



PHPT: Rare Cause for Progressive Shortening of a Finger

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Clinical Image

Bone involvement in primary hyperparathyroidism is typically characterized by salt-and-pepper appearance in the skull, bone erosions and bone resorption of the phalanges, brown tumors and cysts [1]. Here we report an unusual case of PHPT in a 25-year-old male presenting with history of bone pain, difficulty in walking and progressive shortening of index finger of left hand. X-ray of the left hand showed sub-periosteal bone resorption of proximal, middle and distal phalanges along with terminal tuft erosions (acro-osteolysis) (Figure 1). Biochemical evaluation revealed hypercalcemia (serum calcium 13.4 mg/dL), hypophosphatemia (phosphate 1.2 mg/dL), alkaline phosphatase 3529 IU/mL, intact parathyroid hormone (iPTH) 1412 pg/mL (reference range, 15-65 pg/mL), 25-hydroxyvitamin D 18.9 ng/mL, and serum creatinine 0.9 mg/dL. On enquiry, he had history of recurrent renal calculi with no significant family history. He had no history of pancreatitis. Based on the above findings, a diagnosis of Primary Hyperparathyroidism (PHPT) was made. To rule out syndromic association, serum prolactin was done which was within reference limits (5.05 ng/ml, reference range, 1.9 to 25 ng/ml). CT scan revealed right (1.0 cm × 0.7 cm) and left (2.1 cm × 1.7 cm) inferior parathyroid adenoma (Figure 2). Hypercalcemia was managed with IV fluids and diuretics. He underwent bilateral parathyroid adenectomy. Six hours post surgery PTH levels dropped down to 40.3 pg/ml. currently patient is managed on calcium and vitamin D supplements.

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Figure 1: X-ray hand showing sub-periosteal bone resorption of proximal, middle and distal phalanges (white arrows) and terminal tuft erosions (acro-osteolysis) (white arrowhead).

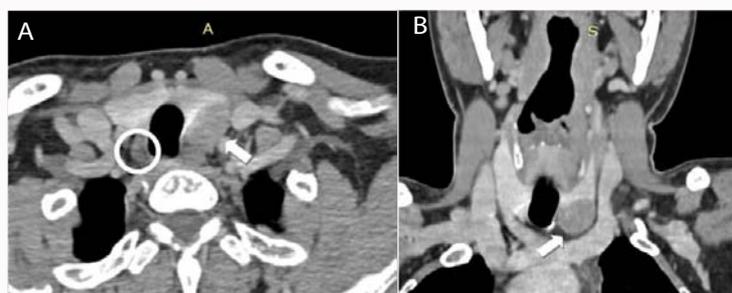


Figure 2: (A) CT Axial image shows a right (white circle) and left (white arrow) inferior parathyroid adenoma, (B) CT Coronal image shows a left inferior parathyroid adenoma (white arrow).

References

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