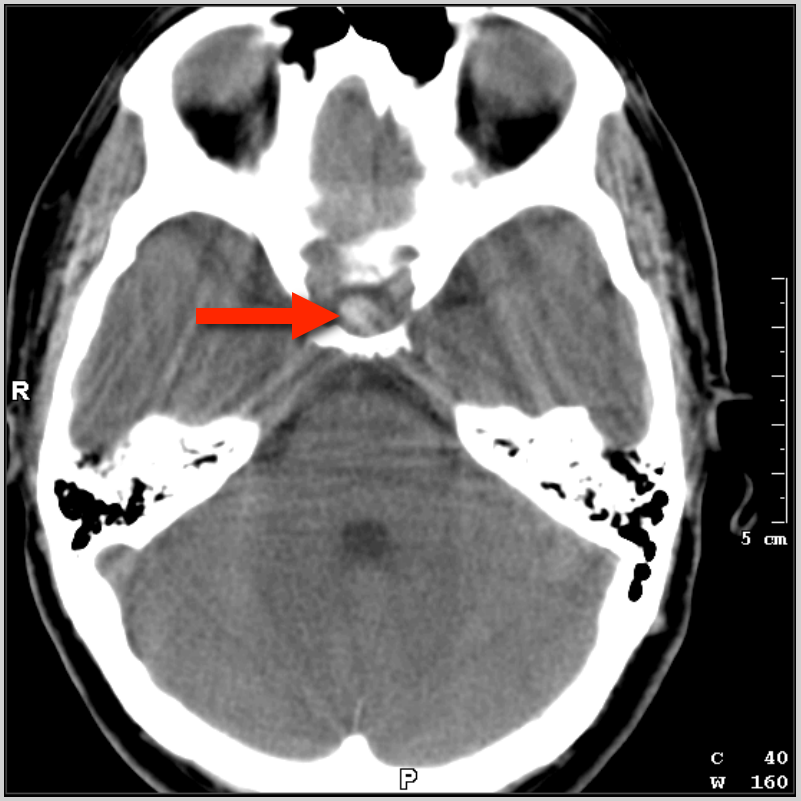
M. Losa, Rep. Neurochirurgia, Ospedale San Raffaele, Milano

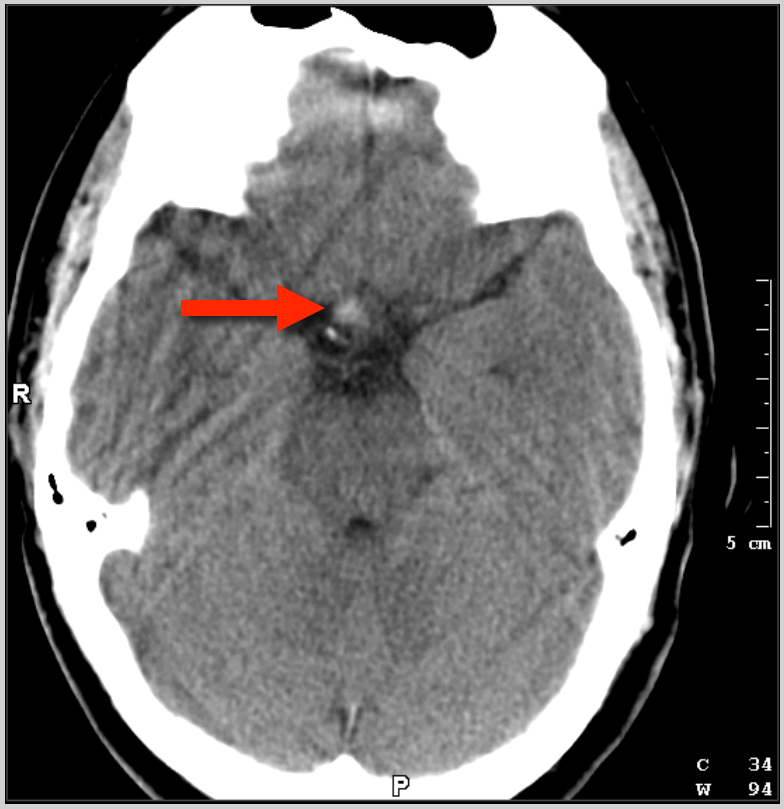
Terapia e follow-up

CASO CLINICO

Bari,
7-10 novembre 2013

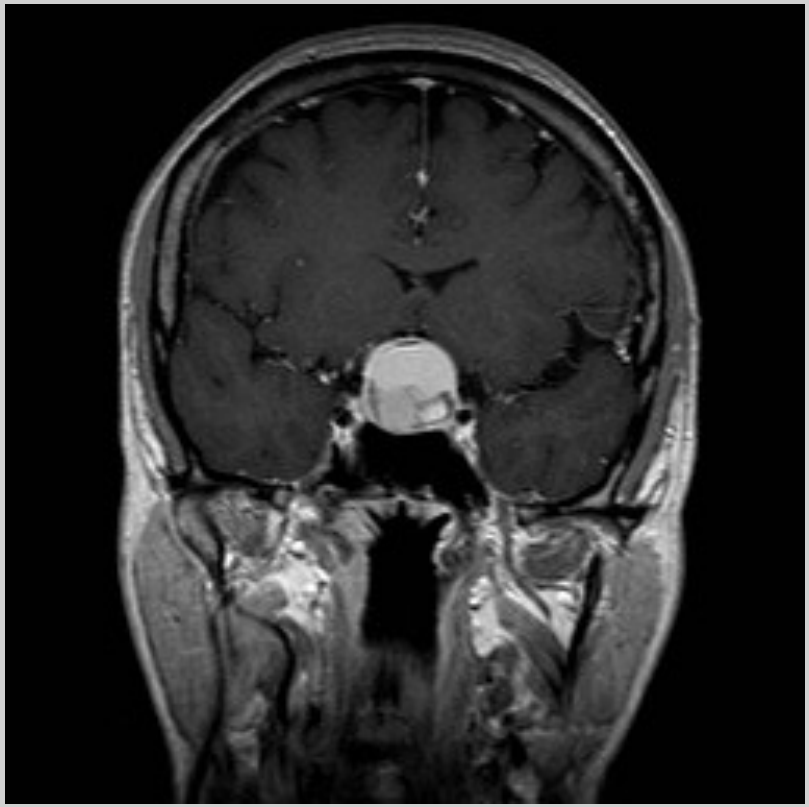
Donna di 37 anni. Comparsa improvvisa di forte cefalea, annebbiamento visivo e diplopia nello sguardo laterale a sinistra. Accesso al P.S. TAC smdc mostra lesione iperdensa in regione sellare. Ricovero in Neurochirurgia

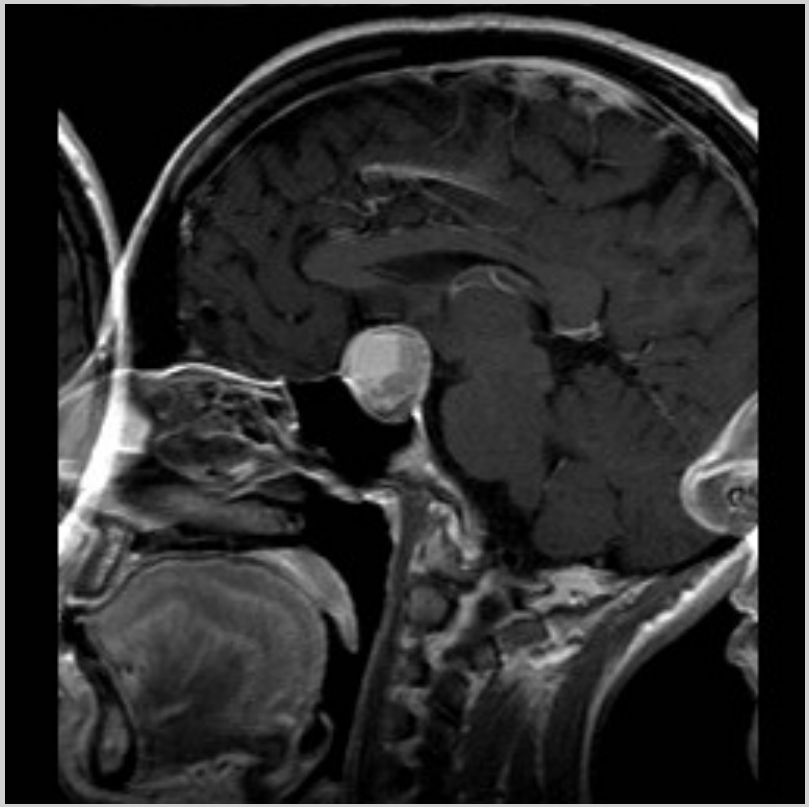




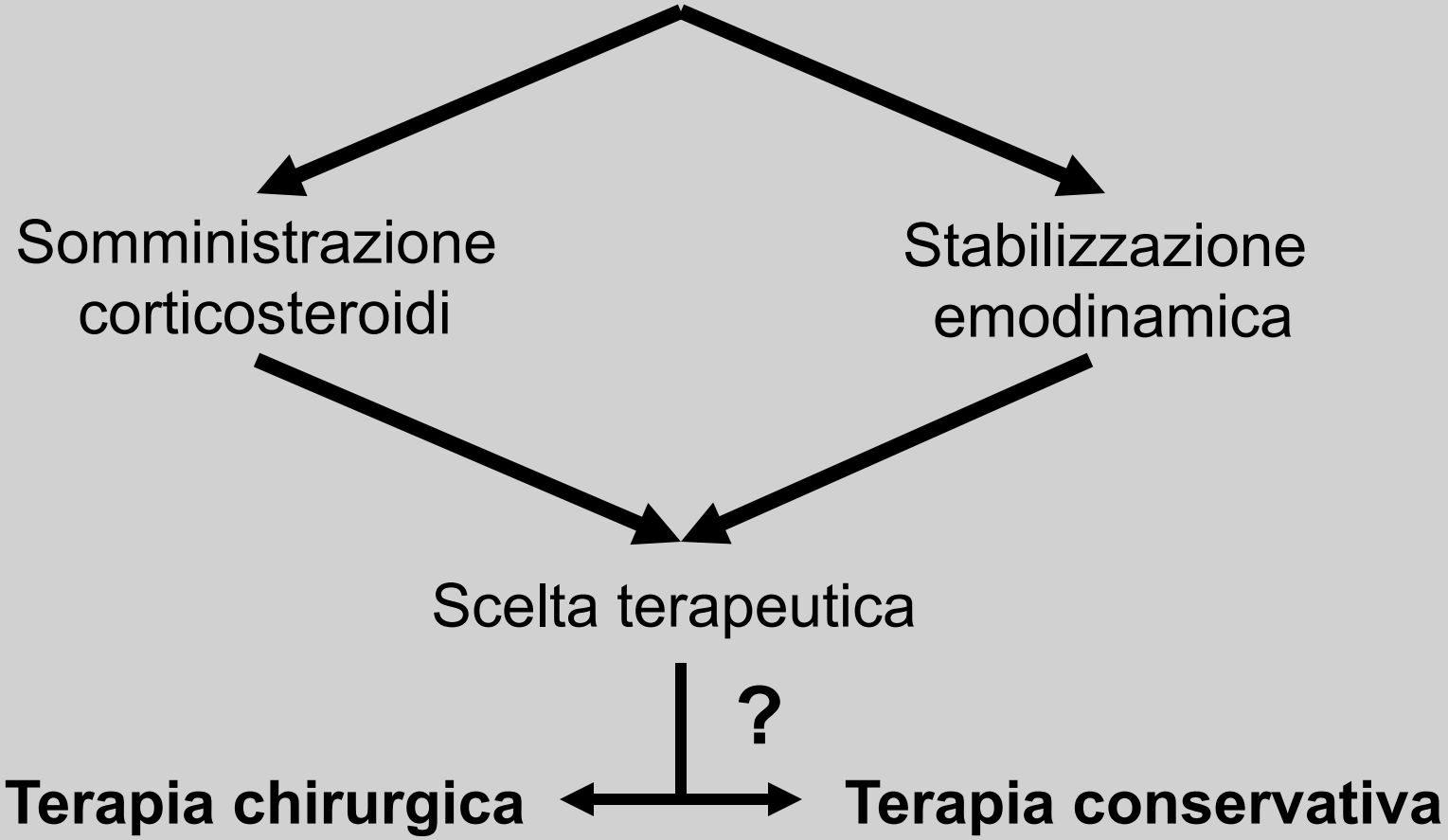
CASO CLINICO

Visita oculistica: quadrantopsia temporale superiore in OD ed emianopsia temporale in OS. Paresi VI° nervo cranico sinistro.
Esami ormonali: PRL 52 ng/ml; ipopituitarismo.
RM: lesione intra- e sovrasellare con aree disomogenee





TERAPIA DELL'APOPLESSIA IPOFISARIA



APOPLESSIA IPOFISARIA: INDICAZIONI PER LA TERAPIA STEROIDEA

Bari,
7-10 novembre 2013

Clinical Endocrinology (2011) 74, 9–20 doi: 10.1111/j.1365-2265.2010.03913.x

CLINICAL GUIDELINE

UK guidelines for the management of pituitary apoplexy

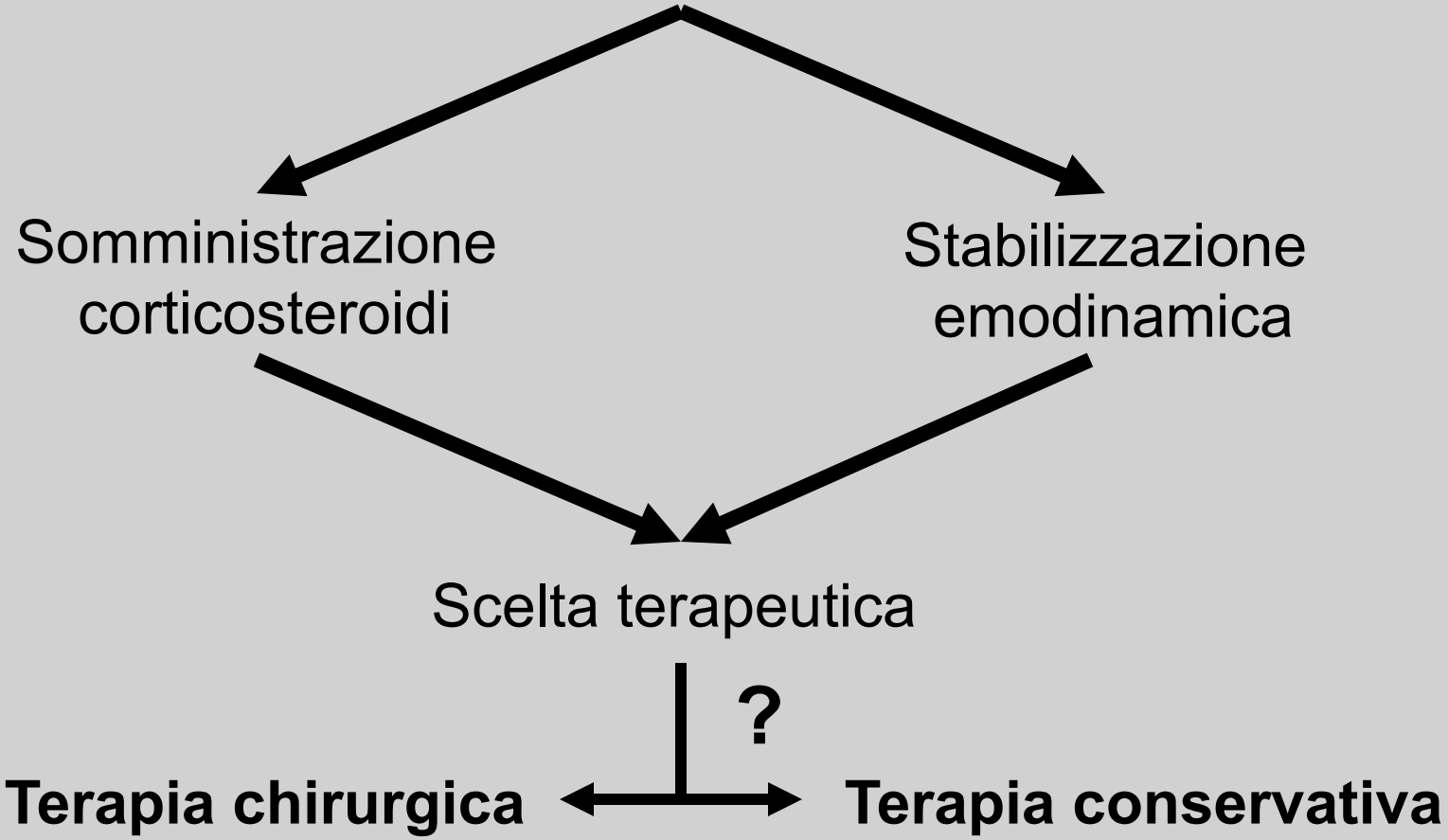
Pituitary Apoplexy Guidelines Development Group: May 2010

Senthil Rajasekaran†, Mark Vanderpump‡, Stephanie Baldeweg§, Will Drake¶, Narendra Reddy†, Marian Lanyon**, Andrew Markey††, Gordon Plant**, Michael Powell‡‡, Saurabh Sinha§§ and John Wass*

- **Indication for empirical steroid therapy are haemodynamic instability, altered consciousness level, reduced visual acuity and severe visual field defects**

- **In adults hydrocortisone 100-200 mg as an iv bolus is appropriate, followed either by 2-4 mg per hour by continuous iv infusion or by 50-100 mg six hourly by im injection until haemodynamic stability followed by usual oral replacement therapy**

TERAPIA DELL'APOPLESSIA IPOFISARIA



ESISTONO LINEE GUIDA?

Bari,
7-10 novembre 2013

SPECIAL FEATURE

Clinical Practice Guideline

Pituitary Incidentaloma: An Endocrine Society Clinical Practice Guideline

Pamela U. Freda, Albert M. Beckers, Laurence Katznelson, Mark E. Molitch, Victor M. Montori, Kalmon D. Post, and Mary Lee Vance

We recommend that patients with a pituitary incidentaloma be referred for surgery if they have the following (1/ØØØØ):

- A Visual field deficit due to the lesion
- Other visual abnormalities due to the lesion
- Lesion abutting tho optic nerves or chiasm
- **Pituitary apoplexy with visual disturbances**

ESISTONO LINEE GUIDA?

Bari,
7-10 novembre 2013

Clinical Endocrinology (2011) 74, 9–20 doi: 10.1111/j.1365-2265.2010.03913.x

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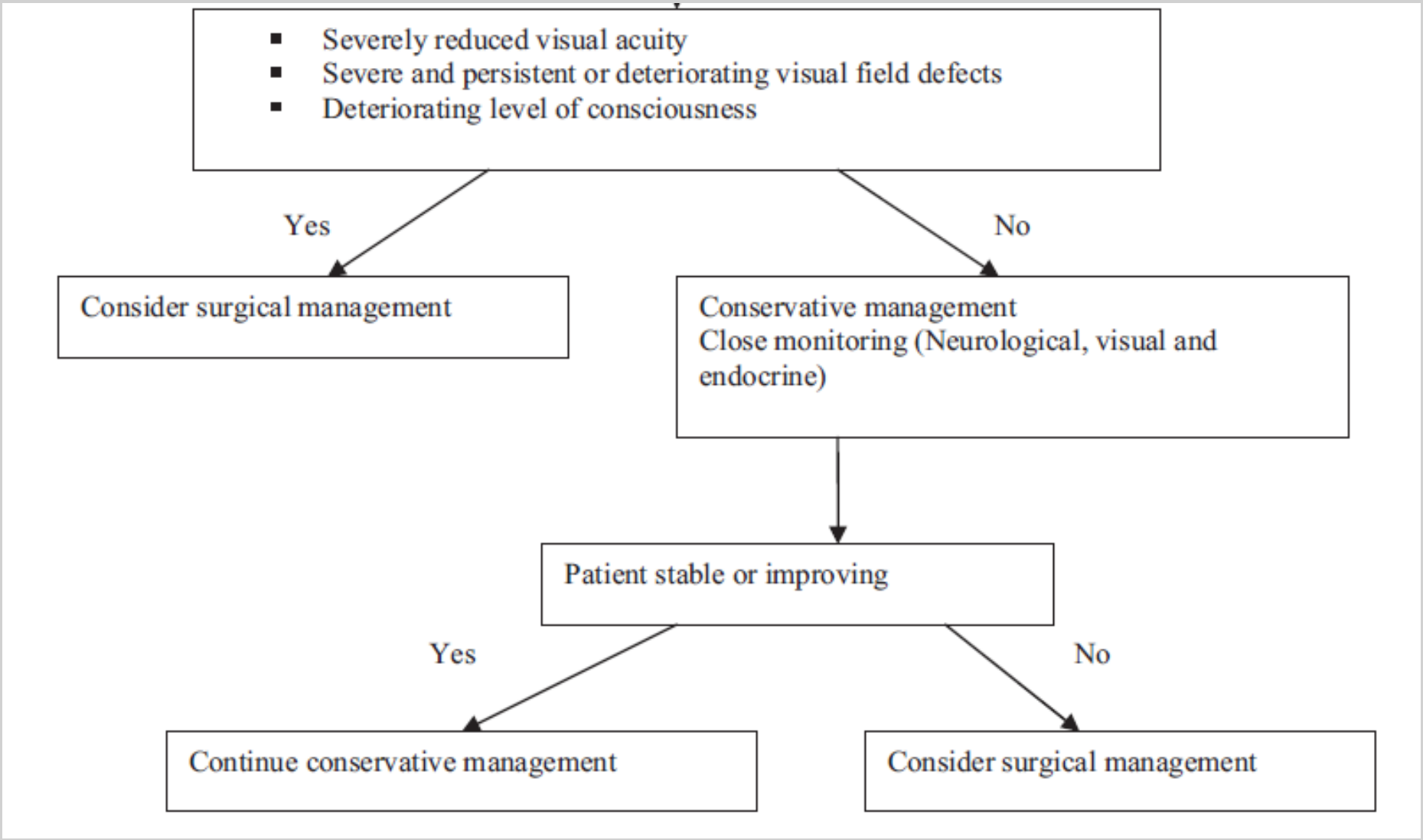
- **The principle controversy in management relates to the role and the timing of surgery**
- **Owing to the rarity of the condition there are no randomized controlled trials in the literature but several case series and reports**

ESISTONO LINEE GUIDA?

Bari,
7-10 novembre 2013



Rajasekaran S, et al. UK guidelines, Clin Endocrinol (Oxf). 2011 Jan;74(1):9-20

APOPLESSIA IPOFISARIA: PARAGONE FRA DUE DIVERSE STRATEGIE TERAPEUTICHE

Bari,
7-10 novembre 2013

Table 4 Comparison of outcomes in the surgically and conservatively managed groups (P = NS for all)

	Surgical group (n = 15)	Conservative group (n = 18)
Visual field recovery	57% (4/7)	100% (6/6)
Ocular palsy recovery	63% (5/8)	100% (7/7)
Hypocortisolism	87% (13/15)	72% (13/18)
Hypothyroidism	60% (9/15)	87% (13/15)
Hypogonadism	67% (10/15)	83% (15/18)

Ayuk J. et al., Clin Endocrinol (Oxf). 2004 61:747-752

APOPLESSIA IPOFISARIA: PARAGONE FRA TRE DIVERSE STRATEGIE TERAPEUTICHE

Bari,
7-10 novembre 2013

Outcome	Conservative management (n = 22) (%)	Emergency Surgery (n = 23) (%)	Delayed elective surgery (n = 10) (%)	P value
Improvement of visual field defects	**80**	**80**	**60**	**NS**
Improvement of cranial nerve palsies	**100**	**92**	**100**	**NS**
Hypopituitarism	**90**	**96**	**80**	**NS**

Modified from Bujawansa et al. Clin Endocrinol 2013

APOPLESSIA IPOFISARIA: TERAPIA CHIRURGICA O TERAPIA CONSERVATIVA?

Bari,
7-10 novembre 2013

Clinical Endocrinology (2011) 74, 9–20 doi: 10.1111/j.1365-2265.2010.03913.x

CLINICAL GUIDELINE

UK guidelines for the management of pituitary apoplexy

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- **Studies looking at the role of conservative versus surgical management of apoplexy with regard to visual loss all suffer from selection bias and a lack of appropriately matched patients**

APOPLESSIA IPOFISARIA: FREQUENZA SECONDO IL TIPO DI ADENOMA

Bari,
7-10 novembre 2013

Tipo adenoma	Tumori non apoplettici	Tumori apoplettici	%
NFPA	925	75	**7.5%**
GH	694	2	**0.3%**
ACTH	578	4	**0.7%**
PRL	236	16	**6.3%**
TSH	64	0	**0%**
Totale	2497	97	**3.7%**

Serie HSR 1990-2012

APOPLESSIA IPOFISARIA: CARATTERISTICHE CLINICHE IN PAZIENTI CON NFPA

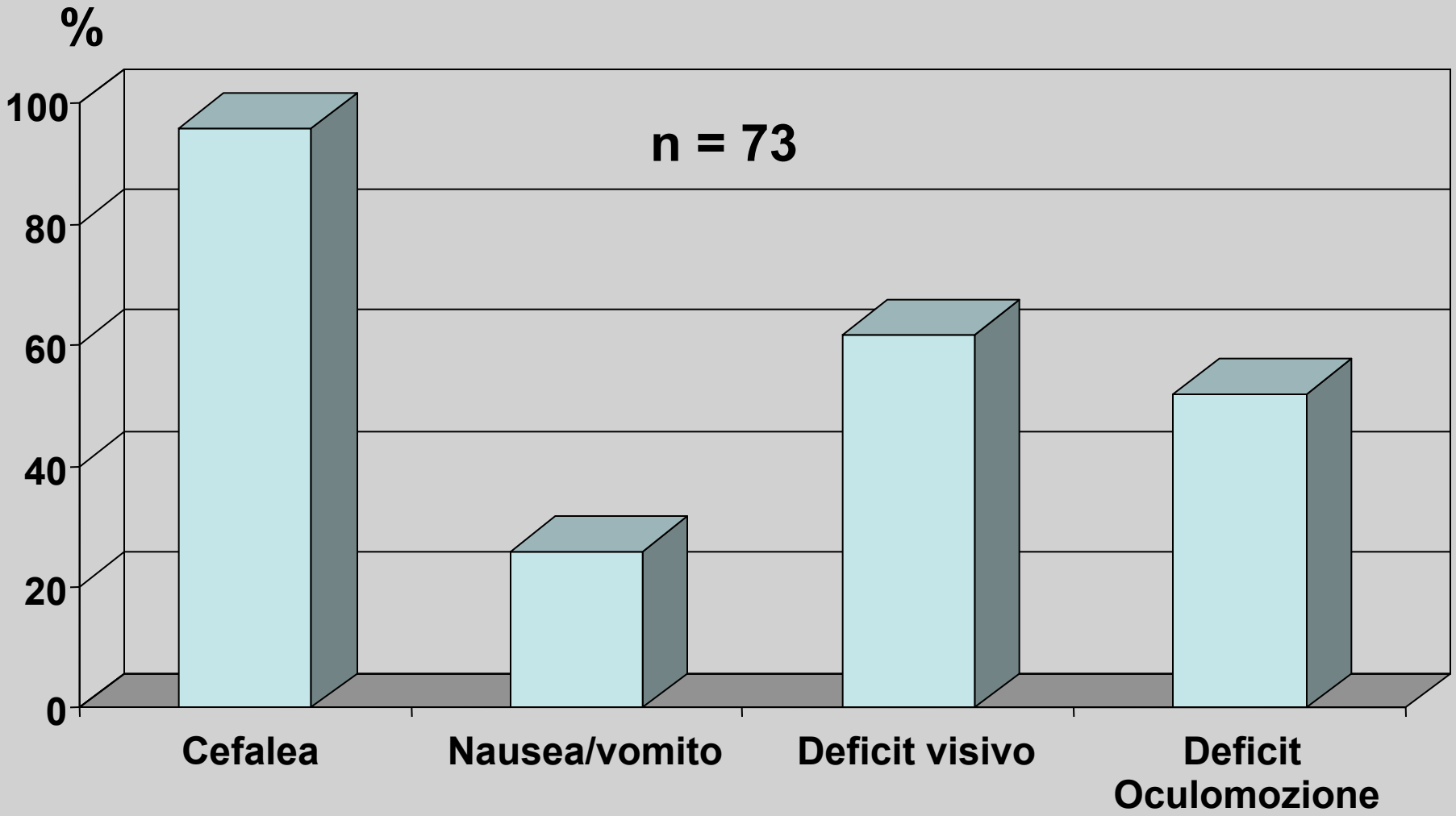
Bari,
7-10 novembre 2013

Caratteristica	Apoplessia (n = 73)	No apoplessia (n = 769)	P
Età	50.4 ± 15.8	53.5 ± 1	0.06
Maschi	65.8%	55.8%	0.19
Diametro tumorale	28.4 ± 8.2	27.8 ± 8.6	0.44
Invasione s. cavernoso	26.0%	29.5%	0.22
Ipogonadismo	**82.2%**	**66.4%**	**< 0.05**
Ipotiroidismo	**45.2%**	**23.7%**	**< 0.01**
Iposurrenalismo	**45.2%**	**21.2%**	**< 0.01**

Serie HSR 1990-2012

APOPLESSIA IPOFISARIA: SINTOMATOLOGIA ALL'ESORDIO IN PAZIENTI CON NFPA

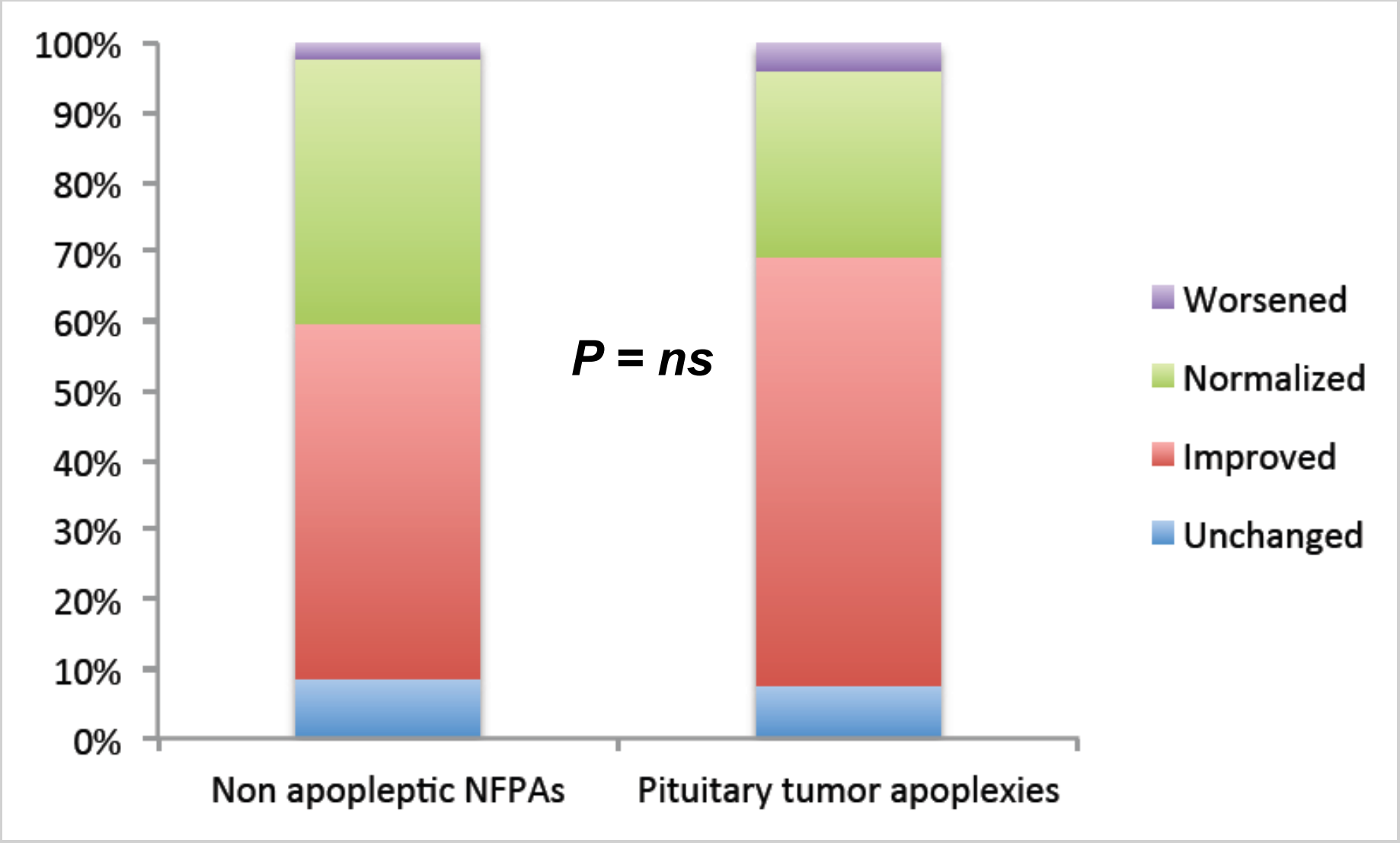
Bari,
7-10 novembre 2013



Serie HSR 1990-2012

APOPLESSIA IPOFISARIA: RECUPERO DI FUNZIONE VISIVA POSTOPERATORIA

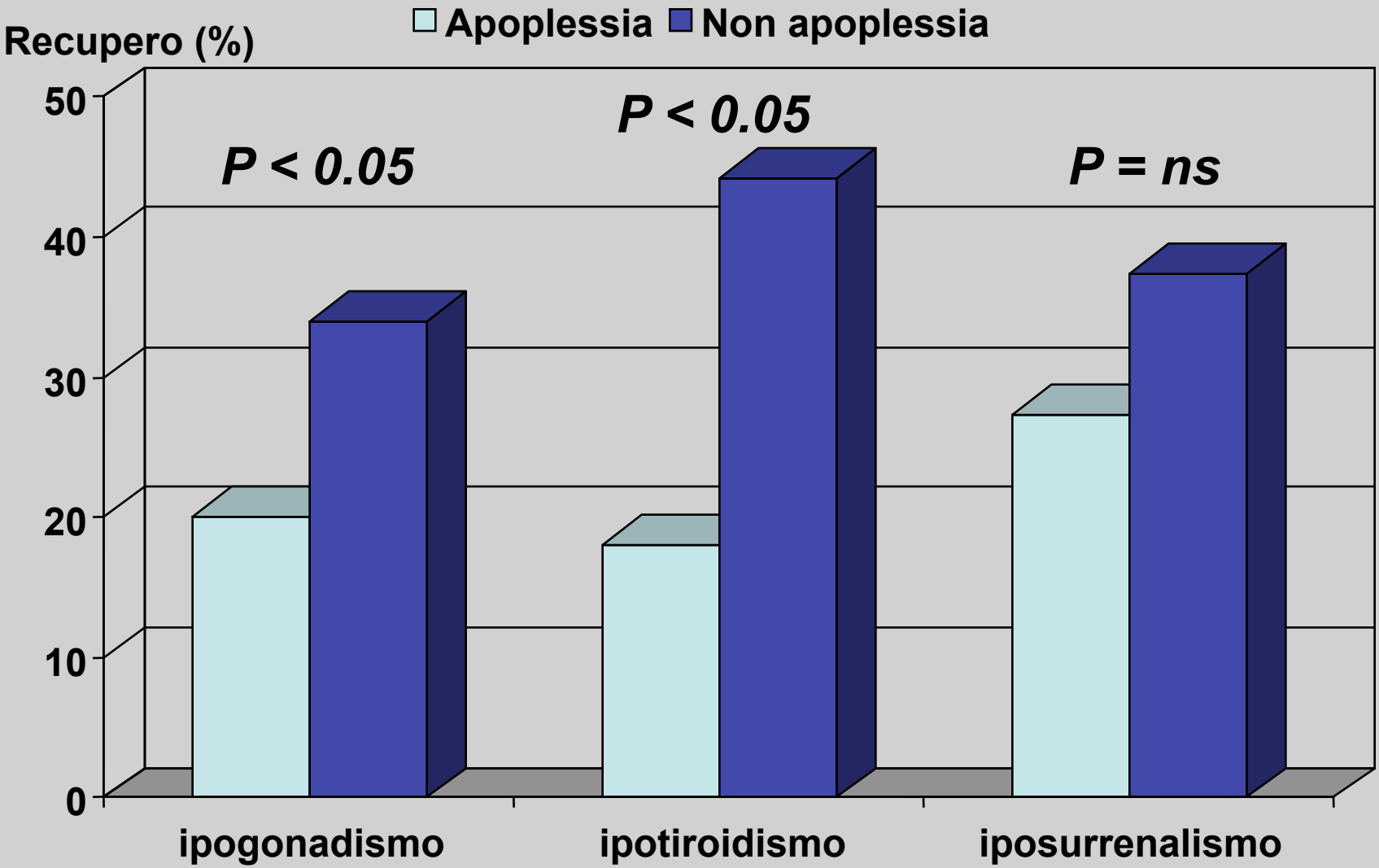
Bari,
7-10 novembre 2013



Serie HSR 1990-2012

APOPLESSIA IPOFISARIA: RECUPERO DI FUNZIONE IPOFISARIA POSTOPERATORIA

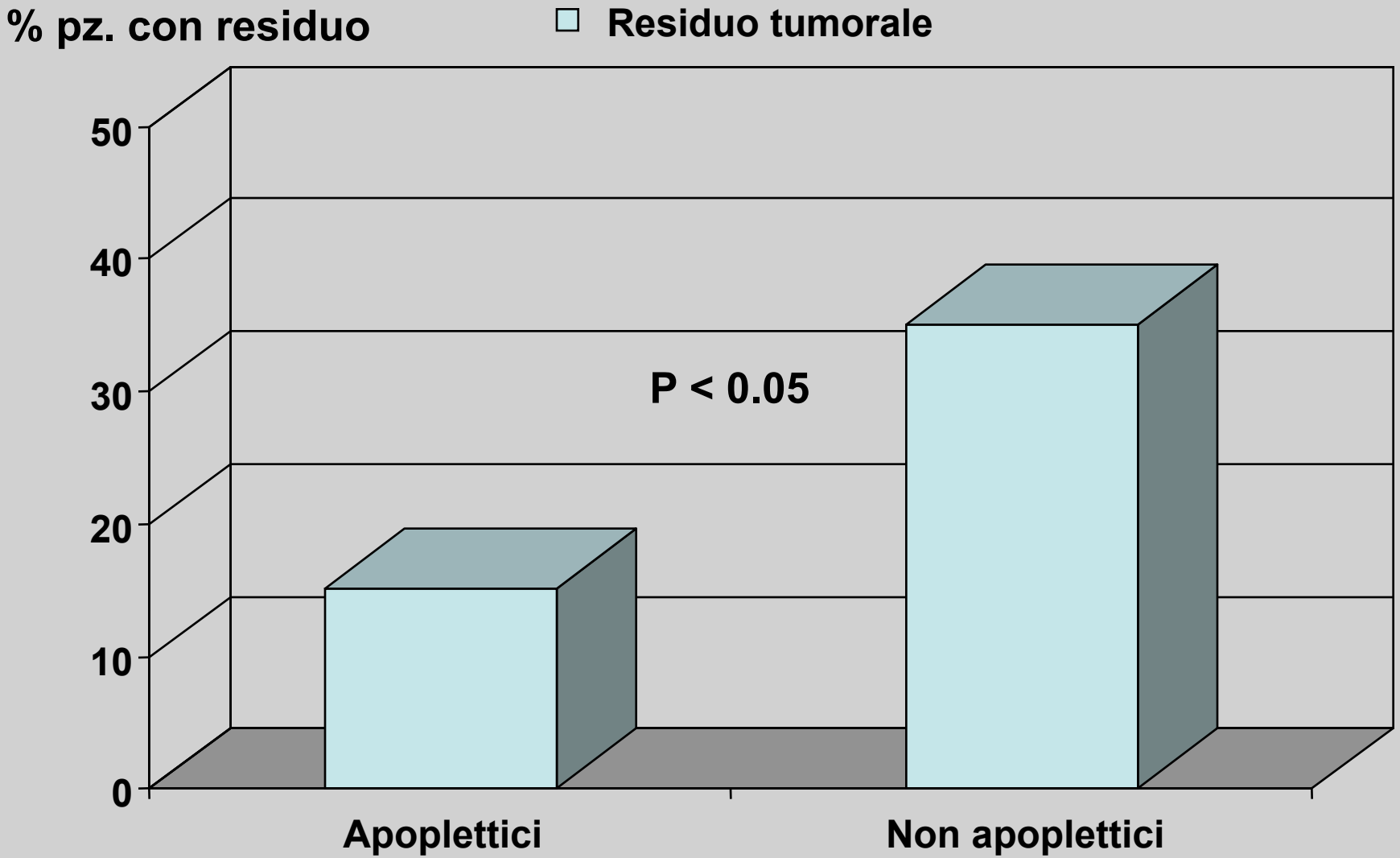
Bari,
7-10 novembre 2013



Serie HSR 1990-2012

APOPLESSIA IPOFISARIA: FREQUENZA DI RADICALITA' CHIRURGICA

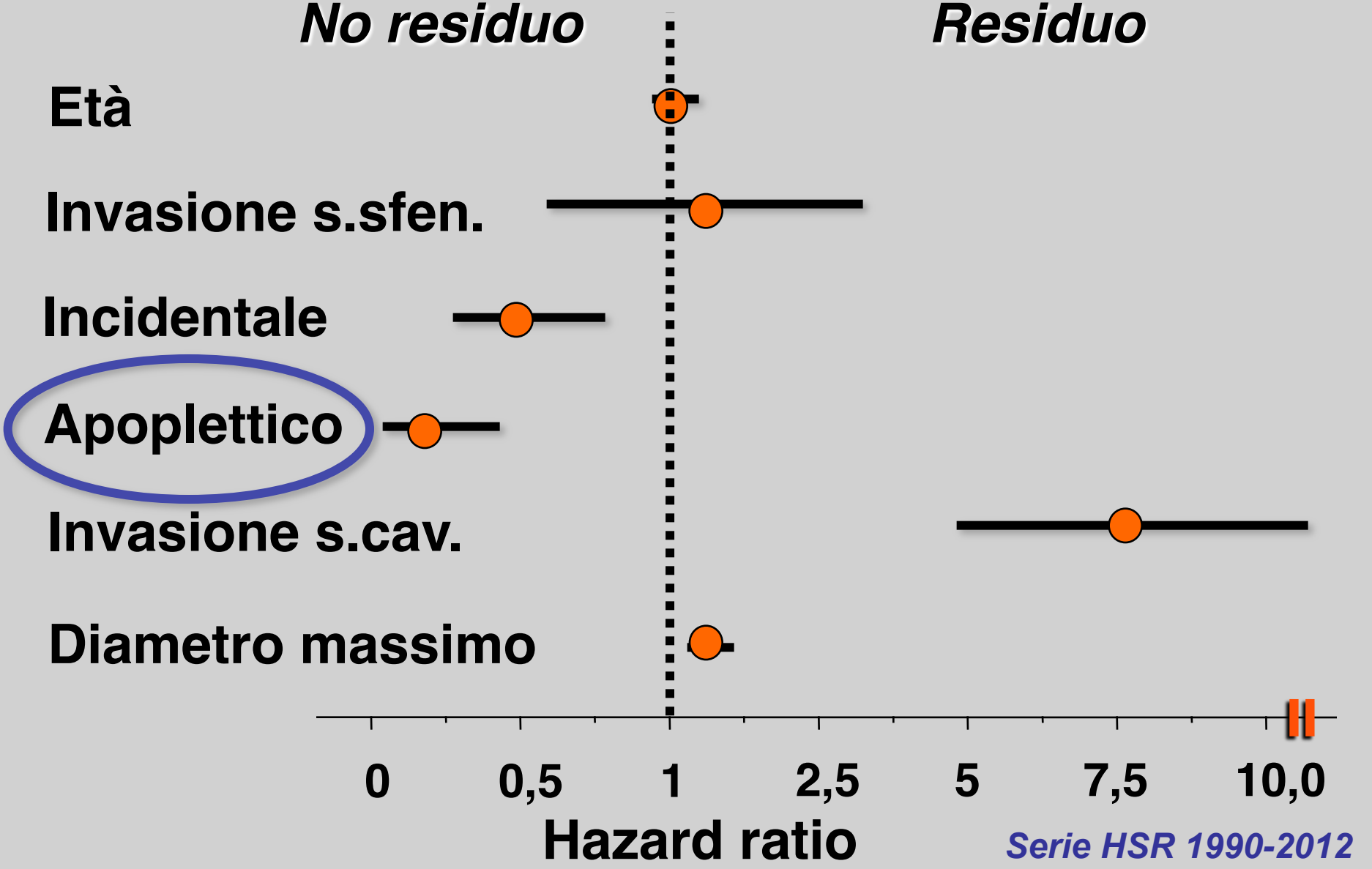
Bari,
7-10 novembre 2013



Serie HSR 1990-2012

ANALISI MULTIVARIATA DEI FATTORI PROGNOSTICI: TUMORI APOPLETTICI vs. TUMORI NON APOPLETTICI

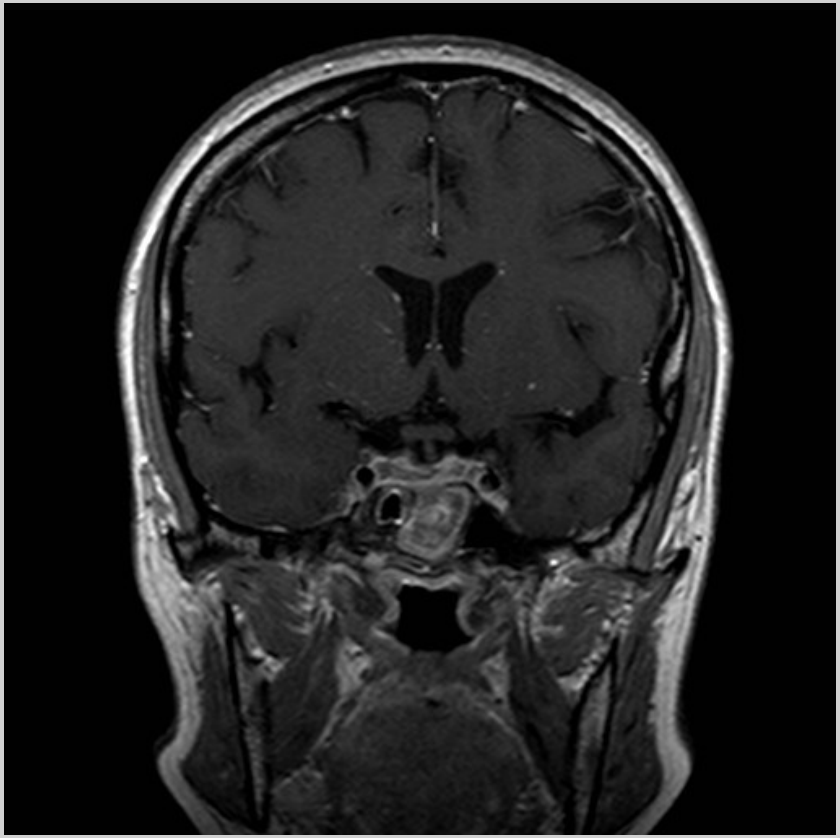
Bari,
7-10 novembre 2013

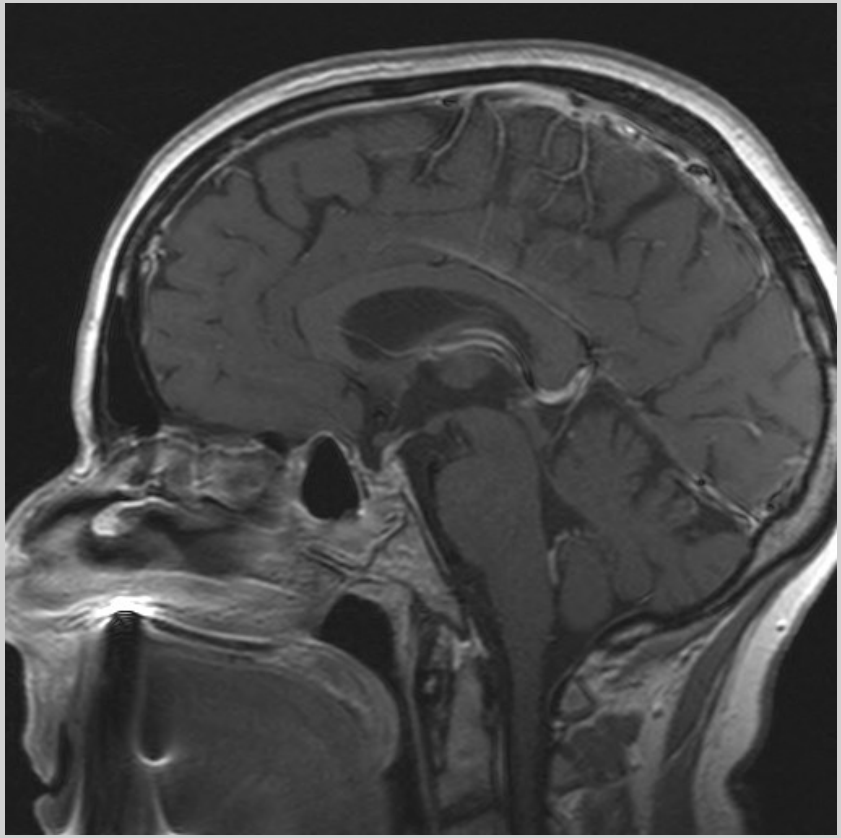


Serie HSR 1990-2012

CASO CLINICO: ESITO POSTOPERATORIO

Assenza di residui tumorali, recupero completo della funzione visiva; normale funzione ipofisaria





APOPLESSIA IPOFISARIA: E' NECESSARIO UN FOLLOW-UP?

Bari,
7-10 novembre 2013

Terapia chirurgica | **Terapia conservativa**

STRETTO MONITORAGGIO RADIOLOGICO E ORMONALE

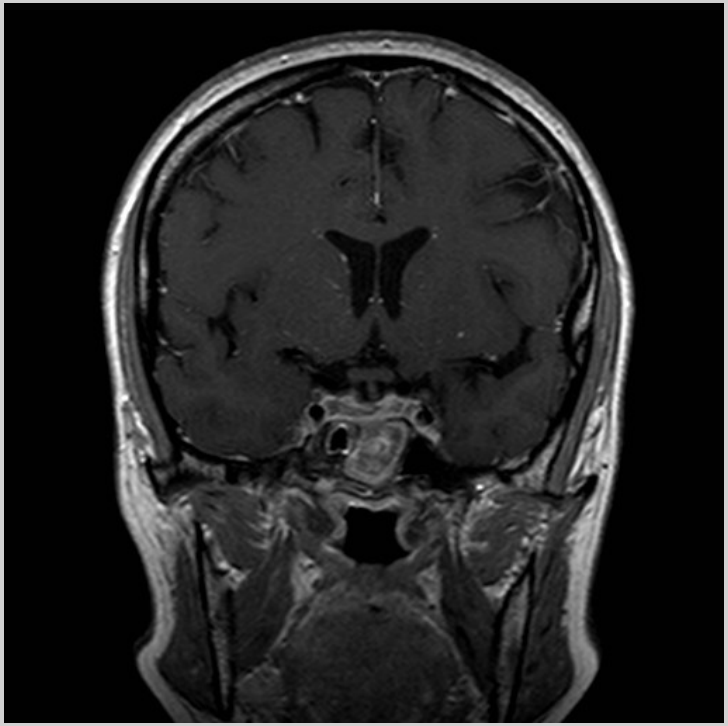
Remissione | Persistenza

Proseguire follow-up

Remissione | Recidiva → Ulteriore terapia: Medica, Chirurgica, Radiante

APOPLESSIA IPOFISARIA: QUANDO E' NECESSARIO UN FOLLOW-UP?

Bari,
7-10 novembre 2013



I° controllo radiologico e ormonale
3-6 mesi

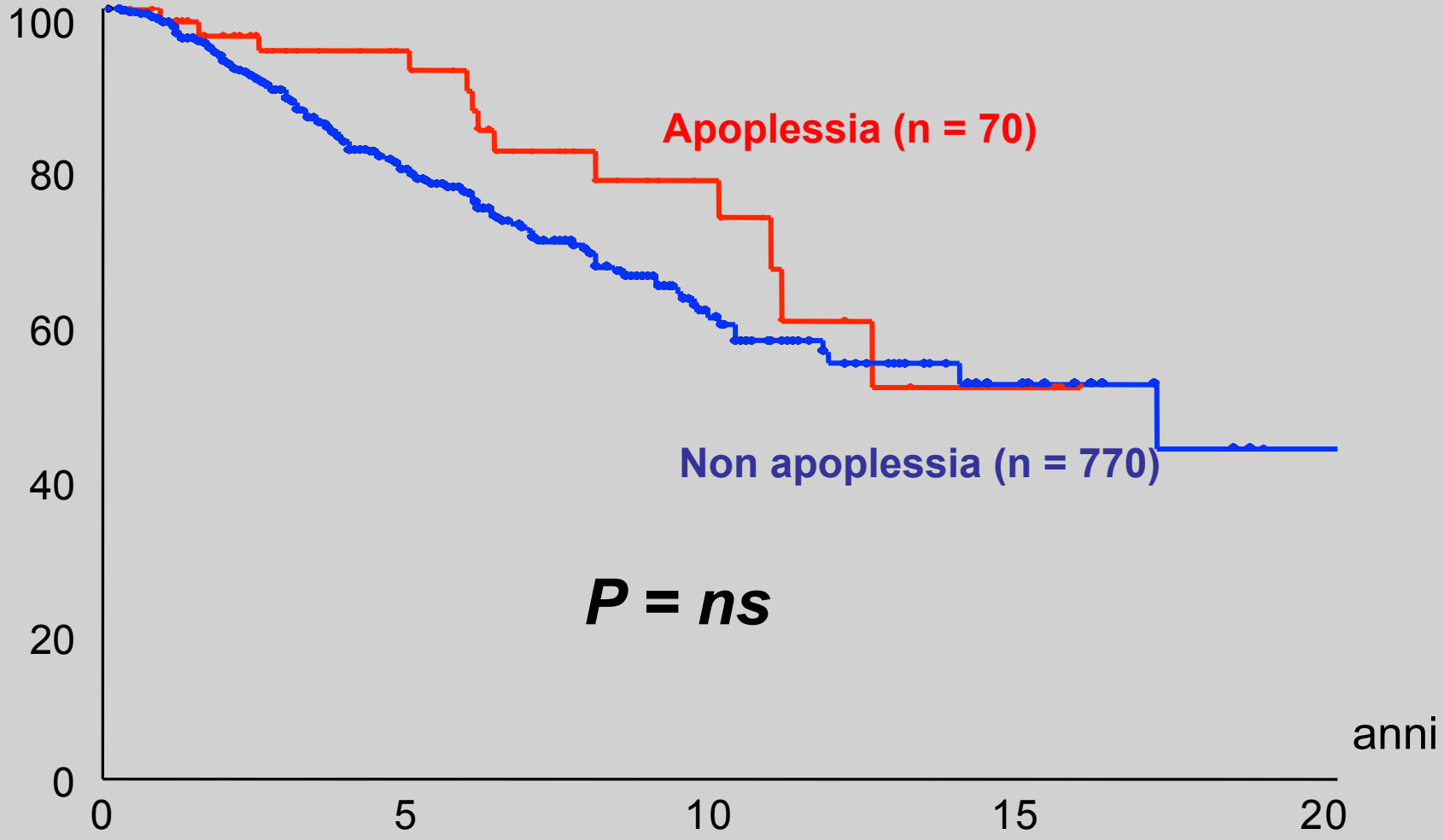
↓

Controlli successivi
Ogni anno x 3 anni e poi ogni 2 anni x almeno 10 anni

RISCHIO DI RECIDIVA DOPO TERAPIA CHIRURGICA: PARAGONE APOPLETTICI vs. NON APOPLETTICI

Bari,
7-10 novembre 2013

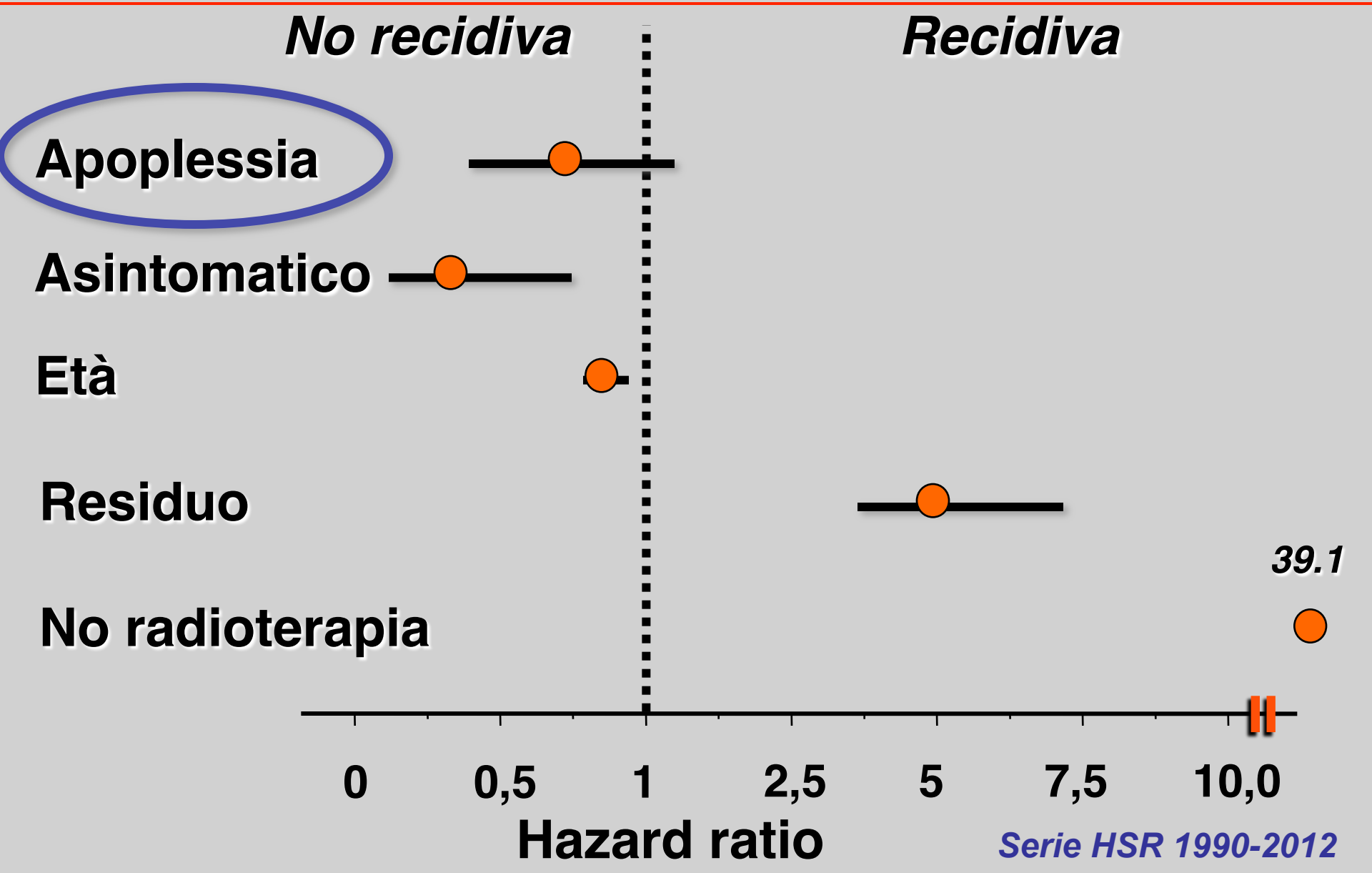
Sopravvivenza libera da recidiva (%)



Serie HSR 1990-2012

COX ANALISI DEI FATTORI PROGNOSTICI DI RECIDIVA: TUMORI APOPLETTICI vs. TUMORI NON APOPLETTICI

Bari,
7-10 novembre 2013



Serie HSR 1990-2012

CONCLUSIONI

Bari,
7-10 novembre 2013

- I pazienti con apoplessia ipofisaria dovrebbero per prima cosa essere stabilizzati dal punto di vista medico e trattati con steroidi se necessario.

- I pazienti senza deficit visivi o neurologici e quelli con segni modesti possono essere considerati candidati per una terapia conservativa.

- In caso di gravi deficit o di peggioramento della sintomatologia, la terapia chirurgica deve essere effettuata in tempi brevi (entro pochi giorni in caso di sintomatologia grave)

Bari,
7-10 novembre 2013

Grazie per l'attenzione!