

Best to Suppress Prolactinoma Before Pregnancy

BY SHERRY BOSCHERT

SAN FRANCISCO — Complications from a prolactinoma during pregnancy are best avoided by treating the adenoma before conception.

But with many women delaying pregnancy, it's not uncommon to see a woman in her late 30s with a macroadenoma who says she wants to get pregnant soon and doesn't have the luxury of suppressing the tumor for a year or two on medical therapy before conception, Dr. J. Blake Tyrrell said at a conference on diabetes and advances in endocrinology and metabolism sponsored by the University of California, San Francisco.

The sparse data available to help guide the management of these patients suggest that suppressing prolactin-secreting adenomas with dopamine agonists reduces the effects of the tumor and allows the patient to get pregnant without increasing the risk of fetal loss or fetal abnormalities.

There is less experience with cabergoline, today's treatment of choice, than with the former first-line agent bromocriptine.

Whether the patient has a microadenoma or macroadenoma, Dr. Tyrrell prefers to treat with cabergoline to allow menstrual cycles to normalize. If the patient misses a period, test for pregnancy, and if she is pregnant discontinue cabergoline, advised Dr. Tyrrell, director of the endocrinology clinic at the university. With this method, fetal exposure to the drug should be no more than a couple of weeks, he said.

Once off of therapy, fewer than 2% of microadenomas will enlarge during pregnancy. Given this low risk, many providers choose to leave them alone during pregnancy. Dr. Tyrrell suggested following prolactin levels every 6 weeks, and if they get as high as 500 ng/mL, "I might get a bit concerned and ask the patient how she's doing," he said.

Macroadenomas that are left untreated during pregnancy will enlarge in about 23% of cases and cause headache and visual field defects. "That's not a situation you want to get into," he said. Only 3% of macroadenomas that were surgically debulked prior to conception enlarged during pregnancy, but medical therapy has largely replaced surgical treatment for prolactinomas.

In the management of macroadenomas during pregnancy, "we're on very thin ice" due to very limited data on the risks from taking dopamine agonists before or during pregnancy, he said.

One study reported on 86 women with macroadenomas who conceived after bromocriptine treatment, which was then stopped. Twenty women (23%) developed visual field defects during pregnancy. Four patients then underwent surgical treatment and 15 received bromocriptine therapy, and all 20 had successful pregnancy outcomes (*Endocrinol. Metab. Clin. North Am.* 2006; 35:99-116).

Data from the early 1980s described 29

women with macroadenomas who were managed with continuous bromocriptine throughout pregnancy. Two developed visual field defects. All had successful pregnancy outcomes. Dr. Tyrrell noted that 7 of these 29 women probably had nonfunctional tumors because their serum prolactin levels were less than 200 ng/mL, which suggests that continuous drug therapy was associated with an even higher rate of visual field

defects in women with functioning tumors (in 2 of 22) patients.

That's about the extent of the world literature on managing macroadenomas during pregnancy, which is "not very good considering that these drugs have been around for 30-plus years," he said. There are no data on continuous cabergoline therapy during pregnancy.


In the worst-case scenario, a macroadenoma may enlarge, usually during


the second or third trimester, causing headache and visual field defects. A non-contrast MRI can be done safely during pregnancy to define the size.

If the tumor is enlarging, try medical therapy, and deliver the fetus early if it's viable. Surgery is a last resort, Dr. Tyrrell said. "Think about this if you can ahead of time to deal with the tumor before conception, before getting into trouble during pregnancy," he concluded. ■

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