
Radiotherapy for Pituitary and Hypothalamic Tumours

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INTRODUCTION

Pituitary adenomas are mostly benign tumours and comprise about 10% of all intracranial tumours [1, 2]. Radiotherapy has an important and long-established role as part of the multi-disciplinary management of both non-functioning and functioning adenomas. There has been a steady evolution in radiotherapy technologies since radiotherapy was first used to treat pituitary adenomas more than 100 years ago [3]. Despite decades of clinical experience there remains a paucity of randomised clinical trials to enable a robust evidence based approach to the optimal use of radiotherapy. This is to some extent compensated for by the large number of non-randomised largely retrospective case series which provide evidence on relevant clinical outcomes and toxicities associated with pituitary radiotherapy. Nevertheless, given the nature of the available data, there continue to be areas of controversy regarding the use of particular radiotherapy modalities and the literature contains examples of partisan interpretations of the published case-series and entrenched beliefs within individual treatment centres. We review the available published data on modern radiotherapy techniques for the treatment of pituitary adenomas to provide a rational basis for the selection of radiotherapy technologies.

RATIONALE FOR PITUITARY RADIO THERAPY

Traditional practice had been to use post-operative radiotherapy for all patients with residual non-functioning pituitary adenoma after surgical resection, as it was considered that otherwise most would subsequently progress [4, 5]. With improvements in surgical techniques, and the development of magnetic resonance imaging (MRI), post-operative radiotherapy is no longer routinely used, even in the presence of residual tumour. The use of post-operative pituitary radiotherapy is now based on a risk assessment. In patients with non-functioning adenomas radiotherapy is generally being withheld until the time of progression, unless there is perceived to be a significant threat to function, particularly to vision, if the tumour were to progress. When radiotherapy is used for patients with non-functioning adenomas, that are progressive on interval imaging, tumour control is achieved in over 90% of patients at 10 years, and in 85-92%

at 20 years [5-13].

In patients with functioning adenomas radiotherapy is used when surgery fails to achieve hormone normalisation and/or when medical treatment is insufficient to control hormone secretion or is not considered appropriate. Hormone levels decline slowly following radiotherapy such that normalisation may take from months to years to achieve. The time required to achieve hormone normalisation is primarily related to the pre-treatment hormone levels. Nevertheless, despite this temporal delay, the majority of patients will eventually achieve normalisation of excess pituitary hormone secretion following radiotherapy [14].

CURRENT TECHNIQUES OF PITUITARY RADIOTHERAPY

The principal aim of pituitary radiotherapy techniques has always been to deliver an effective treatment dose to the target tumour volume while at the same time minimising the radiation dose delivered to surrounding normal tissues, thereby minimising the risk of normal tissue injury. This aim has been realised most completely with the modern high precision localised radiotherapy techniques described in this chapter. Improved radiotherapy treatment precision relies on the increased accuracy in tumour volume delineation achieved by using modern MRI imaging technology. Over the last twenty years there have been a number of developments in techniques for pituitary radiotherapy which have largely amounted to refinements of existing technologies. However, the overall success of modern high precision pituitary radiotherapy techniques is largely a function of the quality of a treatment centre's infrastructure and its expertise and accuracy in identifying the target tumour volume, rather than of the particular radiotherapy technique that is used to deliver treatment.

3D Conformal RT

The current standard of care for pituitary radiotherapy remains three dimensional (3D) conformal radiotherapy (CRT). CRT uses pre-treatment computed tomography (CT) and MRI imaging for computerised 3D radiotherapy treatment planning. CRT treatment is planned and delivered using a non-invasive method of patient immobilisation. The CT and MRI 3D imaging is co-registered and the extent of tumour, described as the gross tumour volume (GTV), is delineated on the MRI scan, while radiotherapy dosimetry is calculated using the CT scan data. Multiple radiation beams are directed at the target, which comprises the GTV plus a small margin to account for various treatment uncertainties, and each beam is shaped by a multi-leaf collimator (MLC) to conform closely to the shape of the target volume. 3D computerised radiotherapy planning is followed by robust quality assurance (QA) procedures to ensure the accuracy of the whole process both before and during treatment.

Reproducible patient immobilisation is vital for the delivery of safe and accurate CRT. The immobilisation system used should be well tolerated and must reliably minimise patient movement during both pre-treatment imaging and treatment delivery itself. The most commonly used system for immobilisation for CRT is a custom made closely fitting lightweight thermoplastic mask which is applied and moulded directly to the face in a single procedure. The repositioning accuracy of this system is very good at around 3-5mm [15], and can be improved

to 2-3mm, by using a tighter fitting but less comfortable mask [16].

CT imaging for CRT planning is performed with the patient lying in the radiotherapy treatment position within the immobilisation system; the planning MRI can be performed with or without immobilisation. The MRI typically consists of unenhanced thin slice MRI in three orthogonal planes co-registered to the CT scan. The extent of the pituitary adenoma, as visualised on the unenhanced MRI, is outlined in all planes using the CRT treatment planning system, to define the GTV. The final GTV must take into account all previous relevant imaging, particularly the pre-operative scans, as areas of uncertainty in the tumour volume, should also be included within the GTV. However, the whole pre-operative extent of the tumour is not included within the GTV as debulking of large, and particularly cranially extending tumours, often leads to the return of normal anatomical structures to their pre-morbid positions with no residual tumour present. On the other hand, tumours are frequently not removed from the walls of the cavernous sinus, particularly if the sinus is involved and the lateral extent of the GTV does not tend to alter with surgery. The resulting GTV outlined on the treatment planning system, therefore encompasses both the visible tumour and also any regions of presumed residual tumour.

The GTV is expanded isotropically in all three dimensions by a margin of 5-10mm to account for the uncertainties of immobilisation, treatment planning, and delivery. The resulting expanded volume is defined as the planning target volume (PTV). The actual GTV to PTV margin should be based on measurements of uncertainty in treatment delivery that are specific to each centre's immobilisation and treatment system. Normal tissue structures adjacent to the pituitary, such as the optic chiasm and optic nerves, the brain stem and the hypothalamus, may also be outlined to aid in treatment planning, and also to enable the calculation and recording of normal tissue dosimetry although with conventional fractionated radiotherapy all the structures are treated to below the limits of radiation tolerance in terms of structural damage.

The CRT computer planning system defines the number, shape and orientation of radiation beams to achieve uniform dose coverage of the PTV with the minimum dose to the surrounding normal tissues. As the dose to the tumour is below the radiation tolerance dose of the surrounding normal tissue structures, no specific measures are generally needed, or taken, during treatment planning to avoid the optic apparatus, hypothalamus, and brain stem. In any case, for many patients requiring pituitary irradiation, some or all of these normal structures lie within, or in close proximity to, the GTV and cannot be avoided.

Traditionally, beam arrangements used for CRT consisted of three fixed beams (an antero-superior beam and two lateral beams), each shaped by the MLC to conform to the shape of the PTV. With modern 3D CRT techniques it is no longer necessary to limit the delivery to 3 beams in such a single plane arrangement and the position can be altered to be equally separated in space and 4 beams rather than 3 can be employed.

Techniques for varying the radiation dose intensity across a beam, by moving MLC leaves into the beam path, are now available and are collectively referred to as intensity modulated radiotherapy (IMRT). IMRT is a form of 3D CRT which can spare critical structures within a concave PTV. This technique is rarely required for treatment of pituitary adenomas, and IMRT, for the most part, offers no advantage in comparison with standard CRT for the majority of

patients with sellar and suprasellar tumours [17]. However, a recent technique of arcing IMRT (described as VMAT or RapidArc) offers a fast way of delivering complex IMRT/3D CRT radiotherapy and is increasingly used as an alternative to fixed field 3D CRT technique.

Stereotactic radiotherapy techniques

Stereotaxy The term “stereotactic” is derived from long-established neurosurgical techniques, and denotes a method of determining the position of a lesion within the brain using an external 3D co-ordinate system based on a method of immobilisation, usually an invasive neurosurgical stereotactic head frame [18-20]. Stereotactic radiotherapy originally referred to radiotherapy treatment delivered to an intracranial target lesion that was located by stereotactic means in a patient immobilised in a neurosurgical stereotactic head frame.

Techniques to deliver stereotactic irradiation Stereotactic radiotherapy was first delivered with a multiheaded cobalt unit described as the gamma knife (GK) which uses multiple cobalt-60 sources arranged in a hemispherical distribution with collimators to achieve a circumscribed spherical dose distribution of 6-18mm diameter [20]. Subsequent development of the GK has allowed larger non-spherical tumours to be treated by combining several radiation spheres using a multiple isocentre technique.

Due to the invasive nature of the GK stereotactic head frame, GK radiation treatment is delivered as a single large dose during one combined treatment planning and delivery session. This single fraction stereotactic radiation technique was termed radiosurgery [18]. The GK radiosurgical procedure aimed to create a non-invasive radiation based analogue of an open neurosurgical ablation of an intra-cranial target lesion. It should be emphasised however, that aside from the use of a surgically fitted stereotactic frame, GK radiosurgery and open neurosurgery are quite distinct procedures, and GK radiosurgery is a radiotherapeutic rather than a surgical intervention particularly as the commonly used doses are not “ablative”.

Subsequently, linear accelerators (linacs) were adapted to deliver radiosurgery (single fraction radiation) using multiple arcs of rotation, achieving the same dose distribution as that delivered by the GK. With the introduction of non-invasive relocatable stereotactic head frames, which enabled stereotactic radiation to be given in a number of treatment sessions, stereotactic radiotherapy was delivered as fractionated treatment to conventional doses [21, 22]. Initially, specifically adapted linacs were required, but the precision of modern linacs is now such that they do not generally require modification for stereotactic radiotherapy. The improved patient immobilisation, more accurate tumour target localisation using cross-sectional image for treatment planning, and high precision radiation treatment delivery to the tumour target enabled a reduction in the margins around the radiotherapy target volume (the GTV to PTV margin), therefore achieving greater sparing of surrounding normal tissues than can be obtained with standard CRT techniques.

The miniaturisation of a 6MV linear accelerator has allowed for its mounting on a high precision industrial robotic arm, and this has been combined with real time kV imaging for target tracking during treatment to create a robotic frameless stereotactic radiotherapy machine that is

commercially known as the Cyberknife (CK) [23]. The CK uses multiple narrow, low dose rate photon beams, which have to be summated, to create a dose distribution equivalent to that achieved with other techniques. The need to summate contributions from multiple narrow beams results in longer treatment times per fraction than with other techniques and requires that CK treatment be given as a single large fraction (SRS), or as a few large fractions delivered over the course of a week or so (hypofractionated stereotactic radiotherapy).

“Stereotactic” terminology While the term stereotactic radiotherapy continues to be used, “stereotaxy” as initially used for neurosurgery and subsequently for target localisation in radiotherapy is no longer necessary and not in routine use, as modern MR and CT imaging with on treatment image guidance allow for equivalent high precision treatment delivery. The appropriate modern terminology for the best and most accurate techniques of treatment delivery should be high precision conformal radiotherapy. Nevertheless, the term stereotactic used in conjunction with fractionated treatment (see below), while largely outmoded, remains in use with no clear meaning other than presumably denoting accuracy. Stereotactic localisation however largely remains the standard of practice with single fraction treatment (radiosurgery).

Radiotherapy Fractionation

Terminology The term radiosurgery is used for radiation treatment that is given as a single large ablative dose (a single fraction), and the term radiotherapy is used for treatment that is given as multiple, usually daily, small doses over a period of weeks (fractionated treatment). The fractionation of radiation treatment is a mechanism for protecting normal tissues, and permits the delivery of higher total doses of radiation than can be given as single fractions [24].

Similarly, stereotactic radiotherapy to the pituitary can be given in multiple doses as fractionated stereotactic conformal radiotherapy (SCRT or fSRT), or as a single large dose when it is described as stereotactic radiosurgery (SRS). SCRT/fSRT is generally delivered using a linac. SRS has most frequently been delivered using a GK, but can also be delivered using a linac or a robotic arm mounted linac (CK). Treatment given in fewer large fractions is described as hypofractionated RT.

Biological rationale The use of single fraction SRS is based on a belief, prevalent in the literature, that there is greater clinical benefit from single fraction rather than fractionated irradiation for pituitary adenomas. This was based on radiobiological modelling which defines equivalent radiation doses and fractionation schemes through biologically derived parameters [24, 25] largely derived from radiobiology of malignant tumours and some normal tissues. Such models are not validated for single fraction treatments [26], and the biological parameters necessary for such models to calculate equivalent radiation doses do not exist for benign tumours. Publications claiming theoretical benefit of single fraction radiosurgery over fractionated irradiation [25] are based on constants that are not derived from experimental data and may therefore be misleading.

The therapeutic effect of radiation on malignant tumours is thought to be due to tumour cell attrition, either as apoptosis, or reproductive cell death, secondary to radiation induced DNA

damage. As a consequence, the time taken for an irradiated tissue to manifest radiotherapy related effects is proportional to the rate of cell proliferation in the tissue. In tissues with rapidly proliferating cells, radiation effects are expressed either during or immediately after a course of radiotherapy, while in a tissue with a slowly proliferating cell population radiotherapy effects may take many months or years to manifest. It is assumed that the beneficial effects of radiation in pituitary adenomas conform to these same mechanistic principles, with the radiation induced depletion of pituitary adenoma tumour cells, and with the adenoma being considered a slowly proliferating tissue. As benign tumours are rarely grown in culture the precise mechanism of the observed clinical benefit of irradiation is not elucidated and remains largely theoretical. The surrounding normal brain tissue is also considered to consist largely of slowly proliferating cell populations, although critical cell populations with faster turnover, such as blood vessels, are also present and are affected by radiation.

Dose fractionation schemes for pituitary adenoma Conventional CRT and fractionated SCRT are given to total dose of 45 to 50 Gy at 1.8 Gy per fractionation, once a day, five days per week. These treatment doses are below the tolerance of central nervous system neural tissue, and the risk of structural damage due to such treatment is <1% [27, 28]. While, theoretically, single large doses of radiation as used in SRS may result in a higher tumour cell kill than the equivalent total dose given over a small number of fractions, this is also true for the normal tissue cell population, and leads to normal tissue toxicity which may not be acceptable if it affects critical regions such as optic chiasm [28]. As the majority of pituitary adenomas requiring radiation treatment lie in close proximity to the optic apparatus, and also to the cranial nerves in the cavernous sinus, SRS is suitable only for small lesions located away from critical structures, and the optic apparatus should not exceed single doses above 10Gy [28].

Practical aspects of linac based SCRT/fSRT

For fractionated stereotactic radiotherapy, patients are immobilised in a non-invasive relocatable frame with a relocation accuracy of 1-2mm [21, 22], or a precisely fitting thermoplastic mask system with an accuracy of 2-3mm [16]. Sub-millimeter repositioning accuracy can now be achieved with thermoplastic mask immobilisation by means of image guidance techniques which can determine and apply daily online setup corrections [29]. As for conventional CRT, the GTV is outlined on an MRI scan co-registered with a CT scan. The PTV margin used for SCRT is smaller than for conventional CRT, typically in the region of 3-5mm based on the overall accuracy of the treatment system, the principal determinant of which is the repositioning accuracy of the patient in the immobilisation device [30] and the ability to correct it with on treatment imaging. For such precision treatment, accurate localisation of the tumour volume is of paramount importance in order to avoid treatment failure due to exclusion of a part of the tumour from the treatment volume.

SCRT employs a larger number of radiotherapy beams than conventional CRT (usually 4-6). Each beam is conformed to the shape of the PTV using a narrow leaf MLC (5mm width known as mini MLC, or 3mm width known as micro MLC). Fractionated SCRT (fSRT) combines the precision of stereotactic patient positioning and treatment delivery with standard radiotherapy fractionation, which preferentially spares normal tissue. Complete avoidance of surrounding

normal tissue structures, such as the optic apparatus, is not generally practiced as the dose fractionation schemes used are below the radiation tolerance doses of the CNS. The fractionated SCRT technique is therefore suitable for pituitary adenomas of all sizes, regardless of their relationship to adjacent critical normal tissue structures.

Linac based SRS

Linac based SRS can be delivered using either a relocatable or an invasive neurosurgical stereotactic frame. Use of an invasive neurosurgical frame necessitates that the treatment planning and delivery procedures are carried out and completed within a single day. Computerised treatment planning defines the arrangement of the radiation beams, as in SCRT. SRS can be planned either as multiple arcs of rotation, simulating GK SRS treatment, and producing small spherical dose distributions, or as multiple fixed conformal fields. Multiple arc SRS using a linear accelerator, employing multiple isocentres, is a cumbersome and rarely used technique. The use of multiple fixed fields is generally confined to fractionated treatment, although it can also be used for single fraction SRS. Because of the potentially damaging effect of large single fraction radiation doses to normal tissue structures, SRS is only suitable for small pituitary adenomas that are at least 3-5mm away from the optic chiasm.

Gamma knife SRS

For GK SRS, patients are immobilised in an invasive neurosurgical stereotactic frame. A relocatable non-invasive stereotactic frame has become available, enabling the delivery of hypofractionated stereotactic radiotherapy treatment in addition to SRS, although there is as yet little experience with this system [31]. GK SRS delivers an ablative single dose, in a spherical distribution, of 6-18mm diameter. Larger, non-spherical tumours, which represent the majority of pituitary adenomas, are treated by combining several such spherical dose volumes using a multiple isocentre technique. The appropriate number and distribution of isocentres is defined using a 3D computer planning system which also allows for selective plugging of some of the cobalt source positions to enable shaping of the high dose volume envelope. The use of multiple isocentres results in dose inhomogeneity within the target volume, with small areas of high radiation dose (hot spots) in the regions of overlap of the radiation dose spheres. This may lead to radiation damage if critical normal structures, such as cranial nerves, lie within these hot spots. GK SRS is given to doses of 12 – 20Gy to the tumour margin with doses to the optic chiasm limited to 8-10Gy.

Robotic mounted linac SRS

Cyberknife has been used to treat pituitary adenomas using a variety of dose/fractionation regimens, with a tendency to deliver treatment as hypofractionated radiotherapy in 3 to 5 fractions, rather than as single fraction SRS doses.

Proton therapy

Proton beams, heavy charged particles with the same radiobiological effectiveness as photons, have been in use at a small number of centres with the relevant facilities since the late 1960s [32, 33]. Proton therapy was initially used in two US centres (Boston, MA, and Loma Linda, CA) and then subsequently in Europe (d'Orsay, France) and Japan (Tsukuba, Japan); these centres have reported the majority of the initial clinical results.

The principal theoretical advantage of proton therapy over photon therapy is the deposition of energy at a defined depth in tissue (the Bragg peak) with little energy deposition beyond that point [34]. The main rationale for the use of protons is two fold: firstly as an alternative treatment for tumours that had shown poor local disease control with conventional photon therapy, and secondly for tumours lying in close proximity to critical dose-limiting normal tissues, which is a bar to safe dose escalation using conventional photon radiotherapy. The introduction of proton therapy had been underpinned by planning studies demonstrating, in selected cases, improved dose distribution of protons compared with photons. Following its introduction in the late 1960s, proton therapy was used for treatment of acromegaly [35-38].

CLINICAL OUTCOMES FOLLOWING PITUITARY RADIOTHERAPY

The clinical efficacy of radiotherapy for pituitary adenomas should be assessed by overall survival, actuarial tumour control (progression-free survival, PFS), and quality of life. Commonly reported endpoints for retrospective studies of radiation treatment for non-functioning pituitary adenomas are local tumour control, and long term morbidity. In patients with functioning pituitary adenomas, the principal endpoint, in addition to PFS and morbidity, is the rate of normalisation of elevated pituitary hormone levels. The rate of pituitary hormone decline after irradiation varies with the type of functioning tumour, and the time to reach normal hormone levels is dependent on the initial pre-treatment hormone levels [39]. The appropriate comparative measure for each pituitary hormone is the time to reach 50% of the pre-treatment hormone level, and this should be corrected for the confounding effect of medical treatment.

Surrogate endpoints such as 'tumour control rate', and the 'proportion of patients achieving normal hormone levels' do not, of themselves, provide adequate information on the efficacy of different pituitary irradiation techniques and are potentially misleading [40]. Tumour control rate must be quoted with an indication of the time or duration of follow up required to achieve the stated level of control. Similarly, the proportion of patients achieving normal hormone levels following treatment is meaningful only when described in terms of the relationship to pre-treatment hormone levels. Due to the use of such surrogate endpoints in published retrospective series, inappropriate and incorrect claims have been made in the literature for superiority of one technique of irradiation over another.

Given that the published data on the efficacy of the various available techniques for pituitary irradiation consist entirely of retrospective case-series, the available data inevitably suffer from selection bias. While SCRT is suitable for the treatment of all pituitary tumours, irrespective of size, shape or proximity to critical normal tissue structures, SRS is only suitable for treatment of small tumours away from the optic chiasm. As a result, studies reporting the efficacy of SRS

mostly deal with smaller tumours, which are typically associated with lower hormone levels if the adenomas are functioning. Therefore, the reported results of studies of SRS do not necessarily apply to the generality of pituitary adenomas, and may give a false impression of greater efficacy if only more favourable cases are treated.

THE EFFICACY AND TOXICITIES OF TREATMENT

Conventional RT and CRT

The efficacy of modern stereotactic pituitary radiotherapy and pituitary radiosurgical techniques must be assessed in the light of the results achieved with standard treatment, which is conventional conformal radiotherapy. Large and mature case series provide data on the long term effectiveness of CRT in controlling pituitary tumour growth and hormone secretion.

Tumour control The long-term results following pituitary CRT from case series published in the literature are shown in Table 1 [5-14, 17, 42-51]. The actuarial PFS is in the region of 80%-90% at 10 years and 75%-90% at 20 years [14, 42]. The single largest series of patients with pituitary adenomas treated with conventional fractionated radiotherapy is that from The Royal Marsden Hospital which reported a 10 year PFS of 92% and a 20 year PFS of 88% [8].

Endocrine control Fractionated irradiation leads to normalisation of excess pituitary hormone secretion in the majority of patients, albeit with some time delay following treatment. For acromegaly, RT achieves normalisation of GH/IGF-I levels in 30-50% of patients at 5-10 years, and in 75% of patients at 15 years, after treatment (Table 1) [14, 42]. As the time to normalisation of GH levels is related to the pre-treatment GH level, the time to achieve a 50% reduction in GH levels which takes into account the starting GH level, is in the region of 2 years, with IGF-1 reaching half of pre-treatment levels somewhat after the GH [45, 47].

Table 1. Summary of results of published series on conventional RT for pituitary adenomas

Authors	Type of adenoma	Number of patients	Follow-up median (years)	Actuarial progression free survival (PFS) (%)	Late toxicity (%)	
					Visual	Hypopituitarism
Grigsby et al 1989 [6]	NFA, SA	121	11.7	89.9 at 10 years	1.7	NA
McCollough et al., 1991 [7]	NFA, SA	105	7.8	95 at 10 years	NA	NA
Brada et al., 1993 [8]	NFA, SA	411	10.8	94 at 10 years 88 at 20 years	1.5	30 at 10 years
Tsang et al., 1994 [9]	NFA, SA	160	8.7	87 at 10 years	0	23**
Zierhut et al., 1995 [10]	NFA, SA	138	6.5	95 at 5 years	1.5	27**
Estrada et al., 1997	SA (ATCH)	30	3.5	73 at 2 years*	0	48**
Rush et al., 1997 [11]	NFA, SA	70	8	NA	NA	42**
Breen et al., 1998 [12]	NFA	120	9	87.5 at 10 years	1	NA
Gittoes et al., 1998 [5]	NFA	126	7.5	93 at 10 and 15 years	NA	NA
Barrande et al., 2000	SA (GH)	128	11	53 at 10 years*	0	50 at 10 years
Biernasz et al., 2000	SA (GH)	36	10	60 at 10 years*	0	54 at 10 years
Sasaki et al., 2000 [13]	NFA, SA	91	8.2	93 at 10 years	1	NA
Epaminonda et al., 2001 [46]	SA (GH)	67	10	65 at 15 years*	0	NA
Minniti et al., 2005 [47]	SA (GH)	45	12	52 at 10 years*	0	45 at 10 years
Langsenlehner et al., 2007 [48]	NFA, SA	87	15	93 at 15 years 78 and 84 at 5 and 10 years*	0	88 at 10 years
Minniti et al., 2007 [49]	SA (ATCH)	40	9	96 at 10 years (NFA), 66% at 10 years (SA)	0	62 at 10 years
Rim et al., 2011 [50]	NFA, SA	60	5.6		0	76 at 10 years

NFA, nonfunctioning adenoma; SA, secreting adenoma; NA, not assessed, ACTH – Cushing's, GH - acromegaly
 * hormone concentration normalization, **no time specified

Figure.

After RT for Cushing's disease, urinary free cortisol (UFC) is reduced to 50% of the pre-treatment levels after an interval of 6-12 months, and plasma cortisol after around 12 months [49]. The median time to cortisol level normalisation is around 24 months after treatment [49]. The overall tumour and hormone control rates in the reported studies, after a median follow up of 8 years, are 97% and 74% respectively (Table 2) [51].

Table 2. Summary of results on published studies on SCRT for pituitary adenomas

Authors	Number of patients	Follow-up median (months)	Tumour growth control rate (%)	Late toxicity (%)	
				Visual	Hypopituitarism
Coke et al., 1997 [70]	19*	9	100	0	0
Mitsumori et al., 1998 [71]	30*	33	86 at 3 years	0	20
Milker-Zabel et al., 2001 [72]	68*	38	93 at 5 years	7	5
Paek et al., 2005 [73]	68	30	98 at 5 years	3	6
Colin et al., 2005 [74]	110*	48	99 at 5 years	2	29 at 4 years
Minniti et al., 2006 [75]	92*	32	98 at 5 years	1	22
Selch et al., 2006 [76]	39*	60	100	0	15
Kong et al., 2007 [77]	64*	37	97 at 4 years	0	11
Snead et al., 2008 [78]	100*	6.7 years	98 at 10 year for NFA and 73 SA	1	35
Roug et al., 2010 [79]	34*	34	91(50% hormonal normalisation)	-	-
Schalin-Jantti et al., 2010 [80]	30	5.3 years	100	0	23
Weber et al., 2011 [81]	27*	72.4	96	4	8
Wilson et al., 2012 [82]	67	5.12 years	88	2	6

*case series includes secreting pituitary adenomas

Figure.

Pituitary radiotherapy is rarely used to treat patients with prolactinoma. Occasional patients who fail surgery and medical therapy have been treated with RT, and the reported 10-year tumour and hormone control rates are 90% and 50% respectively [52-54].

Toxicity The toxicity of RT with total treatment doses of 45-50Gy with daily fraction sizes of < 2Gy is low. The principal toxicities reported in studies of CRT are described below.

Hypopituitarism Hypopituitarism is the most common long-term complication following RT, reported to occur in 30-60 % of patients by 10 years after treatment [8, 9, 14]. Pituitary hormone loss is observed to occur in a characteristic sequence, with GH secretion being affected most frequently, followed by the gonadotrophins, ACTH, and then TSH. Long term follow-up after

pituitary irradiation, with intermittent testing for deficiency of all pituitary axes, is therefore an essential part of the post-treatment management of these patients.

Visual pathways deficit and other structural CNS damage The reported incidence of optic neuropathy resulting in visual deficit following CRT is 1-3% [8, 9]. The occurrence of necrosis of normal brain tissue is almost unknown following pituitary RT, although this complication has been reported to occur in 0.2% of patients [55].

Cerebrovascular disease Pituitary disease is, in itself, associated with increased mortality, principally due to vascular disease [56]. An increased incidence of stroke (relative to the general population) in patients treated with RT for both non-functioning and functioning pituitary adenomas has been reported in a number of retrospective cohort studies [57-60]. Whilst it has long been known that radiotherapy can lead to vascular injury [61], it is not at present clear how much of the excess stroke risk following RT is attributable to radiotherapy, and how much may be due to other potential causes including the metabolic and cardiovascular consequences of hypopituitarism, the effects of associated endocrine syndromes, and the consequences of surgery.

In a retrospective cohort study of 342 patients treated with pituitary surgery and post-operative RT, 31 patients died from stroke after a median follow-up interval of 21 years (range, 2–33) [60] and in all cases the probable location of the stroke lesion was within the irradiated volume. Comparison of stroke patients with matched control patients without stroke drawn from the same cohort showed no significant differences in radiotherapy-dependent variables with the exception of the pre-treatment duration of symptoms of hypopituitarism. This suggests that untreated hormone deficiency may be a significant factor in the pathogenesis of stroke in patients treated for pituitary adenoma, rather than or in addition to treatment with radiotherapy. It is likely that the cause of stroke in patients treated with RT for pituitary adenoma is multifactorial, and the relative contributions of the various possible contributory factors remains to be determined.

Second brain tumour Intracranial radiotherapy is associated with the development of second, radiation-induced, brain tumours. The cumulative incidence of gliomas and meningiomas following radiotherapy for pituitary adenomas in retrospective case series is reported to be in the region of 2% at 20 years [60, 62-64].

Cognitive deficit Radiotherapy treatment to significant volumes of normal brain in children is associated with subsequent neuro-cognitive impairment [27]. However, the evidence for the effect of radiotherapy treatment to small volumes of brain on neuro-cognitive function in adults is weak [27]. The effect of pituitary radiotherapy on neuro-cognitive function is particularly difficult to discern as this cannot be differentiated from the effect of other treatment interventions, and from the effects of the tumour itself [65, 66, 67].

A retrospective study of 84 patients following trans-sphenoidal surgery, of whom 39 received post-operative radiotherapy, compared neuro-cognitive function with a large reference sample, considered to be representative of normal population without pituitary disease. While the pituitary cohort had lower scores on the tests of both memory and executive function in

comparison with the reference sample, patients who had received radiotherapy showed no significant difference compared to patients treated with surgery alone [68]. A dosimetric study did not find a correlation between radiotherapy dose to the hippocampus and pre-frontal cortex (brain regions known to be important in memory and executive function) and the technique of irradiation with cognitive performance [69].

STEREOTACTIC CONFORMAL RADIOTHERAPY (SCRT/FSRT)

SCRT achieves tumour control and normalisation of pituitary hormone hypersecretion at rates similar to the best reports following conventional RT. Longer duration follow-up is required to demonstrate the presumed lower incidence of long-term morbidity following SCRT compared to conventional RT. The results from reported studies of SCRT are summarised below.

Tumour control SCRT data for 748 patients with either non-functioning or functioning pituitary adenomas have been reported in 13 studies to date (Table 2) [14, 17, 42, 51, 70-82]. Analysis of published data up to 2011 shows that, at a corrected median follow-up of 39 months (median range 10-60 months), tumour control was achieved in 98% of patients. The 5-year actuarial PFS of 92 patients (67 non-functioning, 25 functioning) treated at The Royal Marsden Hospital was 97% [75]. These results are similar to the results seen in patient cohorts treated with conventional RT (Table 1).

Endocrine control Detailed data on the rate of pituitary hormone decline are not available, although this is expected to be similar to that seen following conventional RT as the same dose-fractionation is used. In The Royal Marsden case series, 6 of 18 acromegalic patients (35%) had normalisation of GH/IGF-I levels after a median follow-up of 39 months [75]. Similarly, in another single centre study of 20 patients treated with SCRT, normalisation of GH levels was reported in 70%, and local tumour control in 100% after a median follow-up of 26 months [72]. The data available on SCRT for patients with Cushing's disease are limited. In a small series of 12 patients, control of elevated cortisol was reported in 9 out of 12 patients (75%), after a median follow-up of 29 months [74].

Toxicities Following SCRT, hypopituitarism has been reported in 20% of patients after an overall corrected median follow-up of 60 months (Table 2). The length of follow-up after SCRT is shorter than reported for the mature cohorts treated with RT. It is likely that the rate of hypopituitarism following SCRT will continue to increase as the duration of follow-up increases particularly as the technique of SCRT generally does not avoid either the hypothalamus or the remaining pituitary gland. Other late complications have been rarely reported after SCRT. While the incidence of treatment related morbidity with SCRT appears to be low, longer duration follow-up is necessary to detect normal tissue toxicity that may only manifest at a low frequency many years after treatment.

RADIOSURGERY (SRS)

Tumour control The published results of GK SRS for patients with non-functioning and functioning pituitary adenomas have been summarised in systematic reviews [14, 17, 42, 51]

and an update with more recently published studies is given in Table 3 [14, 17, 42, 51, 82-99]. The majority of published reports provide information on tumour 'control rate', without specifying a time-frame, and therefore provide little useful information on the efficacy of GK SRS. The summary figure for the actuarial 5-year control rate (PFS) following GK SRS for non-functioning adenomas is 94% at 5 years (few 10 year results are available). This is a lower rate of tumour control than expected following RT & SCRT, particularly when it is considered that only small tumours suitable for GK SRS are treated, compared to that adenomas of all sizes treated with RT, CRT & SCRT.

Table 3. Summary of results of published series on SRS for non-functioning pituitary adenomas¹

Authors	Number of patients	Follow-up median (months)	Tumour growth control rate (%)	Visual	Late toxicity % Hypopituitarism
Martinez et al., 1998 [83]	14	26-45	100	0	0
Pan L et al., 1998 [84]	17	29	95	0	0
Ikeda et al., 1998 [85]	13	45	100	0	0
Mokry et al., 1999 [86]	31	20	98	NA	NA
Sheehan et al., 2002 [87]	42	31*	97	2.3	0
Wowra & Stummer, 2002 [88]	45	55	93 at 3 years	0	14
Petrovich et al., 2003 [89]	56	36	94 at 3 years	4	NA
Pollock & Carpenter, 2003 [90]	33	43	97 at 5 years	0	28 and 41 at 2 and 5 years
Losa et al., 2004 [91]	56	41*	88 at 5 years	0	24
Iwai et al., 2005 [92]	34	60	93 at 5 years	0	6
Mingione et al., 2006 [93]	100	45*	92	0	25
Liscak et al., 2007 [94]	140	60	100	0	2
Pollock et al., 2008 [95]	62	64	95 at 3 and 7 years	0	32 at 5 years
Kobayashi et al., 2009 [96]	60	>3years	97	4.3	8.2 worsening
Gopalan et al., 2011 [97]	48	80.5	83	9.4	39
Park et al., 2011 [99]	125	62	94 at 5 years and 76 at 10 years	1	24 at 24 months
Wilson et al., 2012 [82]	51	4.17 years	100	0	0
Runge et al., 2012 [98]	61	83	98	0	9.8

*mean follow-up; NA, not available

Figure.

Endocrine control with GK SRS The reported endocrine outcomes following GK SRS for acromegaly are shown in Table 4 [14, 42, 51, 83, 84, 86, 89, 96, 100-126]. A summary analysis of the published literature up to 2011 shows that 37% of patients achieved normalisation of serum GH, after a median follow-up of 39 months. The time to reach 50% of baseline serum GH, reported in only three studies, is in the region of 1.5-2 years with a slower reduction in IGF-I

levels [110, 113, 127], which is similar to the rate reported following conventional RT/CRT.

Table 4. Summary of results of published series on SRS for growth hormone secreting pituitary adenomas

Authors	Number of patients	Follow-up median (months)	Hormone normalisation*	Late toxicity (%)	
			%	Visual	Hypopituitarism
Thoren M et al., 1991 [100]	21	64	10	0	15
Martinez et al., 1998 [83]	7	26-45	NA	0	0
Pan et al., 1998 [84]	15	29	NA	0	0
Morange-Ramos et al., 1998 [101]	15	20	20	6	16
Lim et al., 1998 [102]	20	26	30	5	5
Kim et al., 1999 [103]	11	27	35	NA	NA
Landolt et al., 1998 [104]	16	17	50	0	16
Mokry et al., 1999 [86]	16	46	31	0	NA
Hayashi et al., 1999 [105]	22	>6	41	0	0
Inoue et al., 1999 [106]	12	> 24	58	0	0
Zhang et al., 2000 [107]	68	> 12	40	NA	NA
Izawa et al., 2000 [108]	29	>6	41	0	0
Pollock et al., 2002 [109]	26	36	47	4	16
Attanasio et al., 2003 [110]	30	46	23	0	6
Choi et al., 2003 [111]	12	43	30	0	0
Jane et al., 2003 [112]	64	> 18	36	0	28
Petrovich et al., 2003 [89]	6	36	100	0	NA
Castinetti et al., 2005 [113]	82	49.5*	17	0	18
Gutt et al., 2005 [114]	44	22	48	NA	NA
Kobayashi et al., 2005 [115]	67	63	17	0	NA
Jezkova et al., 2006 [116]	96	54	50	0	26
Pollock et al., 2007 [117]	46	63	11 and 60 at 2 and 5 years	0	33 at 5 years
Jagannathan et al., 2009 [118]	95	57 (mean)	53	5 [#]	34 (new)
Kobayashi et al., 2009 [96]	49	63	17 (normal or nearly normal)	11	15
Wan et al., 2009 [119]	103	60 (minimum)	37	0	1.7 ^{**}
Castinetti et al., 2009 [120]	27	60 (minimum)	42 at 50 months	1.3 ^{**}	23 ^{**}
Iwai et al., 2010 [121]	26	84	38	0	8
Hayashi et al., 2010 [122]	25	36 (mean)	40	0	0
Erdur et al., 2011 [123]	22	60	55	0	29
Sheehan et al., 2011 [124]	130	30	53 at 30 months	0	34
Franzin et al., 2012 [125]	103	71	56.9 at 5 years	0	7.8 (new)
Liu et al., 2012 [126]	40	72	57.5	0	40 (new)

*mean follow-up; NA not assessed

[#] 3 had previous RT

^{**}whole series

Figure.

A summary analysis of the published literature up to 2011, for patients with Cushing's disease, shows that 51% achieved biochemical remission (as defined by plasma cortisol and 24-hour UFC level) at a corrected median follow-up of 42 months after SRS (Table 5) [14, 42, 51, 83, 84,

86, 89, 96, 101, 102, 105, 106, 108, 109, 111, 112, 118-120, 122, 124, 128-136]. The reported time to hormonal normalisation ranged from 3 months to 3 years, with no clear difference in the rate of decline of hormone level compared to RT/CRT. The largest single series of GK SRS for Cushing's disease reported a remission rate of 54%, with 20% of patients who achieved remission subsequently relapsing, suggesting a higher failure rate following GK SRS than following RT/CRT [137].

Table 5. Summary of results of published series on SRS for ACTH-secreting pituitary adenomas

Authors	Number of patients	Follow-up median (months)	Tumour growth control rate (%)	Hormone normalisation*		Late toxicity (%)	
				%		Visual	Hypopituitarism
Degerblad et al., 1986 [128]	29	3-9 years	76	48		na	55
Ganz et al., 1993 [129]	4	18	NA	NA		0	NA
Seo et al., 1995 [130]	2	24	100	NA		0	NA
Martinez et al., 1998 [83]	3	26-45	100	100		0	0
Pan et al., 1998 [84]	4	29	95	NA		0	0
Morange-Ramos et al., 1998 [101]	6	20	100	66		0	16
Lim et al., 1998 [102]	4	26	NA	25		2	2
Mokry et al., 1999 [86]	5	26	93	20		0	2
Kim et al., 1999 [131]	8	26	100	60		NA	NA
Hayashi et al., 1999 [105]	10	>6	100	10		0	5
Inoue et al., 1999 [106]	3	>24	100	100		0	0
Izawa et al., 2000 [108]	12	>6	100	17		NA	0
Sheehan et al., 2000 [132]	43	44	100	63		2	16
Hoybye et al., 2001 [133]	18	17 yr	100	83		0	66
Kobayashi et al., 2002 [134]	20	60	100	35		NA	NA
Pollock et al., 2002 [109]	11	36	85	35		35	8
Choi et al., 2003 [111]	9	43	100	55		0	0
Jane et al., 2003 [112]	45	>18	100	63		1	31
Petrovich et al., 2003 [89]	4	36	NA	50		0	NA
Devin et al., 2004 [135]	35	35	91	49		0	40
Castinetti et al., 2007 [136]	40	54	100	42		0	NA
Jagannathan et al., 2009 [118]	90	45	96	54		6	22
Kobayashi, 2009 [96]	25	64 (mean)	100	35		na	na
Wan et al., 2009 [119]	68	60 (minimum)	90	28		0	1.7
Castinetti et al., 2009 [120]	18	60 (minimum)	-	50 at 28 months		1.3**	23**
Hayashi et al., 2010 [122]	13	36 (mean)	97	38		0	0
Sheehan et al., 2011 [124]	82	30	-	54		0	22

* time not specified; NA not assessed

** whole series

Figure.

In patients with prolactinoma treated with GK SRS the reported time to hormonal response ranged from 5 months to 40 months (Table 6) [14, 42, 51, 83, 84, 86, 89, 96, 101-103, 105, 106, 108, 109, 111, 112, 119, 120, 124, 129, 138-142]. At a corrected median follow-up of 29 months (median range 6-55 months), 33% of patients had normalisation of serum prolactin concentrations following GK SRS [14]. One study of 35 patients reported a hormonal

normalisation of 80% after a median of 96 months and a tumour control rate of 97% [141]. There is insufficient information to assess the rate of decline of prolactin following GK SRS in comparison to that following CRT.

Table 6. Summary of results of published series on SRS for prolactin secreting pituitary adenomas

Authors	Number of patients	Follow-up median (months)	Hormone normalisation %	Late toxicity (%)	
				Visual	Hypopituitarism
Ganz et al., 1993 [129]	3	18	0	0	NA
Martinez et al., 1998 [83]	5	26-45	0	0	0
Pan et al., 1998 [84]	27	29	30	0	0
Morange-Ramos et al., 1998 [101]	4	20	0	0	16
Lim et al., 1998 [102]	19	26	50	NA	NA
Mokry et al., 1999 [86]	21	31	57	0	19
Kim et al., 1999 [131]	18	27	16	NA	NA
Hayashi et al., 1999 [105]	13	>6	15	NA	5
Inoue et al., 1999 [106]	2	>24	50	0	0
Landolt et al., 2000 [138]	20	29	25	0	NA
Pan et al., 2000 [139]	128	33	41	0	NA
Izawa et al., 2000 [108]	15	>6	16	0	NA
Polllock et al., 2002 [109]	7	26	29	14	16
Choi et al., 2003 [111]	21	43	23	0	0
Jane et al., 2003 [112]	19	> 18	11	0	21
Petrovich et al., 2003 [89]	12	36	83	0	NA
Pouratian et al., 2006 [140]	23	55	26	7	28
Jezkova et al., 2009 [141]	35	96	80	na	na
Kobayashi, 2009 [96]	27	37 (mean)	17	0	0
Wan et al., 2009 [119]	176	60 (minimum)	23	0	1.7
Castinetti et al., 2009 [120]	15	60 (minimum)	46 at 24 months	1.3**	23**
Sheehan et al., 2011 [124]	32	30	26 at 25 months	-	38
Liu et al., 2012 [142]	22	36	27	-	4.5

NA not assessed

**whole series

Figure.

Early studies of linac based SRS reported results on small numbers of patients, but the available results are broadly equivalent to those reported for GK SRS [17]. In the largest linac based SRS study to date, which included 175 patients with both non-functioning and functioning pituitary adenomas treated using a single dose of 20 Gy, the local tumour control rate was 97% after a minimum of 12 months follow up [143]. Actuarial 5 year PFS was not reported. Hormonal normalisation rates were 47% for GH-secreting adenomas, 65% with Cushing's disease, and 39% with prolactinomas. The mean time for hormone normalisation was 36±24 months. Within

the limited follow-up period, 12% developed additional pituitary dysfunction, 3% radiation-induced CNS tissue damage, and 1% radiation-induced optic neuropathy. These results from linac SRS are difficult to evaluate but are broadly similar to those achieved with GK SRS and appear inferior to those obtained with fractionated treatment.

Toxicity In common with other modalities of pituitary irradiation, the most commonly reported complication following GK SRS is hypopituitarism, with a crude incidence ranging from 0% to 66% [14, 42]; the actuarial incidence has not been defined. The expected frequency of visual complications would be low if GK SRS is only offered to patients with a pituitary adenoma at a safe distance from the optic chiasm and nerves (~ 5mm). However, one study in patients with Cushing's disease reported a 10% incidence of new cranial nerve deficit, with a 6% incidence of optic neuropathy [118]. Similarly a study reporting results of SRS for prolactinoma noted a 7% incidence of cranial nerve deficit [140]. Although the absolute numbers of patients treated in these studies of GK SRS were small, there is a suggestion that for some patients, possibly with larger tumours, the incidence of optic pathway toxicity with GK SRS is well above what is seen in patients following CRT. Long-term risks of cerebrovascular events and the incidence of second tumours following GK SRS are not yet defined.

ROBOTIC SRS

A small number of retrospective case series on outcomes following CK SRS for pituitary adenomas have been published to date (Table 7) [144-149]. While the published results are comparable to the outcomes achieved with GK SRS, the same criticisms levelled at the GK SRS studies also apply to these early CK SRS series. The duration of follow-up in all the existing CK SRS series is too short to allow meaningful conclusions to be drawn with regard to both efficacy and toxicity outcomes.

Table 7. Summary of results of published series on Cyberknife SRS for functioning & non-functioning pituitary adenomas

Authors	Tumour type	Number of Patients	Follow-up mean (months)	Tumour control rate (%) or hormone normalisation (%)	Late toxicity (%)	
					Visual	Hypotpituitarism
Kajiwara et al., 2005 [144]	14 NFA, 3 PRL, 2 GH, 2 ACTH	21	35.3	95.2% TC, 50% HN	1/21	2/21
Adler et al., 2006 [145]	12 NFA, 4 GH, 2 ACTH, 1 PRL	19	46	18/19 TC	1/19	NA
Roberts et al., 2007 [146]	GH	9	25.4	44.4% HN	0	33%
Killory et al., 2009 [147]	14 NFA, 4 GH, 1 PRL, 1 TSH	20	26.6	100% TC	0	NA
Cho et al., 2009 [148]	17 NFA, 3 PRL, 6 GH	26	30	92.3% TC, 44% HN	7.6%	0
Iwata et al., 2011 [149]	NFA	100	median 33	98% TC	1%	3/74

Figure.

PROTON BEAM THERAPY

An early study of proton beam therapy for pituitary adenomas attempted to compare the effectiveness of this treatment modality to RT/CRT [150]. Follow-up after CRT in 17 patients and after proton therapy in 13 patients found a similar reductions of GH levels in both groups and the small number of patients does not allow for any statistically meaningful comparison. Nevertheless, treatment related side effects, including new hypopituitarism and oculomotor palsies, were more frequent in proton therapy group. Since the efficacy of both pituitary irradiation methods were similar, but proton therapy was associated with a higher incidence of serious side effects, the authors concluded that RT/CRT is the preferred treatment modality [150].

A more recent study of 47 patients treated with fractionated proton therapy for both non-functioning and functioning pituitary adenomas reported tumour stabilisation in 41 (87%) patients after a minimum 6-month follow-up; 1 patient developed temporal lobe necrosis, 3 developed new significant visual deficits, and 11 developed new hypopituitarism [38]. These are disappointing results suggesting considerably worse outcome both in terms of efficacy and toxicity than seen with photon irradiation.

A study of proton beam stereotactic radiosurgery in 22 patients with acromegaly reported normalisation of GH in 59% after a median of 42 months. New pituitary deficiency was reported in 38% of patients, but no visual complications were reported [33].

The recent evidence based review of proton therapy from ASTRO's emerging technology committee examined the evidence for proton therapy across multiple tumour sites and concluded that currently available evidence provides only limited indications for proton therapy [151]. The report recommended that robust prospective clinical trials be conducted to determine the appropriate clinical indications for proton therapy. In the present context, the available published reports of proton therapy for pituitary adenoma demonstrate disappointing efficacy and increased toxicity relative to much more readily available photon based treatment modalities, and therefore it seems difficult to justify proton therapy to the pituitary outside of the context of a clinical trial.

RE-IRRADIATION FOR RECURRENT DISEASE

Re-irradiation for progression of pituitary adenoma after previous pituitary radiotherapy is considered to be associated with a high risk of radiation induced damage due to the presumed cumulative effect of radiation to the optic apparatus, the cranial nerves, and the normal brain tissues. However, re-irradiation using fractionated conventional or stereotactic techniques is feasible, with acceptable toxicity [40], provided that there has been at least a 3-4 year gap following primary radiotherapy treatment to doses below radiation tolerance of the CNS (which is the case for the conventional dose of 45Gy delivered at <1.8Gy per fraction). GK SRS has also been used to re-irradiate small recurrent lesions, particularly if they are not in close proximity to the optic apparatus [152]. While the current impression is that late toxicity following pituitary re-irradiation is uncommon there are at present insufficient long-term data to

demonstrate the safety of pituitary re-irradiation for recurrent disease.

OUTLOOK

The techniques of pituitary radiotherapy have gradually evolved over a number of decades with apparent choice between different technologies. All aim at concentrating the dose to the tumour with minimal dose to surrounding tissue and the irradiation is given in one, few or many fractions. There has been a lack of randomised comparative studies comparing the techniques to date. Systematic review of case series reported in the literature assessing the efficacy and toxicity provides a reasonably objective assessment of the techniques albeit not devoid of bias inherent in the publications and the somewhat entrenched views held by the proponents of the techniques. While prospective randomised trials would provide the best objective comparative information, the beliefs of practitioners in particular treatment modalities, vested interests in technologies and general difficulty of conducting studies in diseases with such long natural history make such comparative trials an unlikely prospect. This is compounded by the fact that new radiotherapy technologies continue to be introduced into clinical practice without the need for establishing efficacy as demanded for new drugs. It seems therefore likely that controversy will persist with regard to the appropriate and optimal methods for treating pituitary adenoma using radiation, and that all of the treatment modalities described here will continue in clinical use for the foreseeable future even though the systematic review suggests that some of the techniques may be less effective and potentially more toxic.

The availability of GK SRS has led to a policy in some centres of using adjuvant single fraction SRS in patients with small residual tumours. It is not clear that this practice is appropriate as the risks from such small non-functioning adenomas are unlikely to be greater than the risks of SRS itself. Similarly, some patients with slowly declining pituitary hormone levels, particularly in acromegaly, have been offered additional SRS. There is insufficient evidence that further pituitary irradiation significantly speeds up the hormone decline and it seems difficult to justify the potential risk of additional morbidity from re-irradiation.

Conformal techniques of fractionated pituitary radiotherapy are standard practice, with many centres able to offer the additional accuracy of higher precision radiotherapy previously termed stereotactic but currently part of mainstream high precision RT. Successful application of high precision treatment is highly dependent on expertise in accurate target definition using modern MR imaging, on the precision of the immobilisation system based on an exhaustive quality assurance programme, and on infrastructure particularly in the form of expertise of staff in complex techniques of treatment planning and delivery. It seems most likely that it is the available expertise at all levels of staff in a treatment centre that is the principal determinant of the success of pituitary radiotherapy rather than the choice of equipment and the precise treatment technique that is used.

SUMMARY

Fractionated radiotherapy is an effective treatment for pituitary adenoma, able to achieve excellent disease control and normalisation of hormone levels. While the overall safety profile of

this treatment modality is favourable, it is not devoid of side effects and it should only be employed when the risks from the disease itself are considered to outweigh the risks from the treatment. The balance of risks should take into account not only the early consequences of the disease and treatment, measured in terms of disease control and immediate morbidity, but also the long-term effects, particularly in terms of the influence of treatment on survival and quality of life, both of which are less well defined.

Residual pituitary adenomas, most of which have indolent natural history, pose little threat to function, unless they lie close to the optic apparatus, or unless they destructively invade adjacent structures, which is an uncommon event. The risks of residual adenoma are therefore often minimal, and in the absence of progression or hormone hypersecretion, there is currently little justification for adjuvant radiation, whether in the form of fractionated or single fraction treatment. However, a policy of postoperative surveillance does require a programme of close monitoring, usually in the form of annual MR imaging, and proceeding to timely irradiation if necessary, and certainly well before the need for further surgery. The aim of radiation treatment is to arrest tumour growth without the risks of re-operation.

For functioning tumours radiation treatment is generally offered to patients with persistent hormone elevation that is not decreasing at the expected rate following previous intervention of surgery and medical therapy. This generally means persistent hormone elevation in patients with acromegaly, Cushing's disease and other functioning adenomas, regardless of how far the actual hormone level is from normal, as the aim in most cases is to achieve normalisation. In patients with acromegaly treated with somatostatin analogues, the expense and inconvenience of protracted systemic treatment also warrants early radiation treatment to allow for the withdrawal of medical treatment. The alternative is to continue medical management indefinitely without radiotherapy. It is not clear at present which policy is associated with better long term survival and quality of life, and this should ideally be the subject of a prospective randomised trial.

Current clinical practice is therefore to offer treatment to patients with progressive non-functioning (or functioning) pituitary adenomas considered to be a threat to function, and to patients with functioning pituitary adenomas with persistent hypersecretion. On the basis of the evidence available in the literature, single fraction radiosurgery, while possibly more convenient, is less effective in achieving long term disease control of pituitary adenoma tumour mass, and does not achieve faster decline in hormone levels in functioning tumours. In addition, single fraction treatment of larger adenomas close to critical structures carries a significant risk of radiation induced damage. Fractionated radiotherapy, currently as high precision CRT (previously considered as SCRT/fSRT), remains the current standard of care for patients requiring radiation treatment for pituitary adenoma.

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