A 50 year old man presented with hypertension for the last ten years. The patient was on medication but had inadequate control of blood pressure. He was otherwise asymptomatic except for some vague complaints of body ache and occasional abdominal pain that was largely overlooked so far. On examination, he had average build, weight 55 kg. B P was 150/90 mm Hg. Examination of respiratory, neurological, and gastrointestinal systems were essentially normal.

Investigations revealed a normal complete hemogram, blood urea 34 mg/dl, creatinine 1.5 mg/dl, fasting blood sugar 87 mg/dl, serum sodium 139 mg/l, potassium 3.8 meq/l. USG KUB showed calcifications in the pyramids of both kidneys. Kidney size and cortical echo pattern as well as thickness were normal. The detection of renal calcifications prompted us to perform serum calcium, phosphate and magnesium. The results were 11 mg/dl, 3.3 mg/dl and 3.8 mg/dl respectively. 24 hour urinary calcium was 480 mg/day (normal < 300mg/day). Immediately serum parathyroid level was sent for and it came out to be 234.2 pg/ml (15-65 pg/ml).

Tc 99m sestamibi subtraction scan showed focal uptake of radiotracer just distal to the inferior pole of the left lobe of thyroid gland consistent with a left inferior parathyroid adenoma. He underwent surgical excision after which he is doing well on one drug.
and catecholamines were found to be normal [1]. Endothelial dysfunction with decreased NO, stiffness of great arteries, and increased responsiveness to vasoconstrictors and TGF B1 have been put forward as hypotheses [5–7].

However it has been documented that simple surgery of adenoma leads to control of BP which was also demonstrated in our case.

Figure 1: Photograph shows Tc99m sestamibi subtraction scan revealing focal increased uptake just distal to the inferior pole of the left lobe of thyroid gland consistent with an inferior parathyroid adenoma.

References


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