Hyperparathyroidism
- Primary hyperparathyroidism generally involves some degree of hypercalcaemia with an inappropriately high PTH level (not necessarily above the normal lab range) indicating autonomous PTH production. Primary hyperparathyroidism is a clinical and biochemical diagnosis – it is not aided by currently available parathyroid imaging.
- Secondary PTH elevation is most commonly due to vitamin D deficiency, hypocalcaemia or renal failure and involves a normal response of the parathyroid glands to a physiological stimulus - it does not indicate any abnormality in the parathyroid glands themselves.

Information Required
- Presence of Red Flags
- Duration of symptoms
- Associated symptoms
- Past medical and family history
- Current drug therapy (and previous lithium use)

Investigations Required
- Total and corrected serum calcium – repeat fasting if borderline
- Serum PTH, PO4, ALP and 25OH vitamin D, creatinine
- Second void fasting morning spot urine for calcium and creatinine

Investigations not Required
- Parathyroid imaging (US, nuclear scanning, CT) should not be performed – these tests are insensitive, do not aid diagnosis and are only useful in guiding the type of surgery once a decision has been made to operate

Fax Referrals to
Flinders Medical Centre 8204 8960
Repatriation General Hospital 8374 2591
Noarlunga Hospital 8384 9711

Red Flags
- Nausea, vomiting, dehydration, weight loss or diminished conscious state
- Corrected serum calcium >3 mmol/L
- Rapid renal function deterioration
- Recurrent renal calculi
- Pancreatitis

Suggested GP Management
- Ensure hypercalcaemia is real by using corrected serum calcium
- Cease potential exacerbating drugs (eg thiazides, calcitriol – lithium if safe to do so)
- Maintain hydration

Clinical Resources

General Information to assist with referrals and the and Referral templates for FMC and RGH are available to download from the SALHN Outpatient Services website [www.sahealth.sa.gov.au/SALHNoutpatients](http://www.sahealth.sa.gov.au/SALHNoutpatients)