

Clinical Case- Clinical Update 2007- Society for Endocrinology
Hypothalamus/ pituitary

'A challenging case of acromegaly'

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JH Male DOB 13/4/51

Initial Presentation- April 1998

Widening of tooth spacing- no longer able to hold fishing hooks between his teeth. Classical symptoms of acromegaly including shoe size changes, changes in appearance, sweating and headaches. Retrospectively, symptoms had been present for at least ten years. He had undergone surgery to correct nasal obstruction three years previously, which was likely related to his acromegaly. Clinical signs included spade hands, thickened skin, coarse facial features, prognathism, macroglossia and hypertension.

Initial Investigations

Acromegaly was confirmed after failure to suppress GH levels during OGTT. IGF-1 711 ng/ml (123-463). CT pituitary confirmed hyperdense macroadenoma with expansion of pituitary fossa and erosion of the lateral walls.

Management/ Progress

Transphenoidal resection of tumour October 1998; difficult- previous nasal surgery.

Residual right pituitary tumour suspected.

Day 4 post op GH day curve levels 38-58 mIU/L.

Clinical trial of lanreotide LA, December 1998-April 2000.

Baseline average GH 5.3 ng/ml, end of trial 3.3 ng/ml

Pre-trial IGF-1 645, end of trial 371 (75-306)

Off treatment IGF-1 833 (80-266) June 2000, MRI shows residual tumour.

NHS Sandostatin LAR treatment commences July 2000

Stereotactic radiosurgery March 2001.

2001-2004. Average GH levels 5-6 mIU/L. IGF-1 340-460.

Cabergoline added December 2004

2005 GH level average 3.0, IGF-1 341 (50-271)

2006 GH level average 2.0, IGF-1 283 (87-238)

2007 GH level average 2.5, IGF-1 328 (81-225)

Referred to Maxillo-facial surgeon for jaw realignment

-thinks that jaw still worsening

Most recent MRI- residual tumour close to/ encircling carotid artery. Not thought accessible (10mm x 10mm)

Comment

This case of acromegaly has been difficult to control despite transsphenoidal surgery, stereotactic radiosurgery and maximal sandostatin and cabergoline treatment. There remains a degree of activity, as reflected by the IGF-1 and continued jaw growth.

Possible discussion points

Monitoring of acromegalic patients during follow-up, use of different units for GH, management of 'difficult' acromegaly, role of stereotactic radiosurgery.

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