Emergency management of acute hypercalcaemia in adult patients
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Introduction

Under physiological conditions, serum calcium concentration is tightly regulated. Abnormalities of parathyroid function, bone resorption, renal calcium reabsorption or dihydroxylation of vitamin D may cause regulatory mechanisms to fail and serum calcium to rise. Serum calcium is bound to albumin, and measurements should be adjusted for serum albumin. This guideline aims to take the non-specialist through the initial phase of assessment and management.

Severity of hypercalcaemia

- <3.0 mmol/L: often asymptomatic and does not usually require urgent correction
- 3.0–3.5 mmol/L: may be well tolerated if it has risen slowly, but may be symptomatic and prompt treatment is usually indicated
- >3.5 mmol/L: requires urgent correction due to the risk of dysrhythmia and coma

Clinical features of hypercalcaemia

- Polyuria and thirst
- Anorexia, nausea and constipation
- Mood disturbance, cognitive dysfunction, confusion and coma
- Renal impairment
- Shortened QT interval and dysrhythmias
- Nephrolithiasis, nephrocalcinosis
- Pancreatitis
- Peptic ulceration
- Hypertension, cardiomyopathy
- Muscle weakness
- Band keratopathy

Causes

Ninety percent of hypercalcaemia is due to primary hyperparathyroidism or malignancy

Less common causes include

- Thiazide diuretics
- Familial hypocalciuric hypercalcaemia
- Non-malignant granulomatous disease
- Thyrotoxicosis
- Tertiary hyperparathyroidism
- Hypervitaminosis D
- Rhabdomyolysis
- Lithium
- Immobilisation
- Adrenal insufficiency
- Milk-alkali syndrome
- Hypervitaminosis A
- Theophylline toxicity
- Phaeochromocytoma
Emergency Guidance

J Walsh et al.

Acute hypercalcaemia

G10–G11

5:G10

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Emergency guidance

G10–G11

5:G10

Endocrine Connections

Investigation

History

– Symptoms of hypercalcaemia and duration
– Symptoms of underlying causes, e.g. weight loss, night
  sweats, cough
– Family history
– Drugs including supplements and over-the-counter
  preparations

Examination

– Assess for cognitive impairment
– Fluid balance status
– For underlying causes, including neck, respiratory,
  abdomen, breasts, lymph nodes

ECG

– Look for shortened QT interval or other conduction
  abnormalities

Bloods

– Calcium adjusted for albumin
– Phosphate
– PTH
– Urea and electrolytes

If further treatment required after intravenous saline, consider intravenous bisphosphonates

Zoledronic acid 4mg over 15min

OR Pamidronate 30–90mg (depending on severity of hypercalcaemia) at 20mg/h

OR Iblandronic acid 2–4mg

– Give more slowly and consider dose reduction in renal
  impairment
– Monitor serum calcium response: will reach nadir at
  2–4days
– Can cause hypocalcaemia if vitamin D deficiency or
  suppressed PTH

Second-line treatments

Glucocorticoids (inhibit 1,25OHD production)

– In lymphoma, other granulomatous diseases or 25OHD
  poisoning
– Prednisolone 40mg daily
– Usually effective in 2–4days

Calcimimetics, denosumab, calcitonin

– Under specialist supervision
– Can be considered if poor response to other
  measures

Parathyroidectomy

– Can be considered in acute presentation of primary
  hyperparathyroidism if severe hypercalcaemia and
  poor response to other measures

Management

Rehydration

Intravenous 0.9% saline 4–6L in 24h

– Monitor for fluid overload if renal impairment
  or elderly
– Loop diuretics rarely used and only if fluid overload
  develops; not effective for reducing serum calcium
– May need to consider dialysis if severe renal failure

Sources

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Disclaimer

The document should be considered as a guideline only; it is not intended
to determine an absolute standard of medical care. The doctors concerned
must make the management plan for an individual patient.

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G11–G11


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