneous conditions with and without hGH deficiency. Idiopathic deficiency of multiple pituitary hormones was much less common than idiopathic “isolated” hGH deficiency, whereas children with acquired pituitary disease, commonly due to a craniopharyngioma, usually had multiple hormone deficiencies.

When children were started on treatment early the long-term results were satisfactory: 77 patients have now reached their final adult height and 22 of the 47 with idiopathic hGH deficiency and 18 of the 30 with intracranial disease have achieved a height above the third centile for stature. Many of those who failed to reach the third centile were started on hGH at very late bone ages.

The prevalence of idiopathic hGH deficiency remains uncertain, since there is a considerable difference between the figures obtained by Parkin2 3 in Newcastle (about one in 30 000) and in a more recent large study from Scotland4 (about one in 5000). The reasons for this discrepancy are not clear, but it creates problems in predicting future requirements for hGH. The working party estimated that an additional 136 new patients will need to be started on treatment in each of the next five years given that most patients with severe or partial hGH deficiency will be recognised and referred for treatment. Adequate supplies of hGH will need to be provided by the Department of Health and Social Security, with which responsibility for providing treatment now lies.5 The working party has taken a pessimistic view of the chances of enough hGH being made available and has suggested that all patients should be treated “until they are of a socially acceptable height.” This is acceptance of second-best: surely all children should be given the treatment needed to bring them to their maximum height.

A second defect in the present system for treating these children is the delay in starting it. The mean age at the beginning of treatment in children with idiopathic “isolated” hGH deficiency remains unsatisfactorily high at 8.1±0.6 (SEM) years with a mean bone age of 5.7±0.3 years. The value of early treatment has been emphasised repeatedly, and the possibility of hGH deficiency should be in the mind of every clinician. With modern diagnostic facilities, treatment should be able to start before the age 5-6 years in most affected children.

All children who are very short (defined by a height that is 3·0 or more standard deviations below the mean for age), or who are less short but growing slowly,6 should be referred to an appropriate paediatrician, endocrinologist, or growth assessment centre (listed in the DHSS Health Circular HC(77)21).6 Other diseases such as coeliac disease may then be excluded, and a positive clinical and laboratory diagnosis of hGH deficiency established by finding a low growth velocity, mild-to-moderate obesity, delayed bone age in the absence of hypothyroidism, and impaired hGH secretion during a valid dynamic test such as the insulin tolerance test.

How closely our management of growth hormone deficiency approaches the optimum should become apparent from the reports of the Health Service Human Growth Hormone Committee. This was recently set up to supervise the selection of patients for treatment, to determine treatment schedules, to maintain the overall supply of hGH, and to monitor the safety and effectiveness of treatment.

6 Joint planning—health and local authorities: joint financing of personal social services projects. DHSS Health Circular HC(77)21, June 1977.

A waste-cutting quango

Cutting waste and getting better value for money are the current Government’s philosophical aims, but setting up a quango to do it seems paradoxical. Nevertheless, the NHS Supply Council announced by Mr Jenkin last month1 may be justified by the wasteful way in which the NHS has used its massive purchasing power—£1000 million each year. Responsibility for buying supplies and equipment is divided among the DHSS supply branch (which arranges many contracts for the NHS) and various tiers of the Health Service.2 As successive reports have shown,3-7 too many of the purchases are made in an uncoordinated way, and the NHS does not get the best value for its money. The most recent assessment, that of the Salmon working group,7 criticised the division of responsibility and recommended a national supply council to draw up mandatory policies for health authorities.

After one and a half years’ consultation the Secretary of State has established a policy-making council, with most of its members from the NHS. The council will have an independent chairman and include a representative of the health-care industry, the controller of supply at the DHSS, seven regional health authority nominees, and a doctor and a nurse nominated by the chief medical and nursing officers. The functions of the council, which will be funded by the health authorities, are vague and suggest that the tough animal envisaged by Salmon has had its teeth drawn: nowhere is enforcement mentioned.

Perhaps the council’s lack of power reflects the Conservative philosophy of devolving power to the NHS or, just as likely, the DHSS’s desire to protect its own interests and influence. The council “will advise . . . on the organisation of supplies work” and “in consultation with authorities, users, and the supplies industry . . . develop policies and arrangements to enable authorities to make the best use of their supplies resources.” In particular, it will arrange evaluation and information systems—work now done mainly by the DHSS. Since the council will have only a small secretariat it will have to rely on (and pay) the DHSS and, where appropriate, health authorities to continue doing this work. The danger is that unless the council’s members are exceptionally well informed