

What Is the Pediatrician's Role?



Why Should I Recognize CPP Earlier?

- Pathology
- Psychosocial concerns^a
- Loss of height potential
- Better height outcomes with earlier treatment

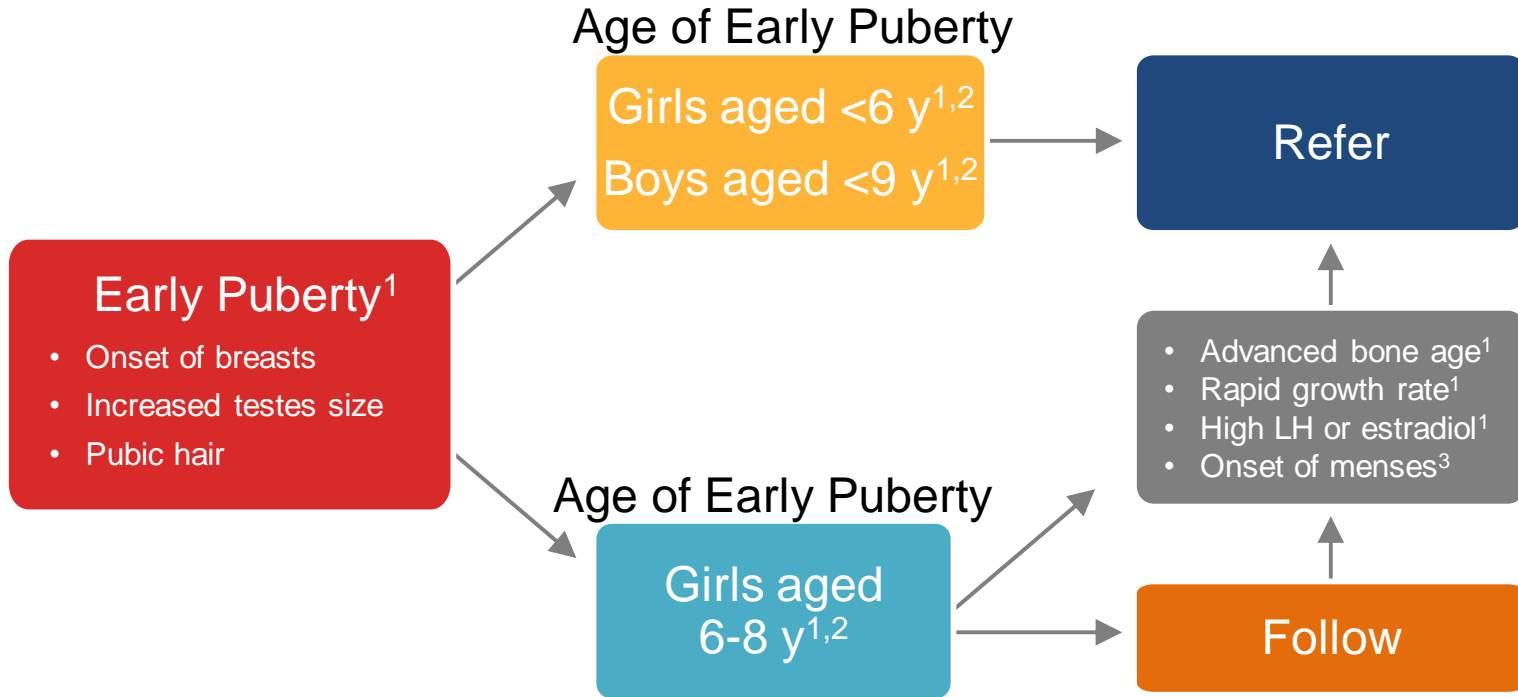
^aFurther research is needed to understand the effects of psychosocial behavior in children with CPP.

2 Reference: Kaplowitz P, Bloch C. *Pediatrics*. 2016;137(1):e2015373.

Pediatrician's Role

- Recognize CPP early and refer to pediatric endocrinologist
 - Plot height, weight, growth velocity, body mass index
 - Examine genitalia routinely and carefully
 - Look for pubic hair between labia or under scrotum – not just across symphysis pubis
 - This should be at each well child visit for assessing rate of progression
 - Palpate for breast tissue
 - Palpate testes size
- Continue health maintenance care
- Track compliance with treatment and follow up with pediatric endocrinologist
- Reassure families of:
 - The need for treatment
 - Potential treatment outcomes
 - The importance of not interrupting treatment
- All children are different heights and family heights matter in outcomes

Clues on When to Refer



LH, luteinizing hormone.

References: 1. Kaplowitz P, Bloch C. *Pediatrics*. 2016;137(1):e2015373. 2. De Silva N, Tschirhart J. *Curr Treat Options Peds*. 2016;2(3):121-130.

3. Chen M, Eugster EA. *PaediatrDrugs*. 2015;17(4):273-281.

Current Treatment Options

- GnRHa agents are the standard of care for CPP¹

Gonadotropin-releasing hormone agonists

- Monthly injections
- 3-month injections
- Yearly implants
- 6-month injections
- Daily nasal spray

Summary of Potential Outcomes Following Treatment Discontinuation

- Gonadal function is promptly restored in girls after cessation of treatment¹⁻³
 - Menses onset occurs on average >18 months after cessation (mean 1.1±0.4 yrs)²
 - The majority achieve ovulatory menstrual cycles of normal timing and duration²
 - Normal pregnancies and live births reported²
- No long-term negative effect on body composition BMI^{2,4}
- No long-term negative impact on BMD²
- **Increases in predicted adult height**⁵

BMI, body mass index; BMD, bone mineral density.

References: 1. Thornton P et al. *Pediatr Endocrinol Rev.* 2014;11(3):306-317. 2. Guaraldi F et al. *Eur J Endocrinol.* 2016;174(3):r79-r87. 3. Krishna KB, et al. *HormRes Paediatr.* 2019;1-16. 4. Faienza MF et al. *Horm Res Paediatr.* 2017;87(3):162-169. 5. Klein KO et al. *J Clin Endocrinol Metab.* 2001;86:4711-4716.