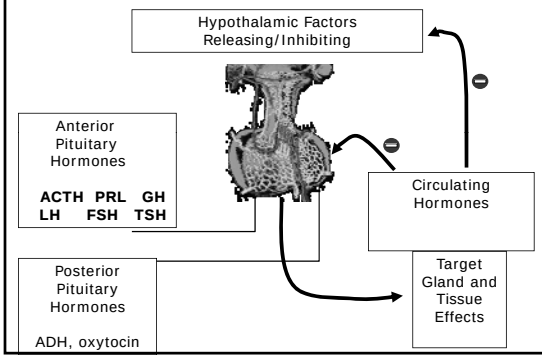
Pituitary

February 10, 2009

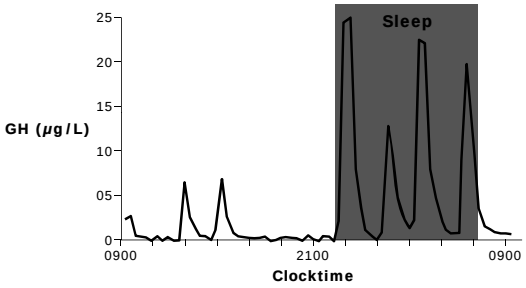
Growth Hormone

- Synthesized in the anterior lobe of the pituitary gland in somatotroph cells
- ~75% of GH in the pituitary and in circulation is
  191 amino acid single chain peptide,
  2 intra-molecular disulfide bonds
  Weight; 22kD
- Amount of GH secreted:
  Women: 500 µg/m²/day
  Men: 350 µg/m²/day

Hypothalamic-Pituitary Axes

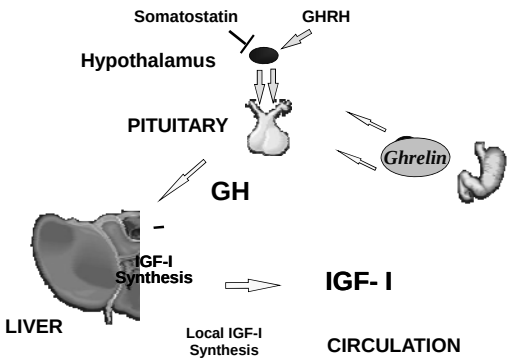


Pulsatile Pattern of GH Secretion in a Healthy Adult

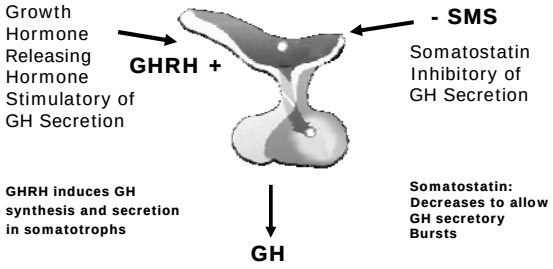


From: "Acromegaly" by Alan G. Harris, M.D.

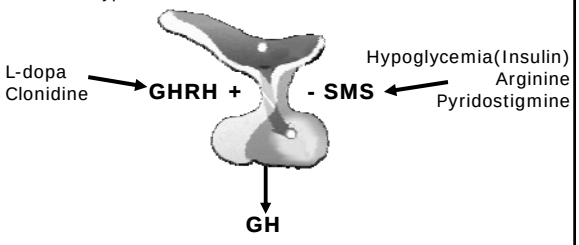
The GH/IGF-I Axis



GH Secretion: Primarily Regulation by two hypothalamic hormones



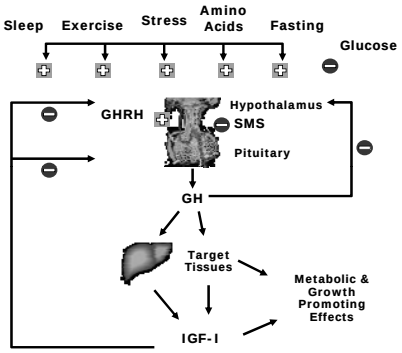
Pharmacologic Agents Used to Stimulate GH Secretion



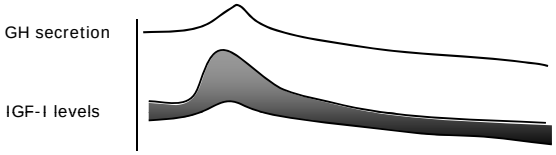
Major Determinants of Circulating IGF-I Levels

- **Growth Hormone**
  - Increases IGF-I production in liver, major source of circulating IGF-I
- **Nutritional Status**
- **Age**
- **Genetic Factors**
- **Binding proteins**
- **Increased levels in pregnancy and puberty**

Other Physiological Regulators of GH Secretion



GH Secretion & IGF-I Levels Across Lifespan



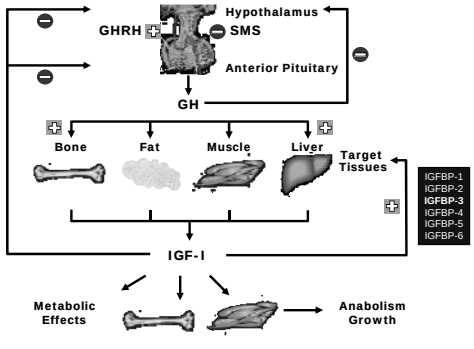
Prepubertal Pubertal Adult <35 yr Adult >35 yr

- GH secretion declines with age
- Serum IGF-I levels also decline with age.

Insulin-like growth factor I (IGF-I)

- **70 amino acid polypeptide**
- **Produced predominantly in the liver**
- **Endocrine and autocrine/paracrine actions**
  - **Mediates major anabolic and growth-promoting effects of GH**
  - **Insulin-like effect, independent of GH**
- **Does not mediate the lipolytic effects of GH**

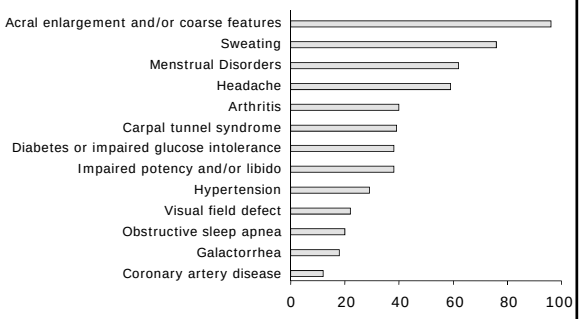
GH & IGF-I Actions



Disorders of GH Secretion

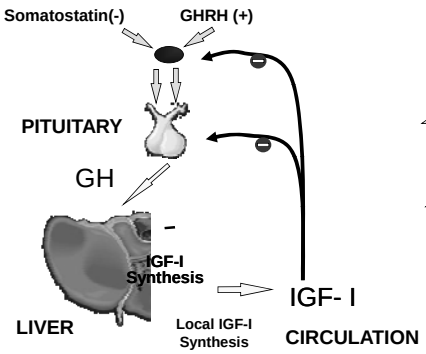
- **GH Excess**:
  GH overproduction by a GH Secreting pituitary tumor - ACROMEGALY
- **GH Deficiency**:
  Childhood onset
  Adult onset

Prevalence of Clinical Features at Diagnosis

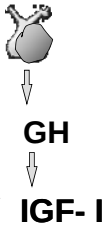


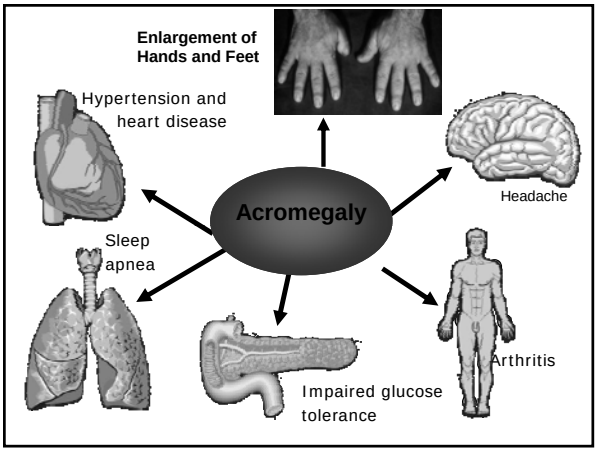
Clemmons DR, et al. *J Clin Endocrinol Metab.* 2003;88:4759-4767.

GH/IGF-I Axis



Acromegaly





Biochemical Diagnosis of Acromegaly

Growth Hormone

Random GH Levels

GH Suppression after Oral Glucose:

Failure of GH to Fall < 1 µg/L

Serum IGF-I Level:

Elevated above age-adjusted normal range

Current Therapies for Acromegaly

- **Primary therapy**
  - **Transsphenoidal surgery**
  - **Medical therapy**
- **Adjunctive therapy**
  - **Medical therapy**
    - **Dopamine agonists**
    - **Somatostatin analogs**
    - **GH receptor antagonist**
  - **Radiotherapy (+ Interim medical therapy)**

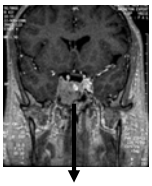
Role of Surgery for Acromegaly

First Line Therapy in Nearly All patients:

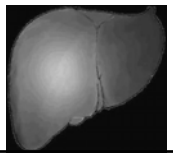
- Potential for cure
- Leads to immediate decline in GH level
- Reduces tumor size and relieves mass effect
- Surgical complication rate is low

Pegvisomant

- GH molecule that has been mutated to function as a receptor antagonist
- GH Receptors are blocked.
- GH does not fall, but GH actions are blocked.
- IGF-I levels fall and clinical symptoms of acromegaly improve



GH



Functional GHR Dimerization Is Prevented

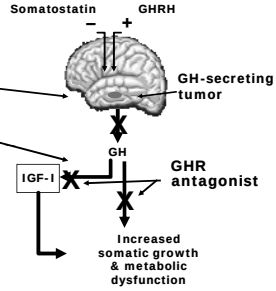
IGF-I Levels Fall

Targets of the GH/IGF-I Pathway for Medical Therapy of GH Producing Pituitary Tumor

Somatostatin Analogs (SA)
- Directly inhibit GH secretion

Dopamine Agonists (DA)
- Directly inhibit GH secretion

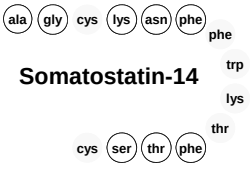
Growth Hormone Receptor (GHR) Antagonist (pegvisomant)
- Blocks the GH receptor, negating effects of GH in periphery
- Directly inhibits IGF-I secretion



Goals of Therapy

- Biochemical control
  - GH suppression
  - IGF-I normalization
- Relieve signs and symptoms
- Reduce tumor size & mass effect
- Preserve pituitary function
- Minimal side effects

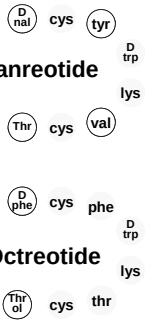
Somatostatin



Somatostatin-14

Amino acids common to native hormone & analog.

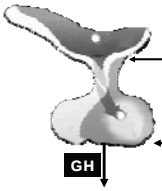
Analogs: Clinical Use



Lanreotide

Octreotide

Etiologies of Clinical Syndromes of Growth Hormone Deficiency



Hypothalamic Disease: GHRH Deficiency

Pituitary Disease: Failure to Secrete GH

GH

Liver & Other Tissue

Failure to generate IGF-I peripherally
- Deficiencies of GH or IGF-I receptors in liver; IGF-I not produced; GH resistance, GH not low.

IGF-I

Etiologies of Adult Onset of GH Deficiency

Cause N=1034	Percent
Pituitary tumor	53.9
Craniopharyngioma	12.3
Idiopathic	10.2
CNS tumor	4.4
Empty sella syndrome	4.2
Sheehan's syndrome	3.1
Head trauma	2.4
Hypophysitis	1.6
Surgery other than for pituitary treatment	1.5
Granulomatous diseases	1.3
Irradiation other than for pituitary treatment	1.1
Other	4.0

Abs R, et al. *Clin Endocrinol (Oxf)* 1999;50:703-713.

Hyperprolactinemia

- **Defined as excess serum prolactin:**
  Prolactin >20 µg/L in men or >25 µg/L in women
- **Most common endocrine disorder of the hypothalamic-pituitary axis**
- **Prevalence: 0.4% in unselected normal adult population**
  - **Many different etiologies**
  - **Prolactinomas are the most frequent cause of hyperprolactinemia**

Clinical Consequences of Adult Onset GH Deficiency

- Increased cholesterol and increased levels of some cardiovascular risk markers eg. CRP.
- Abnormal body composition; increased central body fat.
- Decreased bone density
- Decreased quality of life

Therapy of GH Deficiency:
- Requires daily subcutaneous injections of human growth hormone. (Some newer formulations may be longer acting)
- Effect in GH deficient adults; Modest improvements in the effects of GH deficiency listed above.

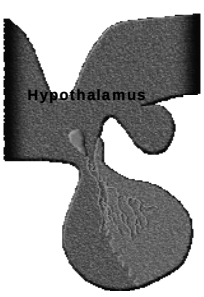
Pathological Causes of Hyperprolactinemia

Pituitary/Hypothalamic Disorders
- Prolactinoma
- Acromegaly
- Other sellar masses
- Infiltrative disorders
- Hypothalamic and pituitary stalk disease or damage

Other Causes
- Primary hypothyroidism
- Seizures
- Polycystic ovary disease
- Neurogenic causes (chest wall trauma or surgery, herpes zoster)
- Renal insufficiency
- Cirrhosis
- Medications

Regulation of Prolactin Secretion

Stimulated by:
- Sleep
- Food
- Stress
- Pregnancy
- Nursing
- Breast stimulation



Suppressed by:
- Dopamine

Under Tonic Inhibition

Pharmacologic Causes of Hyperprolactinemia

- Antihypertensives
  - Verapamil
  - Methydopa
  - Reserpine
- GI Medications
  - Chlorpromazine
  - Metoclopramide
  - Domperidone
  - H2 blockers?
- Antipsychotics
  - Phenothiazines
  - Butyrophenones
  - Atypicals
- Antidepressants
  - Tricyclics
  - MAO inhibitors
  - SSRIs
- Other
  - Cocaine
  - Opiates
  - Protease Inhibitors?

Clinical Manifestations of Hyperprolactinemia

Hyperprolactinemia: Suppresses gonadotropins
- leads to varying degrees of gonadal dysfunction.

Women
- Oligo-amenorrhea
- Infertility
- Galactorrhea
- Estrogen deficiency
- Acne/hirsuitism
- Osteopenia

Men
- Decreased libido
- Erectile dysfunction
- Gynecomastia
- Galactorrhea
- Infertility
- Osteopenia

Hyperprolactinemia: Treatment Goals

- Restore gonadal function
  - Improvement in sexual dysfunction
  - Fertility
- Resolve galactorrhea (if bothersome)
- Reduce/stabilize tumor size
  - Reverse mass effects
  - Preserve/restore pituitary function
- Normalize PRL level

Treatment of Hyperprolactinemia

- **Dopamine agonist therapy** is primary treatment for almost all patients
- Surgery and radiation therapy ocassionally used
- Careful follow-up without treatment is an option for patients if they
  - do not have a macroadenoma
  - are asymptomatic
  - have normal gonadal function
  - are not seeking fertility

Pituitary Tumors

Nearly All Benign

Can be: Non-secreting
Hormone Secreting
Prolactin
Growth Hormone
ACTH- Cushing's
TSH, LH, FSH

Cause Disease:
Problems related to: Excess hormone

Pressure of tumor on: optic nerves, other surrounding

Or normal pituitary - pituitary insufficiency

Dopamine Agonists used to treat Hyperprolactinemia/Prolactinomas

- Bromocriptine
- Cabergoline

Evaluation of the Patient for Pituitary Disease

- History and Physical examination
- Laboratory: Pituitary hormone overproduction and hypopituitarism
  - Prolactin
  - Free T4, TSH
  - Cortisol, ACTH
  - GH, IGF-I
  - LH, FSH, testosterone
  - Pregnancy test
- MRI
- Visual fields