BÖLÜM
14

ASEMPTOMATİK PRİMER HİPERPARATİROİDİ

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Giriş

Primer hiperparatiroidi (PHPT) klinik olarak üç farklı fenotipte karşımıza çıkabilir. Bunlar hedef organ tutulumlarının, yani esas olarak renal ve iskelet tutulumlarının olduğu klasik PHPT, hafif asemptomatik PHPT ve serum kalsiyum değerlerinin normal paratiroid hormon (PTH) seviyelerinin yüksek olduğu normokalsemik PHPT'dir (1). Asemptomatik PHPT, biyokimyasal olarak PHPT varlığına karşın hiperkalsemi veya PTH yüksekliği ile ilişkili belirti ve bulguları olmayan hastaları tanımlamak için kullanılmaktadır (1). Literatürde ve kılavuzlarda semptomatik/asemptomatik PHPT tanımı net olarak yapılmamış olsa da kemik kırığı, nefrolitiazis hikayesi veya varlığı, osteoporoz, ciddi kemik ve eklem ağrıları, belirgin nöropsikiyatrik bozukluk veya hiperkalsemi bulguları ile başvuran hastalar semptomatik kabul edilir (2). Bazı asemptomatik PHPT'li hastalarda da hiperkalsiüri, nefrolitiazis veya osteoporoz gibi bulgular saptanabilir ancak hastalar semptomatik değildir.

Asemptomatik PHPT, klasik PHPT'nin daha hafif bir formu olarak görülebilir. Bu nedenle "hafif" ve "asemptomatik" PHPT terimleri sıklıkla birbirlerinin yerine kullanılmaktadır (3). Bununla birlikte ilk defa 2015 yılında İtalyan Endokrinoloji Derneği tarafından yayımlanan uzlaşı kararlarında da bu iki durum birbirinden net olarak ayrılmış, asemptomatik PHPT "hiperkalsemi ya da PTH fazlalığıyla ilişkili klinik semptom ve bulguların olmaması", hafif PHPT ise "uluslararası kılavuzlar tarafından belirlenen cerrahi kriterleri taşımayan asemptomatik hastaların hastalığı" olarak tanımlanmıştır (4). Ancak bu ayrım henüz tüm dünyada yaygın kabul görmemiştir ve sık kullanılmamaktadır. Asemptomatik PHPT'li birçok hastada cerrahi tedavi yapılmasını gerektiren kriterler olmadığından cerrahi yapılmadan takip edilirler (5). Bununla birlikte bu hastaların bazılarının zamanla semptomatik hale geldiği ve cerrahi gerekebileceği bilinmelidir. Her ne kadar asemptomatik olarak adlandırılsa da daha ayrıntılı bir araştırma ile bu hastaların da önemli bir kısmında hem azalmış kemik mineral yoğunluğu (KMY) ve nefrolitiazis gibi tipik, hem de gastrointestinal, kardiyovasküler bulgular, halsizlik, güçsüzlük, iştahsızlık, hafif kognitif ve nöromüsküler fonksiyon kaybı, yaşam

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arasında en çok çalışılmış olandır (1,88). Cerrahi istemeyen ya da yapılamayan PHPT'li hastalarda t skoru -2.5 veya altında veya frajilite kırığı varsa antirezorbtif tedavi verilmelidir (10).

Postmenopozal kadınlarda östrojen replasmanı serum kalsiyumun normal seyretmesini sağlayabilir ve kemik kaybını azaltabilir (89). Ek olarak hem östrojen replasman tedavinin hem de bir selektif östrojen reseptör modülatörü olan raloksifenin kemik döngü belirteçlerini azalttığı gösterilmiştir (90,91).

Bir kalsiyum duyarlı reseptör agonisti olan sinakalset, kalsimimetik etki gösterir ve özellikle cerrahi ile tedavi edilemeyen PHPT'li ve paratiroid kanserli hastalarda kalsiyum düzeylerini düşürmekte yardımcı olabilir. PHPT'li 78 hastanın alındığı ve sinakalset ile plasebonun karşılaştırıldığı bir çalışmada sinakalset grubunun %73'ünde, plasebo grubunun ise sadece %5'inde normokalsemi sağlanmıştır (92). Sinakalsetin 5 yıla kadar verildiği uzun dönemli çalışmalarda da ciddi hastalığı olanlarda dahi kalsiyum seviyelerini kontrol edebildiği görülmüştür (7). Sinakalset PTH seviyelerinde bir miktar düşüklük sağlayabilir ancak KMY üzerine etkisi yoktur (10,92). Günümüzde sinakalset, cerrahi ile kontrol altına alınamayan veya cerrahinin kontrendike olduğu hastalarda ve rezeke edilemeyen paratiroid kanserli hastalarda etkin bir yöntem gibi görünmektedir.

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