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How Would You Treat?

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. Here with me today is my colleague, Dr. Kevin Yuen.

So let's dive into a case. Dr. Yuen, we have a 40-year-old man who's been diagnosed with acromegaly. He has an invasive macroadenoma. He undergoes transsphenoidal surgery, and pathology shows that it's a sparsely granulated tumor. After surgery, he has a very high IGF-1 level. So we also know that he's been diagnosed with type 2 diabetes, but it's well controlled. So which treatments would you consider for this patient, and why?

Dr. Yuen:
Thank you, Dr. Geer. This sounds like an interesting and complicated patient. So for starters, I think that the fact that he has an invasive macroadenoma and the fact that he has a pathology that is sparsely granulated with high post-op IGF-1 makes it a challenging patient. So in terms of treatment options, obviously given the fact that he continues to have high IGF-1, medical therapy or perhaps maybe even radiotherapy. But regardless of whether radiotherapy or not, medical therapy needs to be considered, given the fact that radiotherapy takes time for it to work. So we certainly have 3 options, I guess. You have the first-generation somatostatin receptor ligands such as octreotide and lanreotide. We also have the second-generation pasireotide LAR, and also the growth hormone receptor antagonist pegvisomant. I think, given the fact that this is an invasive macroadenoma with a high IGF-1, certainly there is a possibility that the disease is going to be difficult to manage, and I think what we could do is to consider a somatostatin receptor ligand. And this is because it can work by potentially reducing the tumor size and potentially lowering the IGF-1.

However, I think after trying him on the first-generation somatostatin receptor ligands, I've got some bad news in that his biochemical control remains suboptimal with persistent symptoms, and also the fact that he may have some adverse events. So I think we have to then consider thinking about what are our options next and certainly maybe even either increasing the current dose or perhaps considering combination therapy or switching the patient to another agent completely.

Dr. Geer:
Yeah, so these are some good possibilities. So it sounds like he's had sort of a suboptimal response to a first-generation SRL, which I guess is not surprising because he has a sparsely granulated tumor, and we know those tumors don't respond as well to first-generation SRLs. If he's really not receiving benefit in terms of IGF-1 reduction and symptom management, then we may consider just switching to a second-generation SRL, pasireotide, since we know that patients who have not responded to first-generation SRLs, about 15%-20% of them will receive control, in terms of IGF-1 levels, from pasireotide and that the sparsely granulated tumors tend to respond better to pasireotide. It's also reassuring that he has well-controlled diabetes, because we know that pasireotide may cause diabetes or hyperglycemia, and that's a significant risk with that medication. So I would suggest possibly, you know, if he's not receiving any benefit

from first-generation SRL, switching to pasireotide. If he still needs further control on pasireotide, then we could consider combination therapy. So if he's received some benefit from pasireotide, we could add pegvisomant. And we know that the benefit of continuing an SRL with pegvisomant is that we can then hopefully use lower doses of pegvisomant. And there was the recent study by Vivien Bonert that looked at low doses of SRL plus weekly pegvisomant and showed very good outcomes in terms of both being an efficacious treatment regimen but also was a lower cost than other treatment regimens. So that's something else to consider is if he has large tumor volume but some symptom or IGF-1 control from pasireotide, we could add pegvisomant and we can also consider other combinations. But it sounds like he may need pasireotide, and then if pasireotide is not effective, either switching to another therapy or adding on pegvisomant to pasireotide might be a good option for this patient.

Dr. Geer:
Well, this has been a brief but great discussion. We hope you'll put these tips into practice. Thanks for tuning in.

Announcer:
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