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Best Practices for Individualizing Treatment Selection

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr Geer:
This is CME on ReachMD, and I'm Dr. Eliza Geer. Today my focus is best practices for individualizing treatment selection for patients with acromegaly.

So we have some recent data that we can really use a more personalized approach for treating acromegaly patients with medical therapy. Just remember that these are patients – the vast majority have already had transsphenoidal surgery and may need additional therapy to control IGF-1 levels.

We can first consider cabergoline, which we don't have clinical trial data on, but overall there's about a 30% response rate, and typically this is better for a patient with mild disease.

When thinking about somatostatin receptor ligands, which are really the cornerstone of medical therapy, we know that overall there's a 55% IGF-1 normalization, but when we look at predictors, we can get better response, depending on how we select the patients. So we know that patients with densely granulated tumors, which is associated with high SSTR2 expression, and hypointensity on T2-weighted MRI, these patients tend to respond better to first-generation SRLs, octreotide and lanreotide. Also, patients with milder IGF-1 elevations at baseline tend to have a better response to octreotide and lanreotide, and we've also seen that older patients, which often have milder disease, have a better response to first-generation SRLs.

So patients that tend to respond less well to first-generation SRLs are those with sparsely granulated tumors, either low or absent SSTR2 expression, or hyperintensity on T2-weighted MRI. For these patients, we can consider our second-generation SRL, which is pasireotide. And we know from the PAOLA study that 15%-20% of patients who did not achieve control on octreotide or lanreotide did achieve IGF-1 control when treated with pasireotide. And it also showed that pasireotide resulted in greater tumor volume reduction versus octreotide or lanreotide. So pasireotide can be considered in those with sparsely granulated tumors and T2-weighted hyperintensity on MRI and patients who would benefit from a tumor-directed therapy and tumor volume reduction. We do need to monitor for hyperglycemia with pasireotide, which occurs in about 42% of patients, and new-onset diabetes in about 24% of patients.

We also have oral octreotide, and for this we have similar predictors as the ones we have for first-generation SRLs. So these are patients with densely granulated tumors and hypointensity on T2-weighted MRI. These are patients who could respond to oral octreotide. And patients who are really experiencing significant burden with the injections, these are patients we could consider oral therapy with. Patients who have a loss of independence, injection-related side effects, or worsening symptoms but responding to first-generation SRL, we could consider oral octreotide.

And finally, we have pegvisomant, which is a growth hormone receptor antagonist. The advantage and disadvantage of this medication

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is that it's not tumor directed. This is an advantage because we're not dependent on the receptors present in the tumor for the effect, so this works on growth hormone receptors in the liver. And we know from 10-year follow-up data in the ACROSTUDY that, overall, 73% of patients achieved biochemical control and, you know, also patients can have some improvement in their glycemic control, with improvement in A1c by 0.5%. So patients with preexisting diabetes, patients with small tumor volumes, those with a tumor that has low or absent SSTR5 expression, these are patients who we'd consider pegvisomant for. We also know that we need higher doses of pegvisomant often for patients with diabetes or higher BMI.

Other things to think about is that we really want to set our expectations for our patients. We want to consider their symptoms, and we want to use patient-reported outcomes to look at how they're responding to therapies. Many studies have shown that, unfortunately, acromegaly patients often continue to have some symptoms despite treatment and despite IGF-1 normalization, so we want to be aware of that, that patients often have long-term physical symptoms, psychological symptoms, and also treatment-related effects in some cases. But hopefully improving the awareness of the ongoing symptoms and that this is a chronic disease that can be well treated, with improvements in morbidity and mortality, but often there are chronic morbidities that need to be addressed. Sort of discussing this with our patients can hopefully improve to better care and better outcomes for our patients.

So my time is up, but I hope I've given you something to think about. Thanks for listening.

Announcer:
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