available SGLT2i. It is prudent to evaluate its effectiveness & tolerability in comparison to other SGLT2i in real world setting. **METHODS:** In this observational retrospective study, medical data from EMR of tertiary care hospital in Kolkata was retrieved. The records of adult Type 2 diabetes mellitus (T2DM) patients who were on a dual therapy of Metformin plus SGLT2i (Canagliflozin, Dapagliflozin or Empagliflozin) for at least 6 months with adequate glycaemic control (HbA1c to target based on age & duration of diabetes) & subsequently switched over to Remogliflozin 100 mg twice daily because of economic reasons were screened. The day of switchover was considered as index day (Day 1) The patient records whose data was unavailable, metformin dose was altered during period of next 6 months, who had evidence of active UTI on index day, were receiving injectable anti-diabetic drugs or had recorded eGFR <45 mL/min were excluded. The effectiveness was assessed in terms of maintenance of HbA1c, FBS, PPBS, body weight after 3 & 6 months of treatment. The safety was assessed by adverse events recorded in medical records in terms of abnormal symptoms, signs or laboratory reported values during the observation period of 6 months & compared to equivalent period of 6 months before index day. The data was collected & analysed using appropriate statistical techniques. **RESULTS:** After screening, medical records of 50 adult T2DM patients (54% male) were found to be eligible. The mean baseline characteristics on Index day in terms of Age, HbA1c levels, FBS, PPBS, weight & BMI was 51.3±12.5 years, 6.8±0.4%, 108.7±8.1 mg/dL, 144.5±21.3 mg/dL, 65.5±5.7 kg & 25.8±2.8 kg/m2 respectively. After treatment period of 6-months with Remogliflozin-based regimen, the mean HbA1c, FBS, PPBS, -Body weight & BMI was 6.7±0.8%, 110.3±10.5 mg/dL, 138.5±12.7 mg/dL, 66.3±6.5 kg & 25.9±3.2 kg/m2 Mean change from baseline in HbA1c levels, FBS, PPBS, weight & BMI were-0.1±0.19%, -1.6±7.2 mg, -6.0±8.3 mg, +0.8±0.2kg, & +0.1±0.0.7 kg/m2 respectively. These change from baseline of all above parameters were not found to be statistically significant (P>0.05) No events of hypoglycaemia, disturbance in electrolytes or any unusual adverse events were reported. Combined incidence of UTI & genital Mycotic infection was similar during 6 month observation period as compared to 6 months prior to index day. (8% vs 6%) **CONCLUSION:** In real world clinical practice, replacement of ongoing SGLT2i with Remogliflozin was observed to provide consistent glycaemic control without any tolerability issues. Hence, novel SGLT2i Remogliflozin can be considered as equivalent alternative for SGLT2i based regimen in management of Indian T2DM patients

Neuroendocrinology and Pituitary

PITUITARY TUMORS II

Metabolic Profile in 107 Patients With Childhood Onset Growth Hormone Deficiency (CO-GHD) at the Time of Transition From Pediatric to Adulthood Endocrine Care

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Vulnerability of the transitional period from childhood to adulthood is particularly challenging in treatment of adolescents with CO-GHD. Altered metabolic profile is well described in GHD, but relevant large monocentric studies in transition patients and young adults with CO-GHD are lacking.**Patients and Methods**: In a monocentric, observational, retrospective cross-sectional study conducted from 2005-2019, 107 CO-GHD patients were analyzed (17-26 years old, 80 males) at the time of transfer from pediatric to adult endocrine care. Median age at transfer was 19.6 ± 2.2 years. Subjects with congenital and idiopathic GHD (CON) were compared with age-, sex- and BMI-matched patients with hypothalamic/pituitary tumor history (TUM). Glycaemia and insulin during OGTT (peak and AUC), HbA1c, serum total cholesterol, HDL, LDL and triglycerides were analyzed in all patients.**Results:** Congenital and idiopathic causes of CO-GHD were more frequent than hypothalamic/pituitary tumoral causes (74.8% vs. 25.2%). All patients received GH replacement during childhood for average duration of 5.4 ± 1.4yrs. GH replacement was discontinued prior to transfer for 2.7 ± 0.9yrs. Glycaemia peak, glycaemia AUC and insulin peak in OGTT were not significantly different in TUM vs. CON (p>0.05). However, insulin AUC in OGTT was significantly higher in TUM compared to CON (134.38 ± 23.2 vs 114.62 ± 12.4; p<0.05). HbA1c was similar between the two groups (5.2 ± 0.4% TUM vs 5.0 ± 0.3% CON; p>0.05). Total cholesterol (5.2 ±1.1 vs 4.5 ± 0.8 mmol/l; p>0.05), LDL (3.1 ± 0.9 vs 2.7 ± 0.8 mmol/l; p>0.05) and triglycerides (2.1 ± 1.1 vs 1.1 ± 0,7 mmol/l; p<0.05) were increased in TUM compared to CON, while HDL was decreased in TUM group (1.0±0.1 vs 1.4±0,3 mmol/l; p<0.05).**Conclusion:** Patients with CO-GHD caused by hypothalamic/pituitary tumors are burdened with a worse metabolic profile at the time of childhood to adulthood transition compared to matched transition patients with congenital CO-GHD.

Neuroendocrinology and Pituitary

HYPOTHALAMIC-PITUITARY DEVELOPMENT AND FUNCTION

Undernutrition Reduces Transcript Abundance of Kisspeptin and Neurokinin B in Young Male Sheep.

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Proper energy balance is important to ensure reproductive success. Chronic nutrient restriction is known to suppress hypothalamic-pituitary function, but the central mechanisms whereby undernutrition inhibits GnRH/LH secretion remain largely unknown. KNDy neurons, which co-express *k*isspeptin, *n*eurokinin B (NKB), and *dy*norphin,