Special Section

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Chairman's Summary

It is clear that octreotide (Sandostatin) works. It lowers growth hormone (GH) levels and has biochemical and beneficial clinical effects. The usual effective dose is about 100 µg 8-hourly, although in occasional patients increasing their dose to 200 µg produces a greater fall of GH. Whether that increase is of clinical benefit is yet to be shown. It must also be borne in mind that this increase would double the cost to over E10,000 per year.

The incidence of tumour shrinkage on octreotide is a little controversial. Most people seem to think shrinkage is a very rare occurrence. Everybody in any large centre has seen the odd case. It is always difficult to be sure of shrinkage if one does not have properly reproducible CT scans. It is clear to me that some tumours do shrink, but it is also clear to me that shrinkage is not nearly as common as in patients with prolactinomas on bromocriptine, where it is over 80%, and it is probably not as common as in acromegalic patients on bromocriptine, where John Wass showed that in pure GH-secreting tumours there is a 50% shrinkage rate. Clearly, however, bromocriptine is not nearly as effective in lowering GH.

Side-effects are quite common at the beginning of therapy, as we have seen, particularly abdominal discomfort and steatorrhoea or diarrhoea, but these go away – in 1 week usually but almost always within 3 weeks. The steatorrhoea and malabsorption are not a problem in the long term. We are all worrying about gall-
bladder disease. The prospective trials are not published yet, but this may be a problem with long-term therapy. I am rather intrigued about carbohydrate tolerance. Certainly bromocriptine cures diabetic carbohydrate intolerance in acromegaly in at least 60-70% of patients. That does not appear to be the case in octreotide therapy. While we all expected carbohydrate tolerate to worsen, generally this does not seem to happen on long-term treatment, but it is rather unusual for diabetes actually to get better with the fall in GH. I suppose octreotide is offsetting insulin suppression against reduction in GH.

Maybe in the future we shall be treating more patients with a combination of bromocriptine and octreotide, especially if they have diabetes and especially if they have macro-adenomas of the pituitary and we do not want to operate on them.

Those are the impressions I have from today's meeting. I think we would all agree octreotide is a remarkable innovation in an area of endocrine disease that has been so difficult to treat. Prof. Lamberts has mentioned that Sandoz Pharmaceuticals are working on an oral preparation of a version of somatostatin and that clearly would be an even greater innovation. Perhaps the next time we meet, that is what we shall discuss.

Thank you all for coming to this symposium and thank you, Sandoz, for giving us the opportunity to do so.

G.M. Besser