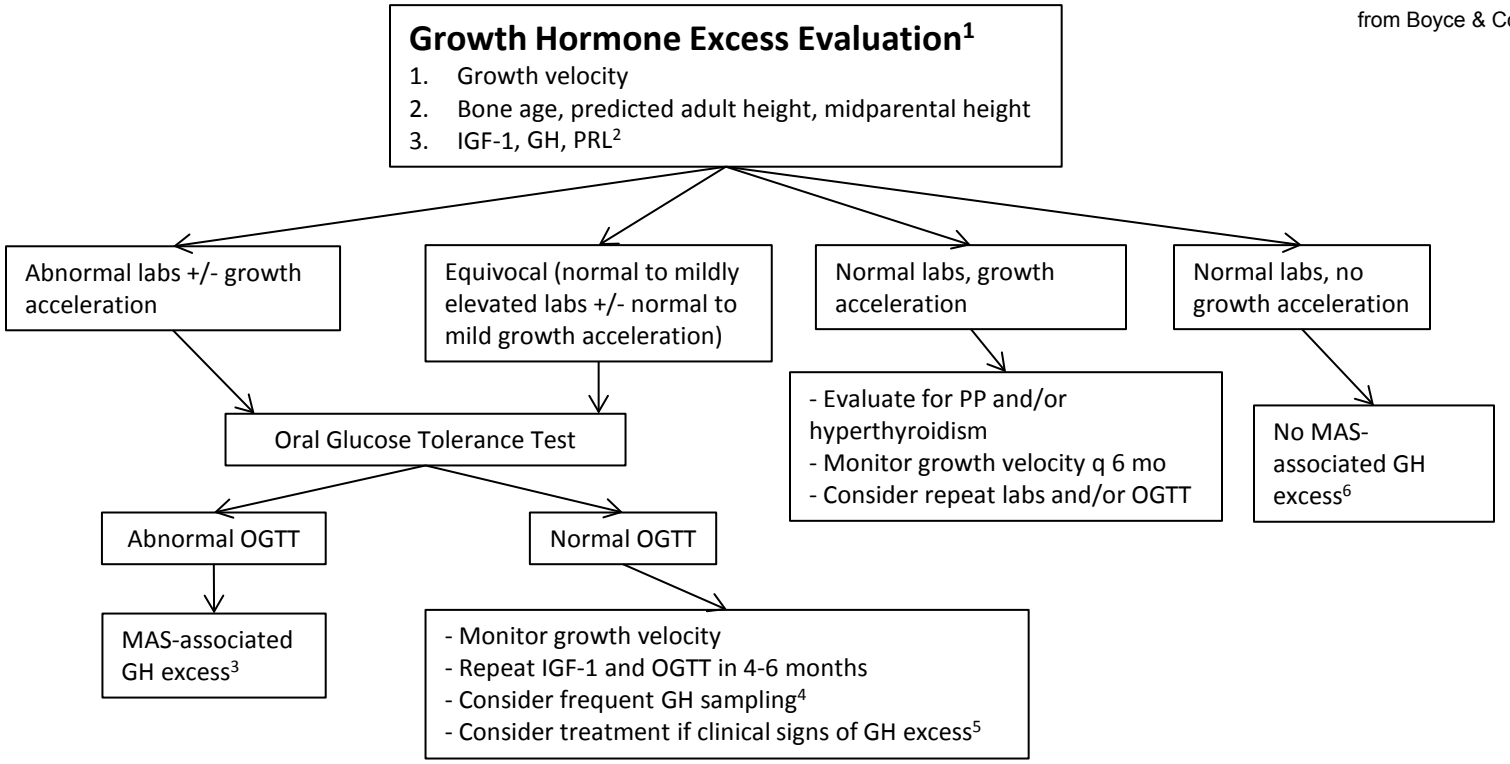
from Boyce & Collins [2012]



[1]To be performed at initial presentation in all patients suspected of having MAS, regardless of clinical symptoms. [2]The majority of patients with MAS-associated GH excess will have prolactin co-secretion. [3]Practitioners may consider pituitary MRI in patients suspected of having MAS-associated GH excess, however findings may be non-specific and rarely change management. [4]There are a variety of techniques for frequent GH sampling. Ours involves collecting GH samples every 20 minutes for 12 hours from 8 PM to 8 AM, with a lack of nadir below 1.0 ng/mL considered consistent with GH excess. [5]In patients with craniofacial FD it is prudent to have a low threshold for initiating treatment, as uncontrolled GH excess is associated with increased craniofacial morbidity. [6]If no clinical or biochemical evidence of GH excess is evident by age 5 years, MAS-associated GH excess is effectively ruled out.

References

Boyce AM, Glover M, Kelly MH, Brillante BA, Butman JA, Fitzgibbon EJ, Brewer CC, Zalewski CK, Cutler Peck CM, Kim HJ, Collins MT. Optic neuropathy in McCune-Albright syndrome: effects of early diagnosis and treatment of growth hormone excess. J Clin Endocrinol Metab. 2012.
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Legend

FD = fibrous dysplasia; GH = growth hormone; IGF-1 = insulin-like growth factor-1; MAS = McCune-Albright syndrome; mo = months; OGTT = oral glucose tolerance test; PP = precocious puberty; PRL = prolactin; q = each; TRP = tubular reabsorption of phosphate; TSH = thyroid stimulating hormone