Obstructed labour due to parathyroid adenoma in pregnancy

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A 42 years old Mrs. S., $G_8 P_6 A_1 L_3$ presented to casualty of M.A.M. College on 27.12.96 with amenorrhoea 9 months and labour pain for the last 12 hours. She was immobilised due to deformities of both lower limbs for the last 2 years. There was no pregnancy complication in this pregnancy. The patient had history of pathological fractures of right tibia and femur 2 years back which resulted in malunion and deformity. She was incompletely investigated for these pathological fractures when biochemical parameters were normal and X-rays showed fractures and multiple osteolytic lesions, FNAC from which showed giant cells raising suspicion of haemotological malignancy or para-thyroid adenoma. However patient stopped attending any hospital after this and reported as an emergency obstetric admission. On admission, patient was cachexic, febrile, BP - 140/120, deformities in both lower limbs and crowded rib cage. There was swelling in the neck. P/A exam showed term foetus with cephalic presentation and head 4/5th above the brim with moderate uterine activity and good foetal heart. On PV exam.Cx was fully dilated, Vx at -3, caput and moulding +, SP easily tipped with DC-10 cm, right sacral wall convergent, both IS prominent and TDO 3½ K.

The patient was taken for LSCS with sterilisation with diagnosis of obstructed labour due to asymmetrically contracted pelvis and male baby weighing 2.5 kg was delivered. Baby died after 36 hours due to HIE and seizures. After 48 hours, skeletal survey of the patient was done on surgeons advice which showed generalised osteoporosis and multiple fractures (including pelvis) suggesting possibility of parathyroid adenoma. USG neck detected adenoma 3 x 2 cm near inferior pole of right lobe of thyroid. Though serum Ca was normal, PO_4 was decreased and parathyroid hormone levels were abnormally increased (376 pg/ml). Surgical removal of parathyroid adenoma was done on 7.2.96 and histopathology confirmed the diagnosis of chief cell adenoma of parathyroid gland. Patient tolerated the procedure well and was improving at one month follow up.

About 100 cases of primary hyperparathyroidism in pregnancy are reported in literature of which 80% are due to parathyroid adenoma. Symptoms are nonspecific like GIT upset, bone pains except in severe cases of renal and bone involvement as in this case.

Parathyroid adenoma in pregnancy is associated with 45% perinatal complication rate (Shangold) like prematurity, still births, neonatal deaths and neonatal tetany which are well documented in literature. However pathological fractures and osteoporosis leading to asymmetric pelvis causing obstructed labour is not yet recorded in literature and prompted us to report this case.