



ORIGINAL RESEARCH PAPER

Obstetrics & Gynaecology

A RARE CASE REPORT OF HYPERPARATHYROIDISM COMPLICATING PREGNANCY

KEY WORDS:
hyperparathyroidism, Endocrine disorders, Hypercalcemia, Maternal, Fetal .

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ABSTRACT

Primary hyperparathyroidism is third most common endocrine disorder after diabetes and thyroid disorders. Maternal complications are as high as 67%. Prompt diagnosis is necessary in pregnancy to prevent maternal and fetal morbidity and mortality.

1.INTRODUCTION

Primary hyperparathyroidism with pregnancy is rare and most serious problem and is mostly caused by parathyroid adenoma. Maternal complications can be as high as 67%. We present a case of pregnant patient with hyperparathyroidism which mimicked as acute pancreatitis and preeclampsia. The complications due to hyperparathyroidism mimic common medical problems in pregnancy.

She was managed with Multidisciplinary involvement with hydration by parenteral fluids, antihypertensives and thyroid hormone replacement. Monitored daily with Sr calcium, electrolytes and phosphorus levels, Vitamin D3 6,000iu supplements and aspirin 75mg. She was administered betnesol for fetal lung maturity anticipating complication needing delivery any time. Patient was delivered by Emergency LSCS for raising Blood pressures.

2.CASE REPORT

A 27 year unbooked pregnant woman, second gravida with previous late pregnancy loss of 31 wks and 4 days period of gestation known case of hypothyroidism presented with diffuse pain and distension abdomen associated with vomiting, headache, shortness of breath since 5 days, she had hyperemesis and chronic hypertension in 2nd month and was on labetalol 100mg BD. Patient had hysterotomy for early onset of preeclampsia at 27 weeks period of gestation in her previous pregnancy. On examination she was anemic and restless with pain, edema was upto grade III, her pulse rate was increased and blood pressures were 150/90, neck examination revealed multinodular thyroid swelling. Abdomen was distended and tender with pfannenstiel scar and uterine size was difficult to makeout. Her blood parameters showed to be anemic (9.5%), hypothyroid (12.11 uIU/ml), Serum (Sr) calcium - increased (12.5 mg/dl), serum phosphorus 5.8 mg/dl, urine protein creatinine ratio mildly elevated (0.5), Sr Parathormone (PTH) - 10-30.3. All her liver parameters were normal except for LDH-1013 mg/dl. Ultrasound (USG) showed a cystic lesion in liver of 12x10cm with cholelithiasis and presence of bulky pancreas with thin rim of peripancreatic free fluid suggestive of acute pancreatic and bilateral medullary nephrocalcinosis with viable fetus of 32 weeks with increased liquor. USG of neck showed features of parathyroid adenoma which was confirmed by fine needle aspiration cytology. Positive findings going in favor of primary hyperparathyroidism

POSTPARTUM:

Pt underwent right hemithyroidectomy with parathyroidectomy

HPE: PARATHYROID ADENOMA, RIGHT INFERIOR POLE CAPSULAR INFILTRATION PRESENT.

3.DISCUSSION

Primary hyperparathyroidism has prevalence of 0.15%. Asymptomatic cases can be as high as 1.4%. (1). It is the third most common endocrine disorder and women are affected twice as often. (2,3)

First case of hyperparathyroidism in pregnancy was documented in 1931 by Hunter and Turnbull. (4,5)

Patients often have nonspecific complaints like diffuse abdominal discomfort and pain, hyperemesis. Calcium levels with 12mg/dL or more have nausea, vomiting, constipation, findings like end organ calcification. Calcium levels with 14mg/dL or more is rare and is a medical emergency and may go into coma or cardiac arrest. (1)

Hyperparathyroidism can cause hypertension and preeclampsia in pregnancy due to hypercalcemia. So calcium levels should be monitored daily and should be in controlled levels. (3) if not controlled then bisphosphonates should be considered.

Fetal complications can be prematurity, intra uterine growth restriction, low birth weight, fetal congenital anomalies and neonatal hypocalcemia. (1)

4.CONCLUSION

Treatment of hyperparathyroidism in pregnancy is very important as it causes maternal and fetal mortality and morbidity. It causes hypertension and preeclampsia and also causes end organ calcification, cholelithiasis.

As clinical features are non-specific, high index of suspicion is needed to avoid its adverse outcomes.

Investigations	Report
Serum calcium	12.5mg/dl
TSH	12.11 micro IU/ml
Serum phosphorus	5.8mg/dl
Vitamin D3	29.5
Parathormone (PTH)	10-30.3mg/dl
Sr.creatinine	0.6 mg/dl
Sr.alkaline phosphatase	153 IU/L

- Calcium levels should be monitored as a routine in all pregnancies.
- Plan for delivery should be done accordingly by the gestational age and severity of the condition.
- Parathyroidectomy should be considered at the earliest.

5. REFERENCES

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