Introduction

A single glandular adenoma or hyperplasia are the most frequent cause of primary hyperparathyroidism (PHPT). It is rarely caused by hyperfunctioning carcinoma, that accounts for 0.5% up to 5% of the patients with PHPT. A pre-operative diagnosis is difficult, and many features of malignancy are discussed. The first case was described over 60 years ago, but because of its rarity is difficult to establish clinical, histopathological and radiologic criteria of malignancy. Most of PC are hyperfunctioning, with marked serum PTH levels; a palpable mass also suggest malignancy. Surgical approach of PC is the gold standard treatment, with en
Parathyroid cancer as rare cause of primary hyperparathyroidism. Case report and review of the literature

bloc resection of pathologic parathyroid gland, ipsilateral thyroid lobe and muscles.

Local recurrence occurs in up to 30%, in the primary site rather than in distant ones, and can be treated with a palliative surgical reexploration.

Chemotherapy and radiotherapy are not able to control local recurrence or distant metastases.

Case report

Clinical features and diagnostic work-up

A 52 years-old female was referred to us in October 2006 with a diagnosis of primary hyperparathyroidism (PHPT) and a single parathyroid gland mass, suspicious for adenoma. The patient complained of profound asthenia at the legs over the past 2 years. About 3 months before, she had suffered of dysphonia and sense of obstruction in the throat, bone pain and demineralization.

Ultrasonography of the neck showed an asymmetry of the thyroid gland with marked prevalence of the right lobe, and dishomogeneous structure. Close to the upper third of the right lobe there was an hypoecogenous nodule, with regular and clear borders, sized of 28x16 mm. Ecocolor-Doppler fluximetry showed widespread intensity of blood flux around and inside the nodule (Pattern III). Also there were other little thyroid nodules. A fine needle agobiopsy (FNAB) was made on this nodule, with result C3 (stripes and microcyoincluded of microfollicular nodule with anisokariosis and solid-trabecular architectural pattern). Immunohemistry reaction was focally positive for galectyn 3. Laboratory tests showed marked hypercalcemia (13.9 mg/dL, range 8.05-10.1), hypophosphoremia (1.9 mg/dL, range 2.5-4.9), elevated blood levels of PTH (798 pg/mL, range 6.4-52) and serum alkaline phosphatase levels (803 u/L, range 50-136). Blood levels of thyroid hormones were normal. At physical examination a palpable mass in the right side of the neck was evident, and dysphonia was also perceptible.

A laryngoscopic exam revealed lower motility of the right vocal cord. Endocrinologic evaluation confirmed the diagnosis of PHPT. To make clear on the thyroid and parathyroid disease, a scintigraphy with 99mTc-Sestamibi (740 MBq) and 99mTcO4 (110 MBq) was made. The result was that thyroid gland was normal for site, size and symmetry of the lobes. Scintigraphy with 99mTc-Sestamibi showed a fixation area in the upper third of the right lobe after 20 min.; after 2 hours this fixation area persisted in the same site. The digital removal image confirmed the presence of selective fixation of the lipofilic cation in the upper third of the right thyroid lobe (Fig. 2). The scintigraphic diagnosis was of hyperfunctioning right upper parathyroid gland. The right upper parathyroid excision was the treatment of choice. Clinical and pre-operative conditions of the patient were good, and anesthesiological risk was ASA II.

Surgical treatment

With the patient in supine position and extended neck, a Kocher incision was made. At a first examination, behind the thyroid right lobe there was a parathyroid mass. After a careful dissection, an avascular split layer was found between thyroid and upper parathyroid, that was easily isolated. This gland was brownish and increased in consistence. The lower right parathyroid, appeared normal. The right thyroid lobe was thin, compressed by the enlarged parathyroid. After laryngeal recurrent nerve identification, the right upper parathyroidectomy was performed.

Post-operative outcome was regular. In the 1st post-operative day,
blood level of parathormone resulted in 6.4 pg/mL (range 6.4-52); calceinia was 9.5 mg/dL (range 8-10.5). Although normal values of calceinia, the patient had hypocalcemic crisis with swarming and tetanic contraction of the hands, quickly resolved with e.v. calcium gluconate; then, we decided to give oral calcium (1 g/tid) and calcitriol (0.25 mcg/bid) even with normal calceinia, until the symptoms were resolved. These symptoms became slighter and slighter, until disappearing after 10 days.

An endocrinologic evaluation was repeated, and these unexpected symptoms were attributed to the "hungry bone syndrome". The only therapy was oral administration of calcium until symptom's complete resolution. The day after parathyroidectomy, the voice improved.

The patient was discharged in good conditions, and got oral administration of calcium and calcitriol, step by step reduced, based on level of calceinia.

**Pathology**

At histological grossly examination, the nodule appeared yellow-brownish, weight 5.00 grams, diameters 28x20x15 mm. At section, there were two white-greyish areas, with vanished borders, diameters 15 and 13 mm.

The diagnosis after microscopic examination was of chief cells parathyroid carcinoma, with endovascular permeation; resection margins were clear from disease. Immuno-hystochemistry tests revealed positiveness of the neoplastic cells for parathormone.

**Follow-up**

After 3 months, the patient underwent an ultrasonography of the neck, which revealed hyperecogenous signal behind the right thyroid lobe, referable to cicatricial results, and no pathologic laterocervical lymphnodes. PTH blood level was high, 101 pg/mL (range 6.4-52). Then, the patient underwent a scintigraphy with 99mTc-Sestamibi (370 MBq) and 99mTcO4 (148 MBq), which revealed an hypofunctional right thyroid lobe referable to cicatricial results, and the absence of hyperfunctioning parathyroid tissue. Voice quickly improved by logopedic exercises. After 6 months PTH levels were normal, as ultrasonography too.

A careful follow-up was performed every three months. After 2 years, the patient is in good conditions and laboratory tests continue to reveal normal values of serum PTH. Ultrasonographic examination of the neck is normal too, without recurrence of disease and pathologic laterocervical lymph nodes. The patient get oral administration of levotiroxin 50 mcg/die because of hypofunctioning thyroid nodules.

**Discussion**

Primary hyperparathyroidism (PHPT) is frequently caused by a single adenoma or hyperplasia, rarely by carcinoma, and affects more frequently women in their 4th - 5th decades of life (1). Parathyroid cancer (PC) is a rare endocrine malignancy, commonly hyperfunctioning, accounting for 0.5% up to 5% of the patients with primary hyperparathyroidism (PHPT) (2). Diagnosis of PC is not easy, infact 86% of the patients with PHPT receive no pre-operative or intra-operative diagnosis of malignancy (3, 4). There are no sexual differences in patients with PC, despite the female predominance of benign PHPT, but patients with PC are 10 years younger than those with benign PHPT. Most of PC are hyperfunctioning, with marked serum PTH levels, and symptoms occurs more frequently than in benign disease (5).

The first case was described by Armstrong over 60 years ago (6), but because of its rarity, although there are many studies which try to establish clinical, histopathological and radiologic criteria of malignancy, pre-operative diagnosis of PC is difficult. The results of these studies are doubtful and not always useful to allow an accurate pre-operative diagnosis of PC.

Surgical approach of PC is the current gold standard treatment, with en bloc resection of parathyroid gland, ipsilateral thyroid lobe and muscles. Histofeatures for malignancy were proposed by Schantz and Castlman (7) (Tab. 1): local invasion of contiguous structures, nodal or distant metastases, capsular or vascular invasion, fibrous trabeculae, high mitotic pattern.

Clinical findings for pre-operative suspicious of PC are: laryngeal recurrent nerve palsy, palpable mass, tumor size>3cm, calcium>14mg/dL, severe hyperparathyroidism, elevated levels of alkaline phosphatise (6). Intra-operative findings for malignancy are: local infiltration, greyish color, firm mass. Pre-operative imaging
study with ultrasonography, Tc99m-sestamibi scintigraphy and CT scan can’t make differential diagnosis between benign disease or malignancy. Tc99m-sestamibi scintigraphy is the most sensitive imaging modality used for localizing abnormal parathyroid tissue, with an accuracy of 90% (5). Sestamibi is a lipophilic cation that accumulates almost exclusively in the mitochondria; the oxyphil cells have an intensely eosinophilic cytoplasm rich of mitochondria. Principal cells are the active endocrine cells, with slight eosinophilic cytoplasm containing few mitochondria. A positive sestamibi scan is more frequent in adenomas rich in oxyphil cells than in predominance of chief cells (8). In absence of metastatic disease, it is difficult to establish a pre-operative diagnosis of PC. Agarwal et al. (9) examined prospectively 100 patients with PHPT, finding only 4 cases of PC. Clinical, biochemical, radiological and pathological features were examined, but there were no significantly differences among adenoma, hyperplasia and carcinoma. Only the tumor/PTG (parathyroid total gland) weight (mg) in patients with carcinoma (15,080 ± 5,638) was significantly higher when compared with adenoma (10,040 ± 2,568). At histological examination, all the PC presented at least two histological criteria for malignancy, and a mean size of 2.18 cm, lower than the one proposed for malignancy; all cases had signs of vascular or capsular invasion and mitotic pattern was high in 50%.

PC should be considered for differential diagnosis in asymptomatic PHPT, but the absence of severe hypercalcemia and symptoms should not rule out PC. Intra-operative frozen section with finding of high mitotic pattern will suggest the diagnosis, but surgical examination is very important for a radical or conservative treatment. Local recurrence occurs in up to 30%, in the primary site rather than in distant ones, but can be treated with a palliative surgical reexploration. However, Cohn et al. (11) demonstrated that not all patients need a prophylactic radical neck dissection, because there is no improvement in survival rate and morbidity. Hundahl et al. (4) demonstrated that in 286 cases of PC, only 15.2% of the patients that underwent lymph nodes dissection had metastases at the first excision, while 32% had metastases at reexploration; than, lymphnodal dissection is recommended only in cases of evident lymphnodal metastases. Pelizzo et al. (2) also confirmed a low rate of lymphnodal metastases at first surgery and reexploration.

A new challenge is the genetic screening; there isn’t a specific gene involved in the cancerogenesis of PC, but in sporadic cases of PC there is mutation of HRPT2 gene(12). About the follow-up, for hyperfunctioning PC biochemical markers (S-Ca, PTH) are more important than image techniques (ultrasonography, Scintigraphy, CT scan) (2, 5). Survival rate at 5 and 10 years is variable, 35-85.5% (2, 13). Chemotherapy and radiotherapy are not able to control local recurrence or distant metastases (2, 5).

Conclusions

We reported this case of parathyroid cancer because it’s a rare neoplasm and because as described by other authors we had some difficulties to make diagnosis of malignancy. According to the literature, we think that the cure of the parathyroid cancer is difficult to achie-
ve. After two years of follow up the patient is in good conditions and has no evidence of disease. Besides, recurrence is the natural cancer history.

The aim of our careful follow up is to diagnose the local recurrence of disease so that we can perform a second surgical treatment, to achieve, the control of the hypercalcemia, which causes following diseases and death.

References