

INSOO SUH: Hopefully, I can share with you some interesting data about a disease that doesn't gather as much press, but is important, nonetheless, and is relatively common. I have no relevant disclosures.

Just a introduction into what we do-- what is endocrine surgery? It's a field that really became bigger in the past 30 years, ever since pioneers, like our Orlo Clark-- the big tall man in the center-- had pioneered the field. The diseases that we treat are surgical conditions of endocrine organs-- things that make hormones. So the thyroid, in particular, a parathyroid as well, adrenal glands, and then the endocrine functions of the pancreas are things that we specialize in.

Now, typically, the diseases that we treat are, with respect to gender, equal opportunity. We see men and women of somewhat equal proportions for a lot of these disorders. But many of the conditions specifically have gender predilections, both with respect to frequency as well as the ways in which it presents. And one of them happens to be the topic for today. So we'll get to that.

So this is sort of the typical primary care scenario, in which a parathyroid related patient would present. I'm sure that many of folks that are involved in primary care environments may recognize this type of woman-- 60-year-old, postmenopausal, routine checkup, past medical history-- fairly routine. You know, a little bit of hypertension, hyperlipidemia.

But on review of systems, she's starting to tell you a few things. You know, she's starting to get a little bit more fatigued. She almost feels as if things are slowing down a bit-- you know, a little bit of memory deficits maybe, can't really concentrate as well as she used to on her puzzles, things like that.

You get some routine labs-- as usual, it's the CBC, chem panel, things like that. And that usually contains a calcium level. And that comes back mildly elevated at 10.8.

Oh, by the way, there may be some handouts. The slides are slightly different. So apologize in advance. But most of them are the same.

And then the enterprising primary care doc will think, well, you know, parathyroids may have something to do with calcium. So let's just check a parathyroid hormone, or PTH level. And

that also comes back slightly higher than the normal range. Vitamin D levels, which are tied into calcium, is normal.

So this is a typical scenario, where you're going to be confirming a diagnosis of primary hyperparathyroidism-- an elevated calcium with an inappropriately elevated PTH. And I'll get to that in a second as well.

So what does all of this mean? What are the implications of this? Are there long-term consequences of carrying this diagnosis? Is there something we can do about it?

And lastly, in particular for our audience for today, are there any unique aspects when it presents in female patients as opposed to men? And are there different things that we can offer for our female patients as well?

So our agenda-- hopefully, we'll answer a few of these, if not maybe more. We'll go over a little bit of background disease presentation, the workup, indications for treatment of primary hyperparathyroidism, imaging considerations, and surgical considerations, with maybe a gross picture here and there, and then a special scenario that we can talk about a bit more-- pregnancy and primary hyperparathyroidism existing concurrently.