PES Endocrine Monthly Round-Up

June 2026

Editor's Perspective

June brings a particularly substantive set of updates spanning diabetes, reproductive endocrinology, and pituitary disease. Highlights include the long-awaited 2026 ATA Guidelines on Thyroid Disease in Preconception, Pregnancy, and Postpartum — superseding the 2017 version with substantial changes to the management of subclinical hypothyroidism, isolated hypothyroxinemia, and Graves' disease; landmark Phase 3 data on retatrutide, a first-in-class triple GIP/GLP-1/glucagon receptor agonist in type 2 diabetes; and a new Endocrine Society Clinical Practice Guideline on Central Precocious Puberty that meaningfully reframes diagnostic and therapeutic thresholds. The month's Review Article focuses on the long-term burden of craniopharyngioma and the emerging role of setmelanotide in acquired hypothalamic obesity.

Research Highlights

1. American Thyroid Association 2026 Guidelines for Thyroid Disease in Preconception, Pregnancy, and Postpartum

Guideline Focus: Comprehensive update of the 2017 ATA guidelines, developed using GRADE methodology and endorsed by 12 international societies including AACE, ACOG, ETA, Endocrine Society, and the Iodine Global Network.

Key Messages:

- For euthyroid TPOAb-positive women — including those with infertility or recurrent miscarriage — levothyroxine should not be offered, based on three high-quality RCTs since 2017.
- TPOAb status no longer guides LT4 decisions in subclinical hypothyroidism; treatment is now framed primarily by timing of diagnosis.
- For mild subclinical or overt hypothyroidism (TSH <6 mU/L) in pregnancy, repeat testing is recommended before initiating LT4, as approximately half normalise spontaneously.
- LT4 should not be offered for subclinical hypothyroidism diagnosed after the first trimester, or for isolated hypothyroxinemia at any stage.
- Daily iodine intake of 250 mcg in pregnancy and lactation; supplementation of 150 mcg/day ideally from 3 months preconception.

- PTU remains preferred in the first trimester for Graves' disease; greater emphasis placed on TRAb/TSI titres for ATD discontinuation decisions.
- Lactating women undergoing anaesthesia may resume breastfeeding as soon as awake — the prior 24-hour discard recommendation has been removed.

Clinical Takeaway: The 2026 ATA Guidelines move thyroid management in pregnancy toward more conservative, evidence-based prescribing — reducing inappropriate LT4 exposure while reinforcing a structured, mechanism-driven approach to Graves' disease and iodine nutrition.

2. Retatrutide in Type 2 Diabetes — TRANSCEND-T2D-1

Study Focus: Phase 3, 40-week, randomised, double-blind, placebo-controlled trial evaluating once-weekly retatrutide — a first-in-class GIP, GLP-1, and glucagon triple hormone receptor agonist — as monotherapy in adults with type 2 diabetes inadequately controlled on diet and exercise alone.

Key Findings:

- 537 adults randomised 1:1:1:1 to retatrutide 4 mg, 9 mg, 12 mg, or placebo (baseline HbA1c 7.9%, BMI 35.8 kg/m², mean diabetes duration 2.5 years).
- HbA1c reduction of −1.69%, −1.86%, and −1.94% across the three doses vs −0.81% with placebo.
- Up to 89% of treated participants achieved HbA1c <7.0%; up to 83% reached ≤6.5%; up to 46% achieved normal HbA1c.
- Weight reduction of −11.5%, −13.9%, and −15.3% vs placebo −2.6% — a 15.1 kg reduction at the highest dose, with no plateau by week 40.
- Improvements in triglycerides (−39.6%), non-HDL cholesterol (−19.8%), systolic blood pressure (−6.4 mmHg), and waist circumference (−12.4 cm).
- GI adverse events most common (nausea up to 26.5%, diarrhoea up to 22.8%); dysesthesia in 2.3–4.5%; treatment discontinuation 2.2–5.1%.

Clinical Takeaway: Retatrutide delivers the largest combined HbA1c and weight-loss effect yet reported in a Phase 3 type 2 diabetes trial, supporting its potential as a future first-line option in early type 2 diabetes — particularly in patients with significant obesity.

3. Endocrine Society Clinical Practice Guideline on Central Precocious Puberty

Guideline Focus: Updated GRADE-based recommendations from the Endocrine Society, co-sponsored by AAP, ESE, ESPE, SBEM, SLEP, PES, and PPA, addressing 10 prioritised clinical questions in the diagnosis and management of central precocious puberty (CPP).

Key Messages:

- In girls presenting with thelarche between ages 7.0 and 8.0 years, watchful waiting with 4–6 monthly examinations is suggested rather than immediate laboratory or radiological workup.
- In girls under 7 years with Tanner B2, a 4–6 months observation period is recommended to distinguish slowly progressive from rapidly progressive puberty.
- Basal ultrasensitive LH should replace GnRH/GnRHa stimulation as the initial diagnostic test.
- Routine brain MRI is not recommended for girls aged 6.0–8.0 years or boys aged 8.0–9.0 years without CNS symptoms.
- GnRHa treatment is appropriate for many but not all children with CPP — older girls with slowly progressive disease may derive limited benefit.
- Long-acting GnRHa preparations (≥3-month, including the 12-month implant) are preferred over monthly formulations when long-term treatment is planned.

- Routine biochemical monitoring during GnRHa treatment is not recommended; clinical assessment is sufficient.
- Routine addition of growth hormone is not recommended.
- GnRHa treatment should generally be discontinued by chronological age 10–11 years (girls) or 11–12 years (boys), or bone age 11–12 / 12–13 years respectively.

Clinical Takeaway: The new guideline reframes CPP toward more measured, individualised care — reducing unnecessary investigations, biochemical testing, and treatment in slowly progressive cases, while preserving timely intervention in those at meaningful risk of compromised adult height or psychosocial harm.

Review Article of the Month

Quality of Life, Morbidity, Mortality, and Long-Term Prognosis After Craniopharyngioma

Key Insights:

- Craniopharyngioma carries a 3- to 5-fold higher overall mortality compared with the general population; cardiovascular mortality is 3- to 19-fold higher, particularly in female patients.
- Approximately 80–90% of post-surgical patients develop panhypopituitarism; 40–60% of those with hypothalamic involvement develop hypothalamic obesity.
- Hypothalamic syndrome — a distinct entity encompassing disordered eating, sleep disturbance, thermoregulatory dysfunction, behavioural disturbance, and endocrine deficiencies — is the dominant determinant of long-term quality of life.
- Conventional weight management strategies have shown limited efficacy; GLP-1 receptor agonist evidence remains inconsistent, with no agent currently approved for acquired hypothalamic obesity.
- Setmelanotide (MC4R agonist) Phase 3 RCT (NCT05774756): in 120 patients over 52 weeks, placebo-adjusted BMI reduction of −19.8%; 80% achieved ≥5% BMI reduction; significant improvement in hunger scores — the first agent demonstrating efficacy in hyperphagia — and meaningful improvement in QoL (IWQOL-Lite-CT +32 vs +3 with placebo).
- Setmelanotide is now FDA-approved for acquired hypothalamic obesity in adults and children ≥4 years.
- Prevention through hypothalamus-sparing surgical strategies and proton beam radiotherapy remains central to limiting long-term sequelae.

Clinical Takeaway: Craniopharyngioma is increasingly recognised as a lifelong, multisystem endocrine condition rather than a contained neurosurgical event. The emergence of setmelanotide marks a substantive therapeutic advance, but optimal outcomes still depend on hypothalamus-sparing initial management and structured long-term endocrine follow-up.

For Further Reading

ATA 2026 Pregnancy Thyroid Guidelines: https://doi.org/10.1177/10507256261445624

TRANSCEND-T2D-1 (Retatrutide): https://doi.org/10.1016/S0140-6736(26)00967-0

Endocrine Society CPP Guideline: https://doi.org/10.1210/clinem/dgag168

Craniopharyngioma Review: https://doi.org/10.3389/fendo.2026.1768254

Closing Note

This month's updates illustrate the increasingly nuanced direction of endocrine practice — from de-escalating unnecessary intervention in thyroid pregnancy care and central precocious puberty, to a new class of triple-agonist therapy in diabetes, and the first effective pharmacological treatment for acquired hypothalamic obesity. Across these domains, the underlying theme is the same: better-targeted treatment of the right patient at the right time.

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