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Editorial

Primary Hyperparathyroidism has Progressed in Terms of Diagnosis and Treatment

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EDITORIAL

The parathyroid glands, one of the last organs to be identified, are in charge of calcium homeostasis, and they continue to present diagnostic and therapeutic issues to clinicians, which are discussed below. The great majority of parathyroid gland pathology is caused by Primary Hyperparathyroidism (PHPT). The typical variety of PHPT, characterised by high calcium and parathyroid hormone levels, has been extensively investigated, but recent research has added to our knowledge of normocalcemic and normohormonal variations of PHPT, as well as syndromic forms of PHPT. Although the majority of PHPT today is asymptomatic, all variations can cause bone loss, kidney stones, deteriorating renal function, and a variety of neuropsychological, gastrointestinal, and musculoskeletal problems. Surgery is still the only treatment for PHPT, and developments in screening, shifting surgical indications, novel imaging modalities, and intra-operative procedures have drastically altered the picture. In the hands of a skilled parathyroid surgeon, surgery continues to yield great results. Patients who are not surgical candidates can benefit from therapeutic breakthroughs in medical therapy to better control their hypercalcemia. The diagnosis of parathyroid carcinoma is frequently made intra-operatively or on final pathology, and recurrence is common. Normalization of serum calcium via surgery and medical adjuncts is the mainstay of treatment.

The great majority of pathology related with the parathyroid glands, which regulate calcium homeostasis by secreting Parathyroid Hormone (PTH), is caused by Primary Hyperparathyroidism (PHPT), which will be the focus of this editorial. Our understanding of this disease and its more appropriate variations has advanced dramatically. Bisphosphonates have taken the place of hydration and loop diuretics in the treatment of hypercalcemia. Furthermore, modifications in surgical management criteria, as well as advances in preoperative and intraoperative localization modalities and less invasive techniques, have altered the surgical landscape. The goal of this editorial is to highlight these developments and offer doctors with the most up-to-date information on how to treat hypercalcemia caused by excessive PTH secretion.

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