Hypercalcemia due to Parathyroid Adenoma: A Delayed Diagnosis

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ABSTRACT

Hypercalcemia is a serious health problem occurring due to pathology of many organ systems including thyroid, parathyroid, kidney, and bone. Hypercalcemia due to parathyroid is usually a delayed diagnosis as parathyroid adenoma is usually discovered during surgery of thyroid gland disease. We present a case of hypercalcemia due to parathyroid adenoma, who underwent total thyroidectomy with right inferior parathyroidectomy. We conclude that a patient with features suggestive of hypercalcemia should be suspected to have parathyroid adenoma and every effort has to be made to diagnose parathyroid adenoma as this is a surgically resectable medical problem.

Keywords: Hypercalcemia, Parathyroid adenoma, Parathyroidectomy, Thyroidectomy.

CASE REPORT

A 53-year-old woman, a known case of diabetes mellitus since 10 years, presented to the outpatient clinic with complaint of swelling on the right side lower aspect of neck since 4 years duration (Fig. 1). On examination of the neck, there was a single oval-shaped approximately 3 × 2 cm swelling, 2 cm above the sternal end of right clavicle. The overlying skin color was normal, overlying skin temperature was normal, firm in consistency, mobile, nontender, moved with deglutition, and did not move with protrusion of tongue. Ultrasonography neck showed well-defined hypoechoic lesion measuring approximately 11 × 7 mm seen near inferior pole of right lobe of thyroid along with multinodular goiter (MNG). Fine-needle aspiration cytology revealed hyperplastic nodule on lower pole of thyroid gland with MNG. Blood investigations of patient were as follows: Euthyroid (free triiodothyronine – 2.08 pg/mL, free thyroxine – 1.30 ng/dL, thyroid stimulating hormone – 2.21 μIU/mL), serum calcium – 13.9 mg/dL, and parathyroid hormone – 188 pg/mL. Technetium 99m tetrofosmin dual-phase parathyroid scintigraphy was suggestive of right superior parathyroid adenoma (Fig. 2). Contrast-enhanced computed tomography neck showed multiple nodules in bilateral thyroid lobe with a small lesion at the inferior pole of right thyroid lobe (Fig. 3). The patient underwent total thyroidectomy with right inferior parathyroidectomy. During the procedure, right inferior parathyroid gland appeared enlarged and adherent to the inferior pole of right thyroid lobe (Fig. 4). Postoperatively, patient had hypocalcemia, which was treated conservatively. The patient was also managed for diabetes mellitus by intravenous insulin therapy. Histopathology came out as MNG with parathyroid adenoma.

DISCUSSION

We present a case of parathyroid adenoma of right inferior parathyroid as a cause of PHPT in association with a MNG. Multinodular goiter is the most common endocrine disorder affecting 500 to 600 million people worldwide. In India, about 54 million people have goiter and the number at risk is estimated to be about 167 million with an annual incidence of 0.1 to 1.5%.
Primary hyperparathyroidism has become an asymptomatic disease in the Western world, whereas in India, PHPT is still an uncommonly diagnosed, overtly symptomatic disease of “bones, stones, abdominal groans, and psychic moans” due to the fact that screening of the healthy population for hypercalcemia is not a routine practice. The treatment of choice for PHPT is surgical removal of the hyperfunctioning tissue. Hungry bone syndrome is common in the postoperative period. The disease-related mortality rate is 7.4%, recurrence 4.16%, and persistent disease 2.17%.6

CONCLUSION

All patients with features suggestive of hypercalcemia should be suspected to have parathyroid adenoma and every effort to be made to diagnose parathyroid adenoma as this is a surgically resectable medical problem.

REFERENCES