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Guideline and Evidence-Based Best Practices for Treatment Sequencing

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, I'm Dr. Eliza Geer. Here with me today are Dr. Susan Samson and Dr. Kevin Yuen. So let's get right into today's topic.

Dr. Samson, what can you tell us about the treatment guidelines that are in place for acromegaly?

Dr. Samson:
Well, I think most of us would approach a patient with a new diagnosis of acromegaly with how can we normalize the IGF-1 in this patient, and how can we control the tumor? And most of the current guidelines would speak to that. So really, surgery is our first line in the majority of patients, and we need to make sure that after surgery, that that IGF-1 is normalized to decrease any comorbidities or even mortality for our patients. So I would say that one of the most important guidelines we have is to normalize the IGF-1 with surgery and then subsequently medical therapy, and in some patients, radiation therapy. To do this, one of our first lines are somatostatin receptor ligands [SRLs], and that's because they bind the somatostatin receptors that are on the surface of these tumors, and they're able to dampen growth hormone secretion and in some cases also shrink the tumor. We have kind of 2 generations of somatostatin receptor ligands. The first are octreotide and lanreotide, which both come in long-acting intramuscular or deep subcutaneous formulations that can be injected every 4 weeks and, in some cases, in extended dosing every 4-6 weeks. That generation of somatostatin receptor ligands is really a mainstay of our therapy for patients with acromegaly.

But there are patients who do not fully respond to these agents, and about a decade ago pasireotide became available to us as what we might call a second-generation somatostatin receptor ligand because it has been shown to improve IGF-1 and growth hormone levels in patients that may not be fully controlled on octreotide or lanreotide.

So those are the kind of first-line tools we have in treating our patients. And I'm interested, Dr. Yuen, if you select a first-generation somatostatin receptor ligand for your patient, how do you know when it's time to switch over to second-generation?

Dr. Yuen:
So I think there's no right or wrong answer. I think every patient is different, but generally, I would give the patient at least 6 to maybe even 9 months to see if the patient's able to come to some form of a steady state, if you like, of the medication and to see how the patient is tolerating it and to see whether the patient's able to take it as required – typically is usually, like I said, every 4 weeks. There are several factors that actually can predict SRL response or resistance. Typically the reported literature would say it would be the younger male, perhaps patients who had very high IGF-1 and growth hormone at diagnosis. There's also potentially patients who have AIP mutations, for example, and those patients, particularly who have, on pathology, perhaps sparsely granulated pathology. So those are the types of patients I think that might not respond, and if you feel that that is the situation, then I think that's the time to consider switching. And there are several factors you can consider. Either you can switch to another medication, so maybe perhaps a second-

generation SRL, or maybe even considering combination therapy. And I think several factors you need to take into consideration, particularly, for example, if there is tumor concern, perhaps switching to the second-generation SRL would be a consideration. But for example, if the patient has underlying glucose intolerance, then perhaps switching to pegvisomant is also an alternative. And combination therapy could be an option as well, again depending on the tolerability of the patient and also the response to these medications.

Dr. Geer:
Well, that was a good summary, Dr. Samson and Dr. Yuen, an excellent summary of some of the considerations for treatment sequencing. We can really see that this is, you know, multidisciplinary and also multimodal, meaning that our patients with acromegaly often need several lines of therapy to achieve control. And there are several features now that allow us to help predict how patients will respond to each therapy.

So that was a great bite-sized discussion. Thanks for listening.

Announcer:
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