The treatment of pituitary adenomas is complex and multimodal. Treatment is indicated for hormone hypersecretion, disturbance of visual function, tumor growth and other neurologic sequelae secondary to mass effect. Classically, for those patients with pituitary adenomas, treatment has consisted of surgical resection and/or medical management of those secretory tumors.

Surgical approaches consist of transsphenoidal and formal craniotomy, amongst others, in order to debulk and remove as much tumor as possible, with the goal of tumor cure and improvement in neurological function and endocrine status. Radiation therapy has been used in the past as an adjunct to treatment of recurrent and aggressive pituitary tumors, with mixed results. With the introduction of stereotactic radiosurgery,
the ability to focus radiation dosing with sub-millimeter accuracy has allowed us to target pituitary adenomas for treatment with excellent results for tumor growth control and stabilization of endocrine function\textsuperscript{1,2}.

Transsphenoidal approaches, whether microsurgical or endoscopic transnasal, are currently the gold standard surgical treatment modality for pituitary adenomas. Stereotactic radiosurgery (SRS) has generally been reserved for those patients with recurrence or residual tumor, and those patients medically unfit to undergo the physiologic stress of an operation. The indications for SRS are expanding as experience with the technique increases.

Complication rates described with Gamma Knife (GK) for pituitary adenomas are quite variable, with the most common being pituitary axis disorders, ranging from 0-72\%\textsuperscript{2}. Radiation induced optic neuropathy, parasellar cranial neuropathy and cavernous carotid injury have been described but are relatively rare.

We describe our institutional experience with GK SRS in the treatment of pituitary adenomas from November 2003 to June 2011, with the goal to define our local growth control rates, endocrine remission rates, and complications.

METHODS

Between November 2003 and June 2011, 86 patients with pituitary adenomas underwent GK radiosurgery at the Health Sciences Center in Winnipeg, Manitoba. We retrospectively reviewed the records of these patients and recorded data on: age, sex, tumour diameter and volume, GK treatment parameters, complications, time until tumour response, local control rates, and clinical/endocrine outcomes. Follow-up on this patient population was accrued up to Dec 2011, with this data retrospectively accumulated from telephone contact, neuroimaging and neurosurgical clinic chart review. Local research ethics board approval was obtained prior to starting this study.

RESULTS

Patient Demographics and Pituitary Adenoma Characteristics

There were a total of 86 patients identified as being treated for pituitary adenomas with GK during the review. These eighty-six patients received a single GK treatment at our institution, with none having had previous GK. Procedures for tumor debulking were performed in 56 of the 86 patients (65.1\%), prior to GK, with ten patients (11.6\%) having two prior transsphenoidal operations. These surgical approaches included transsphenoidal resection in 50 patients (58\%), and craniotomy in six patients (7\%) for those tumors with significant parasellar/suprasellar extension. Average time from operation to GK treatment was 59.8 months. The average age at treatment was 55 years (range: 5 – 81). Forty-six patients (53\%) were male and 40 patients (47\%) female. Average follow-up time was 32.8 months (range: 2 – 79 months), with ten patients lost to follow-up. The median follow-up time was 35 months. Patient demographics for the 76 patients with follow-up are displayed in Table 1. Data pertaining to those patients lost to follow up can be seen in Table 2.

Of the ten patients lost to follow-up, all were referred to our facility by out of province physicians. They were subsequently lost to post-treatment follow up after returning to their respective provinces. Telephone contact was attempted on multiple occasions using the available contact information on file, but was unsuccessful.

Patients typically had multiple clinical presentations. Clinical manifestations on initial diagnosis were: visual field

<table>
<thead>
<tr>
<th>Table 1: Demographic data of patients with follow-up</th>
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<tbody>
<tr>
<td>Demographic Category</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Sex</td>
</tr>
<tr>
<td>Average Tumour Total Volume (cm\textsuperscript{3})</td>
</tr>
<tr>
<td>Average Tumour Diameter (cm)</td>
</tr>
<tr>
<td>Average % Coverage</td>
</tr>
<tr>
<td>Average 50% Isodose Line Dose (Gy) for Secreted tumors</td>
</tr>
<tr>
<td>Average 50% Isodose Line Dose (Gy) for Non-secreted tumors</td>
</tr>
<tr>
<td>Average Time to Decrease in Tumour Size (months)</td>
</tr>
<tr>
<td>Total Number With Tumor Growth Control</td>
</tr>
<tr>
<td>Total Number of Permanent Complications</td>
</tr>
</tbody>
</table>

n = number; cm = centimetre; Gy = gray
defect (20), acromegaly (18), headache (17), diplopia (7), Cushing’s disease (7), blurred vision (5), amenorrhea (5), low libido (3), apoplexy (2), Addison’s disease (1), diabetes insipidus (1), and relative afferent papillary defect (1). Nine patients had their pituitary adenoma discovered incidentally secondary to cranial imaging for unrelated complaints.

All were selected for treatment due to tumor progression or recurrence on follow-up imaging. Refractory endocrinopathy was a factor in deciding to treat those patients with secreting adenomas, but all had demonstrated some interval change in size on pre-treatment imaging according to radiology interpretation, though some were quite small.

Eighty-one patients (94.2%) had adenomas within the sella turcica (with the remaining five having tumor burden extra-sellar as a result of previous surgical debulking), while tumor extension into the suprasellar cistern occurred in 53 (61.6%), into the cavernous sinus in 53 (61.6%), into the sphenoid sinus in 9 (10.4%), into the clivus in 5 (5.8%), and the middle fossa region in 2 (2.3%). The optic apparatus was compressed in 21 (24.4%) patients. The average maximum diameter of the pituitary adenoma was 2.21 cm (range: 0.22 – 4.08 cm), and the average tumor volume was 5.41 cm³ (range: 0.33 – 14.3 cm³).

Forty-seven (45.3%) of the 86 patients treated had non-secreting pituitary adenomas. Of the remaining tumors there were 21 (24.4%) growth hormone (GH) secreting, 8 (9.3%) prolactin (PRL) secreting, 8 (9.3%) adrenocorticotropic hormone (ACTH) secreting, and 2 (2.3%) LH/FSH secreting adenomas. All patients with secreting tumors were on hormone modulating medications prior to treatment with GK, with the exception of the LH/FSH secreting adenomas. Hormone modulating medications were withheld temporarily prior to treatment with the GK.

Treatment Characteristics

Gamma Knife treatment planning was performed using magnetic resonance imaging (MRI) and computed tomography (CT) in 33 of 86 (38.4%), and only MRI in 53 (61.6%). Gamma Knife treatment parameters consisted of an average maximum tumor dose of 36.8 Gy (range from 25 to 60 Gy). The average number of collimator shots was 15.6 per treatment. The prescription dose to the 50% isodose line was 18.5 Gy (range from 12 to 35 Gy). The average 50% isodose line dose for non-secreting adenomas was 14.2 Gy (range of 12 to 18 Gy). The average maximum dose for non-secreting adenomas was 28.6 Gy (range of 24 to 32 Gy). The average 50% isodose line dosage for secreting adenomas was 23.6 Gy (range from 13 to 35 Gy), with the average maximum dose for secreting adenomas being 46.8 Gy (range from 26 to 70 Gy). The average total volume covered (TVC) was 4.7 cm³ (range: 0.33 – 12.1 cm³), with average percent coverage of 94.4% (range: 82 – 100%). Eighty-four patients (97.7%) had a recorded a maximal dose to the optic nerve (ON) apparatus that was on average 8.9 Gy (range: 3.2 – 12.2 Gy). Twenty-eight patients (32.5%) had an ON dose recorded greater than or equal to 10 Gy. Thirteen (15.1%) patients had ON doses recorded a greater than or equal to 11 Gy. Ten (11.6%) patients had ON doses recorded at greater than or equal to 12 Gy.

Patients received post-treatment follow-up phone interviews within two weeks of GK treatment. Follow-up clinic visits were conducted six to eight weeks post treatment. Imaging was conducted at three and nine months post-GK, and then yearly with MRI to assess tumor control, all with follow-up clinic visits with the treating neurosurgeon.

Overall Tumor Growth Control

Tumor control, which was defined as the absence of lesion growth, or decrease in size, on follow-up imaging occurred in 75/76 (98.6%) of the patients with follow-up; 42 (55.3%) demonstrated regression and 33 (43.4%) stability in tumor size. The average time until change in adenoma size post-GK was 12.6 months.

Only one patient (1.3%) demonstrated mild tumor growth despite GK treatment documented at approximately 3 mm in maximal diameter. This patient had a 2.3 cm non-functioning

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**Table 2: Characteristics of patients lost to follow-up**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Presentation</th>
<th>Location</th>
<th>Function</th>
<th>Diameter of Tumour (cm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>Acromegaly</td>
<td>Sella, Suprasellar</td>
<td>GH</td>
<td>1.8</td>
</tr>
<tr>
<td>F</td>
<td>Cushing’s Disease</td>
<td>Sella, Suprasellar, Lt Cav Sinus</td>
<td>ACTH</td>
<td>2.3</td>
</tr>
<tr>
<td>F</td>
<td>Amenorrhea</td>
<td>Sella</td>
<td>PRL</td>
<td>1.95</td>
</tr>
<tr>
<td>F</td>
<td>H/A, blurred vision</td>
<td>Sella, Suprasellar, Cavernous Sinus</td>
<td>Null</td>
<td>3.51</td>
</tr>
<tr>
<td>F</td>
<td>Cushing’s Disease</td>
<td>Sella</td>
<td>ACTH</td>
<td>1.5</td>
</tr>
<tr>
<td>M</td>
<td>Dizzy, Deteriorating Lt vision</td>
<td>Sella, Suprasellar, Optic Chiasm</td>
<td>Null</td>
<td>2.4</td>
</tr>
<tr>
<td>F</td>
<td>H/A, fatigue</td>
<td>Sella, Supra, Cavernous Sinus</td>
<td>Null</td>
<td>3.52</td>
</tr>
<tr>
<td>M</td>
<td>Visual Blurring</td>
<td>Sella, Suprasellar</td>
<td>Null</td>
<td>1.8</td>
</tr>
<tr>
<td>M</td>
<td>Cushing’s Disease</td>
<td>Sella</td>
<td>ACTH</td>
<td>2.1</td>
</tr>
<tr>
<td>F</td>
<td>Cushing’s Disease</td>
<td>Sella, Rt Cav Sinus</td>
<td>ACTH</td>
<td>1.4</td>
</tr>
</tbody>
</table>

F = female, M = male, Lt = left, Rt = right, Cav = cavernous, GH = Growth Hormone, ACTH = Adrenocorticotropic Hormone, PRL = Prolactin, Null = Non-functioning.
One patient with endocrine stability became hypothyroid as a result of GK requiring thyroid supplementation. Increasing GH and insulin growth factor-1 (IGF-1) levels despite treatment medication continued, and one (10%) had ongoing up, 10 (50%) had endocrine stability or stable doses of their pre-therapy. Of the remaining 11 of the 20 GH patients with follow-up, 10 (50%) had endocrine stability, while the remaining 14 (70%) demonstrated tumour regression. Average time to tumour regression for the GH adenomas was five months. Hormonal status has remained normal. Close imaging follow up has been recommended.

Non-secreting Adenomas

Of the 47 patients with non-functioning adenomas treated during our review period, four were lost to follow-up. The remaining patients demonstrated a 42 of 43 (97.7%) tumour control rate, with 22 (51.2%) showing regression, and 20 (46.5%) showing tumour stability rates. Only one patient (2.3%) in the non-functioning adenoma group had tumour growth despite treatment (as described previously).

Secreting Adenomas

We defined improved endocrine functioning as either being off hormonal modulating medication, or having reduced pre-GK medication doses. In addition, we defined endocrine stability as no change in pre-GK medication dosing after treatment. Results for individual tumour types are as follows:

GH Adenomas

There were 21 patients, with one lost to follow-up. Overall, 100% tumour control was achieved in those with follow up, with 6 of the 20 (30%) patients displaying tumour stability, while the remaining 14 (70%) demonstrated tumour regression. Average time to tumour regression for the GH adenomas was five months.

Nine (45%) demonstrated improved hormonal functioning with 6 of 20 (30%) having their pre-treatment medications discontinued. Three had reductions in medication. However, two of the patients with reduction of their pre-treatment medications developed panhypopituitarism secondary to GK and one became hypothyroid; all requiring pituitary hormone replacement therapy. Of the remaining 11 of the 20 GH patients with follow-up, 10 (50%) had endocrine stability or stable doses of their pre-treatment medication continued, and one (10%) had ongoing increasing GH and insulin growth factor-1 (IGF-1) levels despite treatment. One patient with endocrine stability became hypothyroid as a result of GK requiring thyroid supplementation.

PRL Adenomas

Of the eight patients with PRL secreting adenomas, one was lost to follow up. Tumor control for the remaining seven patients was achieved in 100%, with three (42%) displaying tumour stability, and four (57%) having tumour regression. Average time until tumour regression in the PRL adenomas was 16.3 months.

Of those patients with PRL adenomas and follow-up, five (71.4%) demonstrated improved hormone status, with three (42.9%) coming off medication and having normalization of PRL levels, and two (28.6%) patients achieving a decrease in their medication dosage. However, one patient achieving “medication free” status developed hypothyroidism post-GK requiring supplementation. One patient (14.2%) had endocrine stability, and one (14.2%) had endocrine progression despite treatment.

ACTH Adenomas

We had eight patients with ACTH secreting adenomas; four were lost to follow-up. Of those with follow up there was 100% tumor control, with two (50%) having tumor stability, and two (50%) displaying tumor regression. Average time until tumor regression in the ACTH adenomas was 10.5 months. Endocrine status of these adenomas improved in 100% of those with follow-up. Two (50%) achieved reduction in medication dosage, while two (50%) were free of their pre-operative medication as of their last visit.

LH/FSH Adenomas

Only two patients in our experience had LH/FSH secreting adenomas and neither was on hormonal modulating medications pre GK. Both patients had tumour control as of last follow-up, with one (50%) displaying regression, noted at five months post-GK, and the other having tumour stability. As well, both patients achieved stable LH/FSH levels post treatment and were classified as endocrinologically stable. Neither achieved hormonal normalization.

A summary of the tumour control and endocrine function outcome is summarized in Table 3.

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Table 3: Secreting adenoma type, growth control, and endocrine outcome

<table>
<thead>
<tr>
<th>Tumor Type</th>
<th>Regression</th>
<th>Stability</th>
<th>LTFU</th>
<th>Hormonal Improvement</th>
<th>Hormonal Stability</th>
<th>Hormonal Progression</th>
</tr>
</thead>
<tbody>
<tr>
<td>GH</td>
<td>6 (30%)</td>
<td>14 (70%)</td>
<td>1</td>
<td>9 (40%)</td>
<td>10 (50%)</td>
<td>1 (10%)</td>
</tr>
<tr>
<td>PRL</td>
<td>3 (42.9%)</td>
<td>4 (57.1%)</td>
<td>1</td>
<td>5 (71.4%)</td>
<td>1 (14.3%)</td>
<td>1 (14.3%)</td>
</tr>
<tr>
<td>ACTH</td>
<td>2 (50.0%)</td>
<td>2 (50.0%)</td>
<td>4</td>
<td>4 (100%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>LH/FSH</td>
<td>2 (100%)</td>
<td>0</td>
<td>0</td>
<td>0 (0%)</td>
<td>2 (100%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

GH = Growth Hormone, PRL = Prolactin, ACTH = Adrenocorticotropic Hormone, LH = Luteinizing Hormone, FSH = Follicle Stimulating Hormone, LTFU = Lost to Follow-Up

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pituitary adenoma and received 13 Gy to the 50% isodose line. She described a post treatment headache as a transient complication. Her total follow-up at the time of this study being six months. Hormonal status has remained normal. Close imaging follow up has been recommended.
Complications

We divided our complications into transient minor complications, and serious permanent complications. Overall 31 of the 76 patients (34.2%) had transient complications, and 14 (18.4%) had serious permanent complications.

The transient complications for all tumor types included: pin site swelling (17), pin site infection (1), pin site dysesthesias (5), visual blurring (4), short term memory loss (2), and ataxia (1). All of these had resolved as of last follow-up. Transient complications in the secreting adenomas included: pin site swelling (6), pin site dysesthesias (2), and ataxia (1).

Serious permanent complications for all tumor types included: panhypopituitarism (4), hypothyroidism (4), hypocortisolemia (1), diabetes insipidus (1), apoplexy (1), visual field defect secondary to radiation induced optic neuropathy (2), and diplopia (1). All patients with new pituitary axis abnormalities post-GK required hormonal replacement, which they were on as of last follow-up, making our post-GK pituitary dysfunction rate 13.2%. The patient with apoplexy post-GK had a 3.3 cm GH adenoma treated with 15 Gy to the 50% isodose line. He developed headache and visual blurring five days post gamma knife, with radiographic evidence of hemorrhage consistent with apoplexy. He was taken to the operating theater for transsphenoidal resection due to mass effect on the optic apparatus and visual deterioration. As of last follow-up the patient still has a minor visual field deficit.

Radiation induced optic neuropathy was observed in two patients, leading to permanent visual field defects. One patient had a 4.06 cm GH pituitary adenoma with encroachment on the chiasm. He had previous transsphenoidal and transcranial resection due to optic apparatus distortion, with a mild preoperative right eye temporal visual field defect. Gamma Knife SRS was elected as a treatment option considering the patient had failed both transsphenoidal and transcranial debulking, in addition to external beam radiation in the past. Gamma Knife treatment consisted of 20 Gy to the 50% isodose line, and a maximal recorded ON dose of 8 Gy. The patient developed a bitemporal field cut. On MRI the chiasm looked atrophic at six months post-GK. His symptoms started nine months post-GK. The second patient had a 3.47 cm non-secreting pituitary adenoma with suprasellar and right cavernous sinus extension and encroachment on the optic nerves, leading to right eye ophthalmoplegia. He had failed both transsphenoidal resection and external beam radiation. GK treatment consisted of a dose of 15 Gy to the 50% isodose line, with a maximal recorded ON dose of 9 Gy. During a follow-up visual field analysis 24 months post-GK, a left eye temporal field loss was noticed. This was not noticed by the patient. No specific abnormality of the optic apparatus could be identified on MRI.

Finally, diplopia developed post-GK in one patient who was treated for 3.79 cm non-secreting pituitary adenoma with suprasellar and right cavernous sinus extension. A 13 Gy dose to the 50% isodose line was administered. Diplopia was noted at the 3 month follow up on superior gaze. In addition mild right ptosis was noted, indicating a partial third nerve etiology. This deficit has been persistent since.

For the secreting pituitary adenomas, the serious permanent complications included: hypocortisolemia (1), panhypopituitarism (3), hypothyroidism (2), radiation induced optic neuropathy (1), and diabetes insipidus (1).

Discussion

Gamma Knife treatment has been described in the literature to result in tumor growth control rates ranging up to 92-100% for adenomas of all types. Endocrine stabilization or improvement for those tumors with secreting status varies depending on tumor subtype, with average remission rates for GH, PRL, and ACTH adenomas having been described as 0 - 67%1,5, 0 - 84%1,2,6,7, and 10 - 100%1,2 respectively. Long-term growth control has been described in up to 83% at 80 months8. Extended follow-up at a mean of 54 months for functioning pituitary adenomas post-GK in the literature demonstrates the chance of endocrinologic remission at 87% for ACTH, 67% for GH, and 18% for PRL adenomas9.

Overall our experience of a tumor growth control rate of 98.6% for all adenoma types is comparable to that found in the literature1-2. Our results for growth control of non-secreting adenomas are within the literature experience1,2,10 at 97.7%. We attribute this to lessons learned from the literature including recommendations to maintain a dose between 12 – 18 Gy at the 50% isodose line for non-secreting tumors10. Our growth control rates of 100% for secreting adenomas are within the literature range described1-9. We had four ACTH, one GH and one PRL patients lost to follow-up, however, and the overall tumor control rates may be less than we report here.

We had a relatively large proportion of GH adenomas in our patient population. This may be related to the local good tumor control rates for PRL adenomas and ACTH adenomas with standard transsphenoidal techniques and medical management. Our control of the GH adenomas is slightly better than that described1-5, despite losing one patient to follow-up. Cessation of hormone modulating medications pre-GK10, and adherence to literature standards in dosing secreting adenomas11 has allowed us to achieve this.

Our endocrine improvement and stability rates (see Table 3) for those patients with secreting adenomas are also within literature limits described above. For GH adenomas, our endocrine improvement rate of 45% and stability rate of 50% is slightly higher than described in the literature1-5. This is despite the majority displaying cavernous sinus extension, which has been described as a negative predictor of remission4. We again believe this stems from diligence with pre-operative medication cessation and dose prescription. Similarly our ACTH adenomas and PRL adenomas displayed endocrine improvement/stability rates of 71.4%/28.6%, and 50%/50% respectively. However, as previously mentioned six patients with functioning adenomas were lost to follow-up. Furthermore, two patients displaying hormonal regression developed panhypopituitarism while one developed hypothyroidism post-GK. As well, two patients with hormonal stability of their secreting adenomas developed hypothyroidism post-GK. Thus, despite positive endocrine outcomes in terms of tumour function, some traded one pituitary axis problem for another as a result of dysfunction secondary to radiosurgery.

The total number of patients with previous documented surgical intervention for their pituitary adenomas is small at 65%, relative to other series, and represents the ongoing success
with surgical treatment of pituitary adenomas. As well, the large proportion of patients without previous surgery demonstrates an institutional shift in our multi-modality treatment approach to pituitary adenomas, utilizing GK in some earlier in the disease process before surgery is necessary. Comparing those patients with previous surgery to those treated with GK as their first procedure, 55 (98%) patients versus 20 (100%) patients had tumor control respectively. For those patients with previous surgical resection and tumor control post-GK, 26 (46%) displayed decrease in size, while 29 (52%) demonstrated stability in size. In those patients without previous surgical attempts, 16 (80%) demonstrated tumor regression, while four (20%) demonstrated stability in size. Twenty-five patients with previous attempt at surgical resection had secreting tumors. The endocrine outcome for this group included: Improved hormonal status in 11 (44%), stable endocrine status in 13 (52%), and progression in 1 (4%). The nine patients with secreting tumors and without previous surgery displayed improved hormonal status in six (67%), stability in two (22%), and progression in one (11%).

The permanent complication rate of 18.4% was predominantly secondary to pituitary axis dysfunction. Overall our pituitary axis dysfunction in 10 of 76 (13.2%) patients, is well within the limits described12-15. The majority of the serious permanent complications, 8 of 14 (57.1%), occurred in the secreting adenomas. Of these, the majority of the pituitary axis dysfunction, 7 of the 10 (70.0%) described, post-GK occurred in the secreting adena group. This is likely related to larger infundibular doses seen secondary to the higher marginal dose required for tumor and endocrine control.

The two patients with radiation induced optic neuropathy were of concern. Both of these patients had ON dosing under 10 Gy, and were within the 12 Gy limit recommended by Stafford et al16 and even the 10 Gy dose as recommended by earlier literature17,18. This is just slightly above the literature rate of radiation induced ON at 2.6% compared to less than 2%19. We found that both of these patients had significant suprasellar extension with optic apparatus deformation prior to the surgical debulking performed at pre-GK intervals of 10 and 205 months respectively. No MRI evidence of optic nerve compression secondary to tumour growth post-GK was found. We believe this previous compression of the optic apparatus predisposed these patients to radiation induced optic neuropathy in the setting of ON dosing less than 10 Gy. Finally, the one patient with new onset diplopia was likely related to cavernous sinus radiation dosing that led to a 6th nerve radiation neuropathy despite maintaining low cavernous sinus dosing as recommended19.

Permanent complications for the secreting adenomas were higher, with 8 of the 14 permanent complications occurring in the secreting group. Of interest is the high proportion of pituitary dysfunction, 7 of the 10 cases described occurred in the secreting adenoma group. This is likely related to larger infundibular doses seen secondary to the higher marginal dose required for tumor and endocrine control.

We recognize this study has several limitations. First, ten patients were lost to follow-up. Second, a large portion of the ACTH secreting adenomas were lost to follow-up, making the tumor growth and endocrine outcomes in that category of patients difficult to interpret. Third, the retrospective nature of the study left some follow up data difficult to obtain. Finally, the small patient population makes these results difficult to generalize to all pituitary adenomas treated with GK SRS. Overall we believe good results can be achieved by the following: First, follow literature recommended 50% isodose line dosing for non-secreting and secreting tumors at 12-18 Gy and 18-30 Gy respectively11. Second, attempts at maintaining infundibular and stalk dosing as low as possible to prevent post-GK hypopituitarism12,13 should be made, though adequate tumor dosing remains the primary goal. Third, instruct patients to stop taking their hormone modulating medications prior to GK in order to maximize endocrine remission in functioning adenomas10,11. Fourth, strive to keep ON dosing under 10 Gy to reduce the risk of radiation induced ON as described in the literature16-18, though tolerances up to 12 Gy have been described. Finally, limit the parasellar radiation dosing (less than 19 Gy if possible) to reduce the risk of other radiation induced cranial neuropathies20,21.

**Conclusion**

Gamma Knife stereotactic radiosurgery offers a relatively safe and effective means of achieving both tumor growth control and endocrine remission and stability in pituitary adenomas. With the advent of SRS and the implementation of this tool in the treatment of pituitary adenomas, those patients with residual or recurrent disease, and those medically unfit for surgery have a less invasive radiosurgical option to achieve tumor growth control and, potentially, improvement in hormonal status.
REFERENCES


