

s miernou akromegáliou (47). Existujú tri okolnosti za ktorých by mohla byť liečba PEG zväžená ako prvotínová pooperačne:

1. pacienti, ktorí podstúpili predoperačne dostatočne dlhú liečbu SSA (> 3 – 6 mesiacov), ktorá nebola dostatočne účinná pri kontrole RH a IGF-1 a nemajú veľký reziduálny tumor s útlakom okolitých štruktúr (pri debulkingu viac ako 75 % tumoru) (47, 48)

2. pacienti s reziduálnym nádorom, u ktorých sa plánuje podať rádioterapia ako ďalšia terapia (po ožiarení môžu pretrvávajúť zvýšené hladiny IGF-1 dlhší čas do nástupu účinku liečby, ale pravdepodobnosť opätovného rastu nádoru je malá) (48)

3. pacienti s nedostatočne kontrolovaným DM, u ktorých liečba SSA môže potenciálne zhoršiť metabolizmus glukózy (26, 27, 28)

Farmakologická liečba druhej línie

Pacienti bez odpovede na liečbu SSA po dostatočne dlhom (6 až 12-mesačnom) období liečby maximálnymi dávkami SSA by mali prejsť

na monoterapiu PEG (48). Ak sa nedosiahne biochemická kontrola akromegálie, dávka PEG sa má zvýšiť a/alebo sa má podať kombinovaná liečba s DA (obrázok 1). U pacientov, ktorí nedosahujú biochemickú kontrolu ochorenia (48), ale majú zdokumentovanú čiastočnú odpoveď na SSA (50 % zníženie RH a IGF-1 oproti východiskovej hodnote a/alebo zmenšenie nádoru o 20 %), môžu prejsť na monoterapiu PEG alebo kombinovanú liečbu PEG + SSA. Ak kombinácia PEG a SSA nie je účinná, možnou alternatívou môže byť kombinovaná liečba PEG a DA (Obr. 1).

Záver

V posledných rokoch sa menili indikácie, dávkovanie, pokyny na sledovanie pacientov s akromegáliou a boli vyvinuté nové stratégie kombinovaných terapií na zlepšenie ich kompenzácie. PEG je efektívna a bezpečná možnosť liečby pre mnohých pacientov s akromegáliou, ktorí nedosiahnu adekvátnu kontrolu pri liečbe SSA.

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