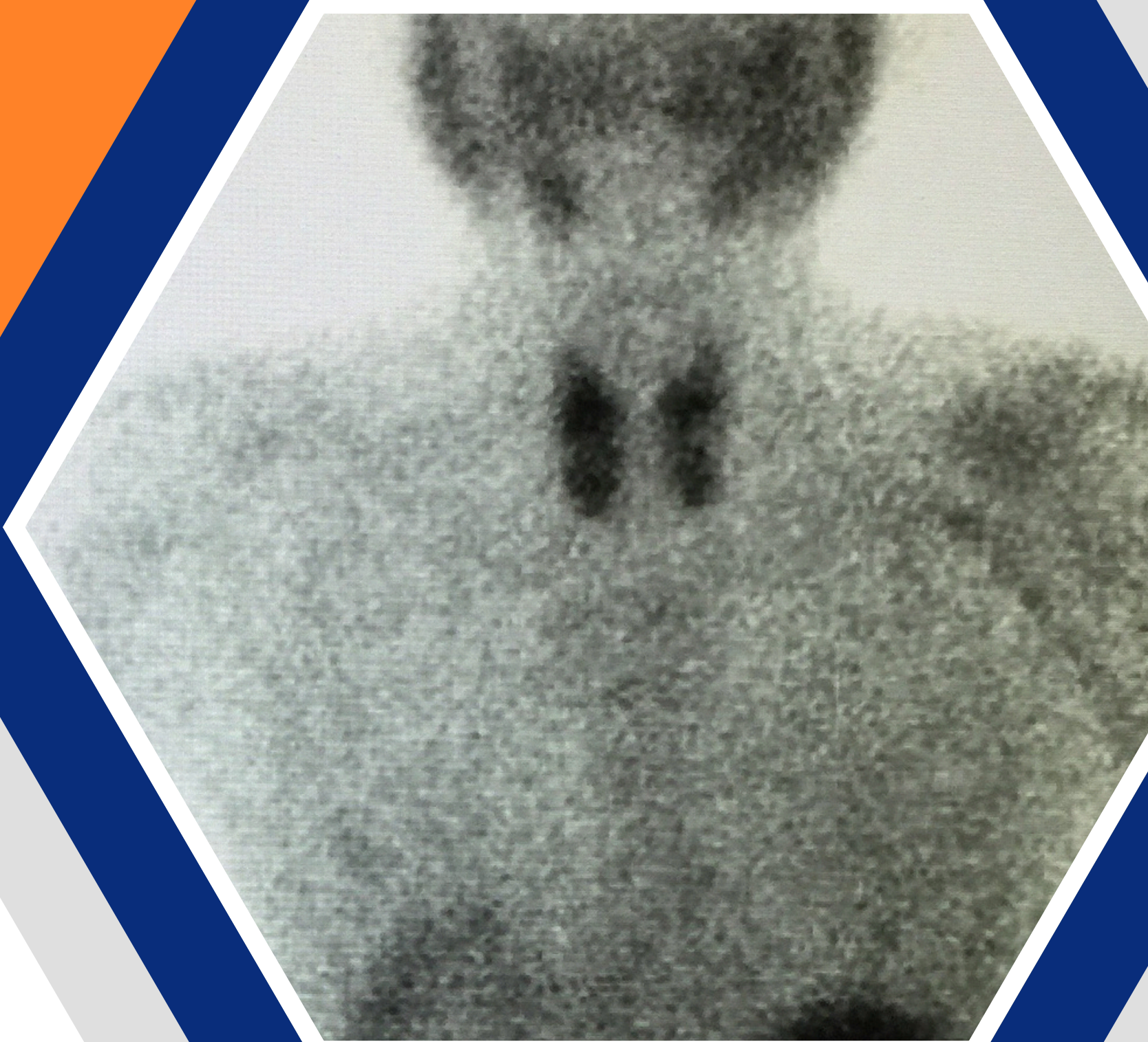


HYPERPARATHYROIDISM

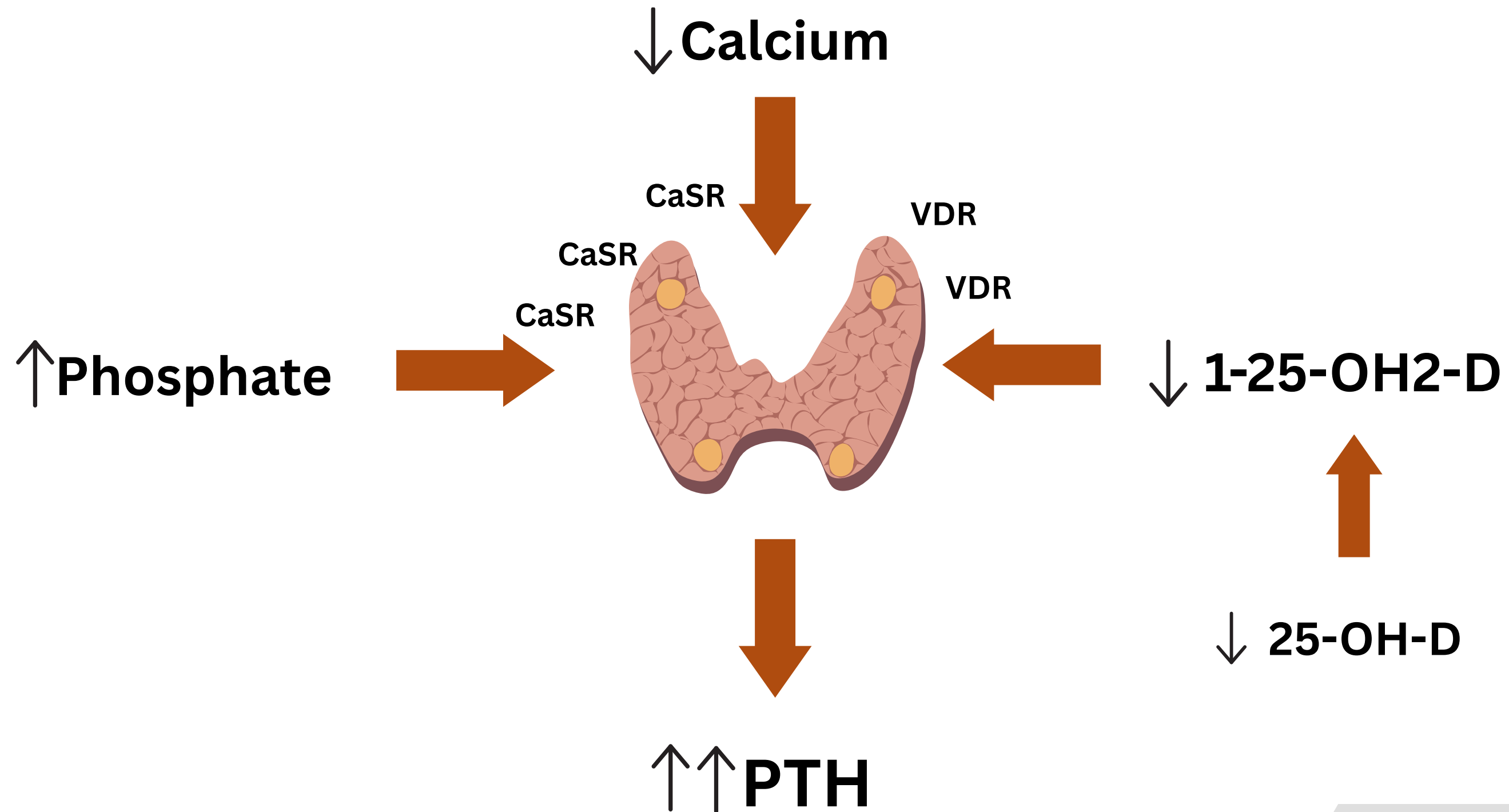
NUTRITION IMPAIRMENT

Sinee Disthabanchong

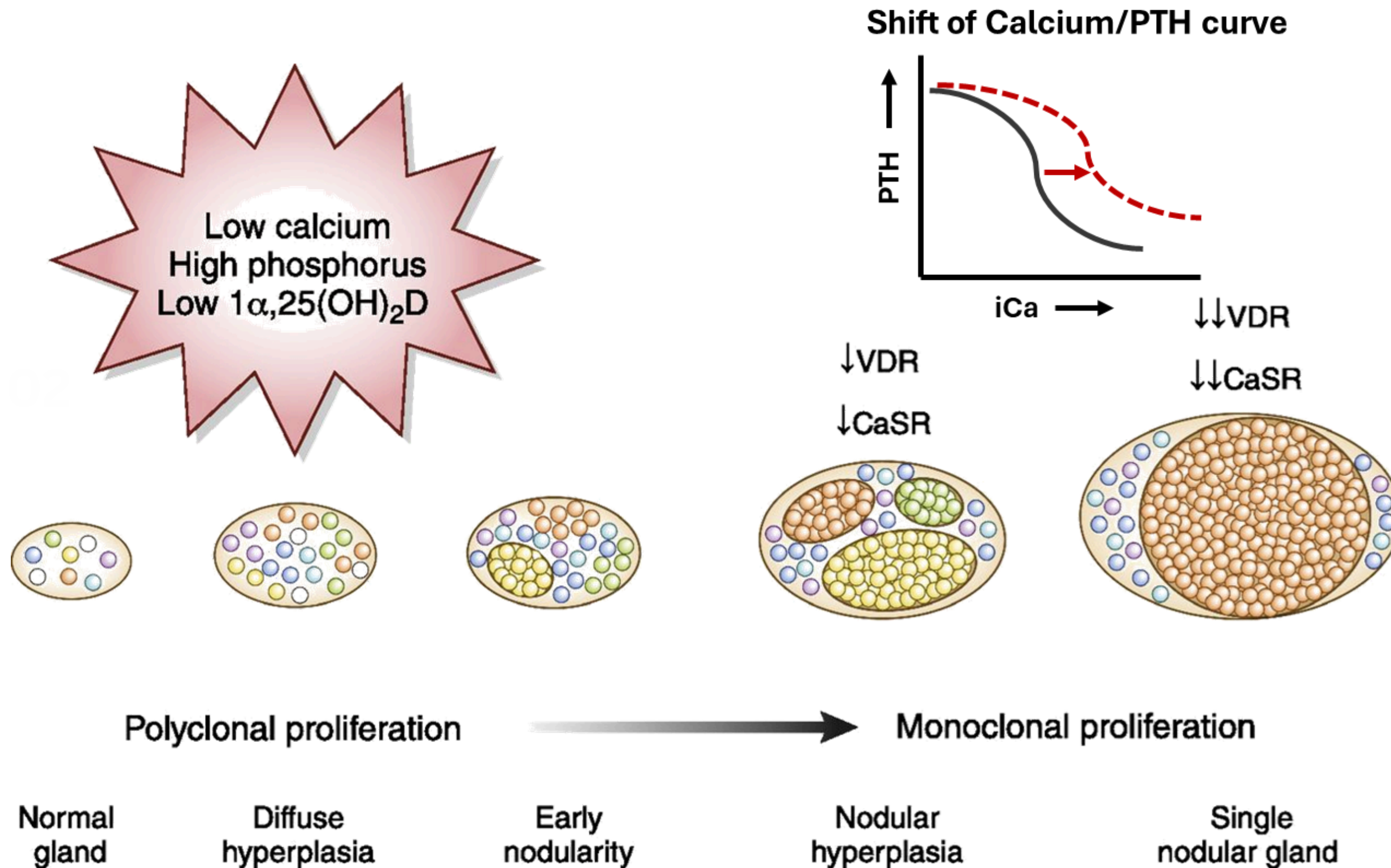
Faculty of Medicine, Ramathibodi Hospital
Mahidol University, Bangkok, Thailand



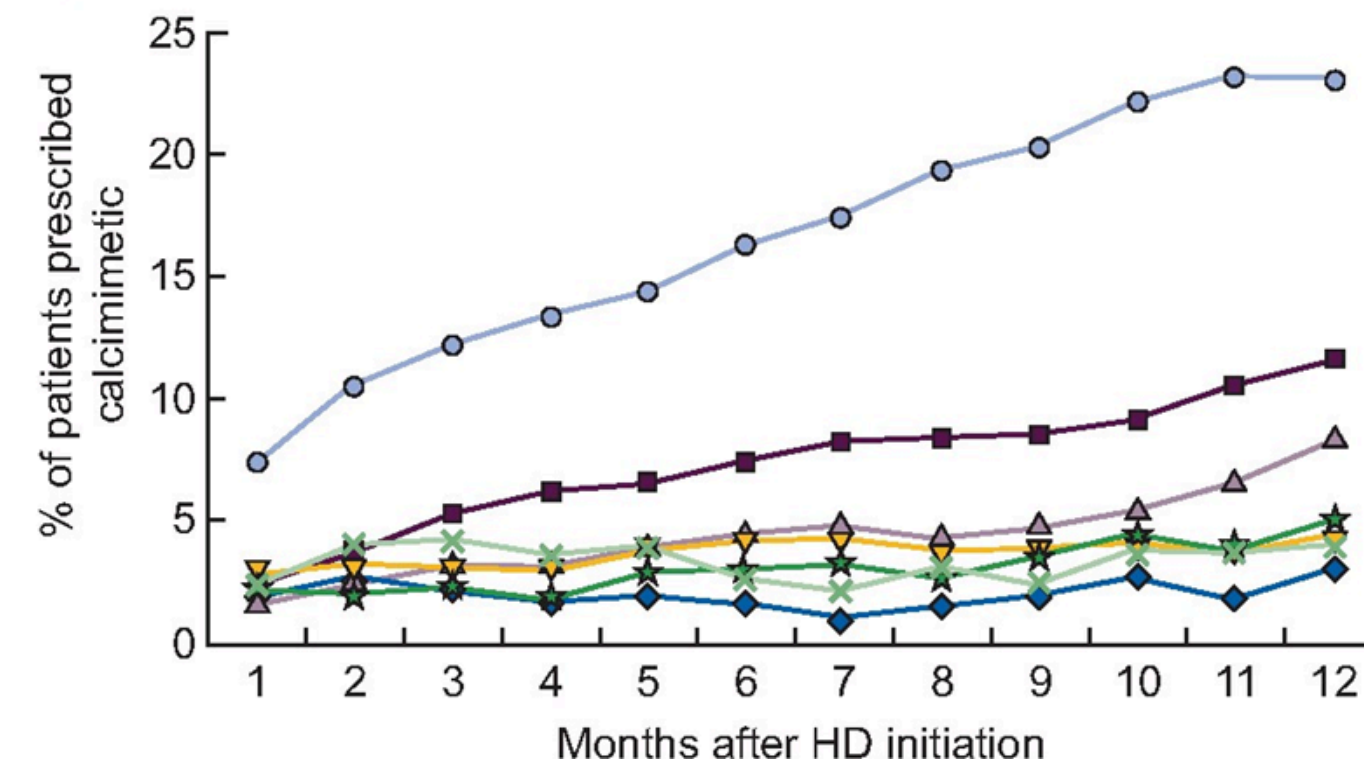
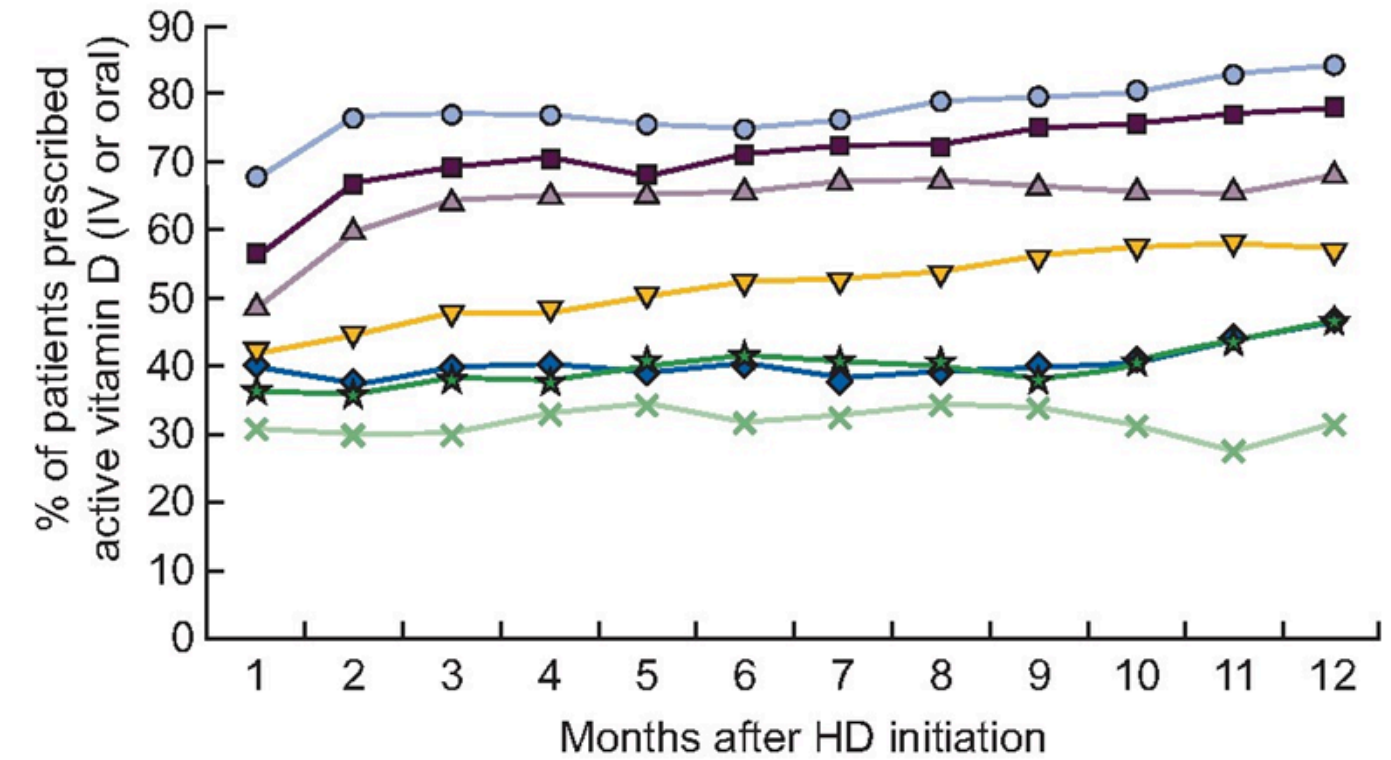
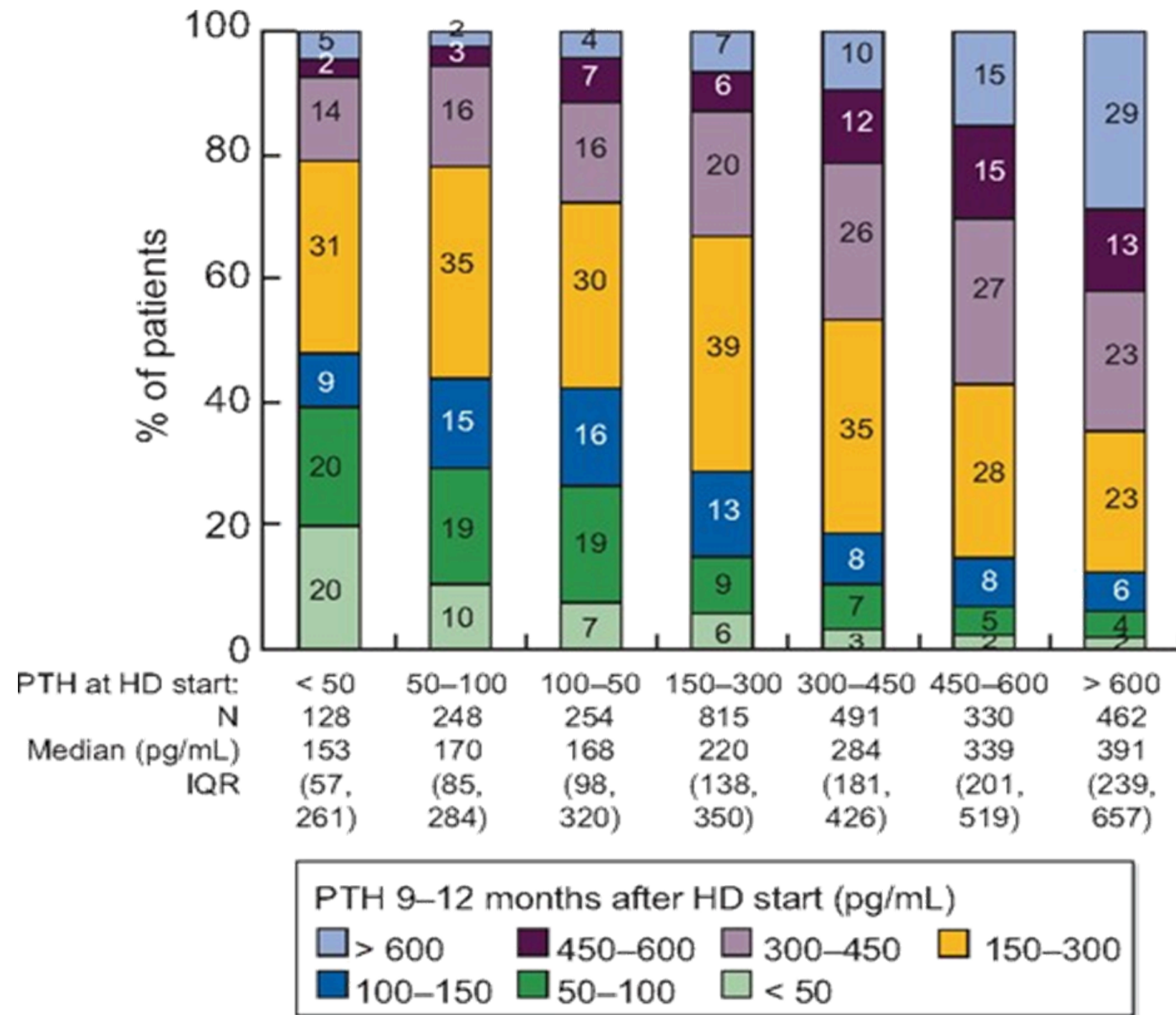
REGULATORS OF PTH SECRETION



PROGRESSION OF HYPERPARATHYROIDISM



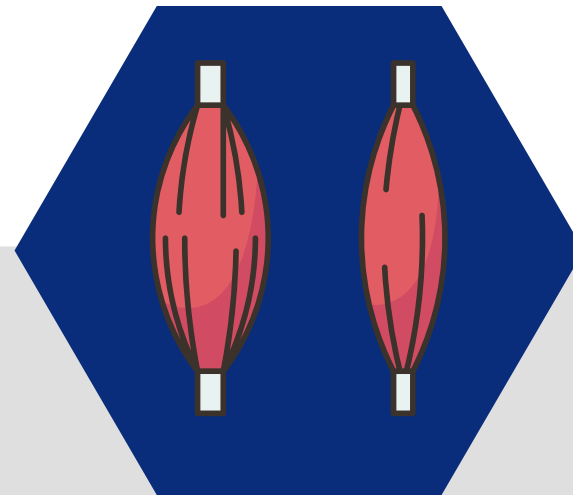
PROGRESSION OF HPT BASED ON BASELINE PTH LEVELS AT HEMODIALYSIS INITIATION



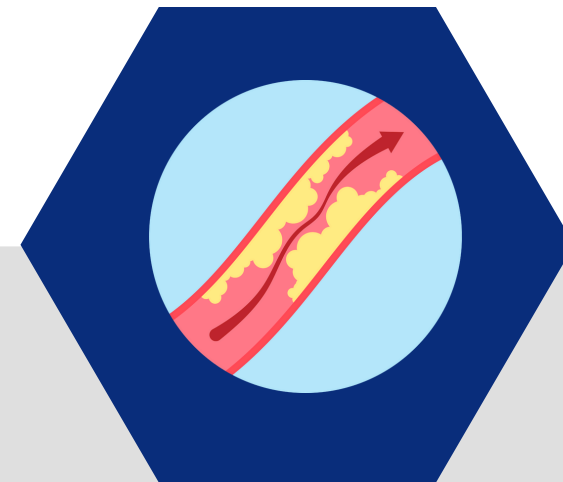
ADVERSE HEALTH EFFECTS OF HYPERPARATHYROIDISM



**Bone Loss
Fracture**



**Protein Energy
Wasting
Weight Loss**



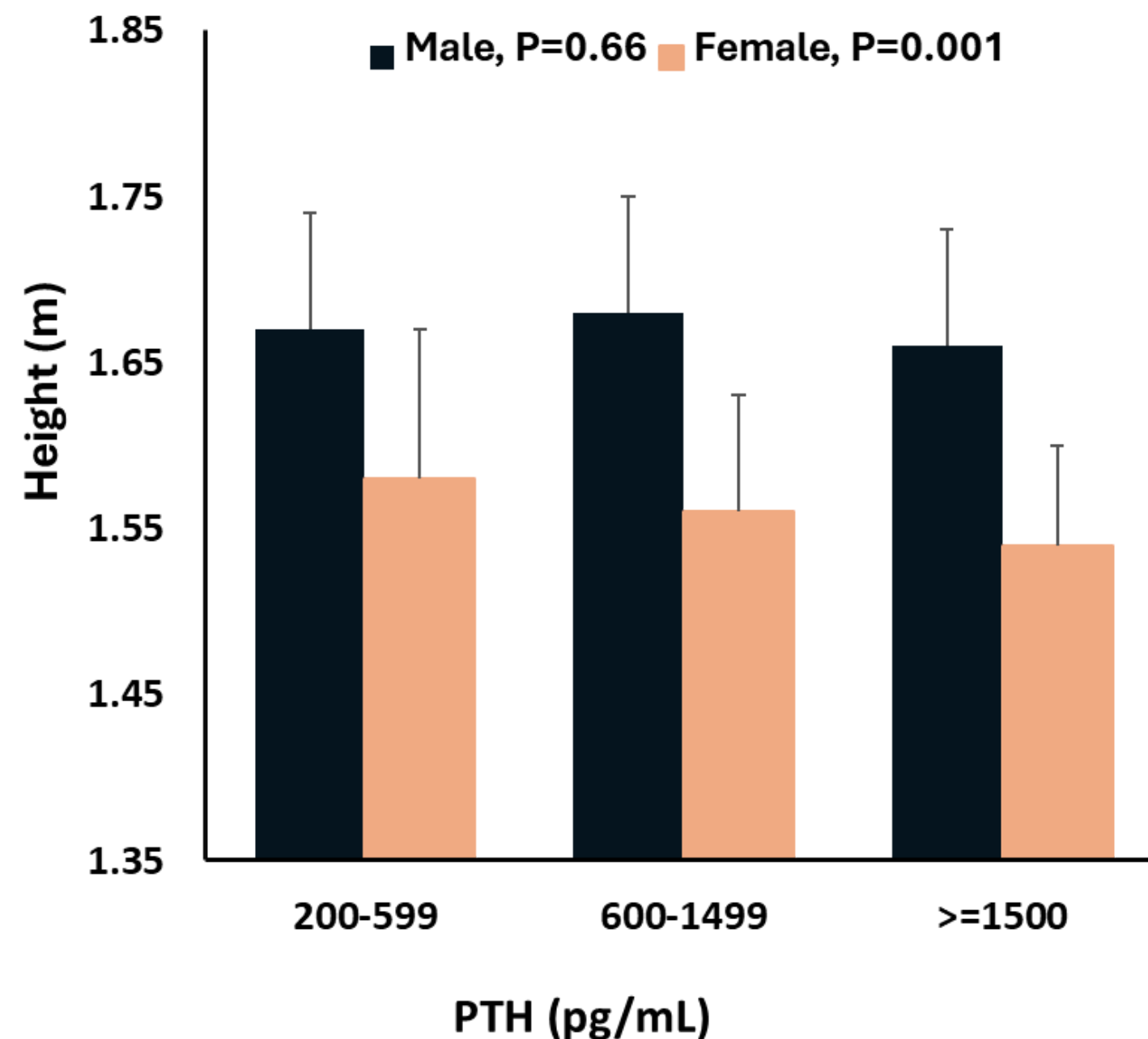
**Vascular and
Soft Tissue
Calcification**



Mortality

BONE LOSS AND PROTEIN-ENERGY WASTING

BONE AND HEIGHT LOSS

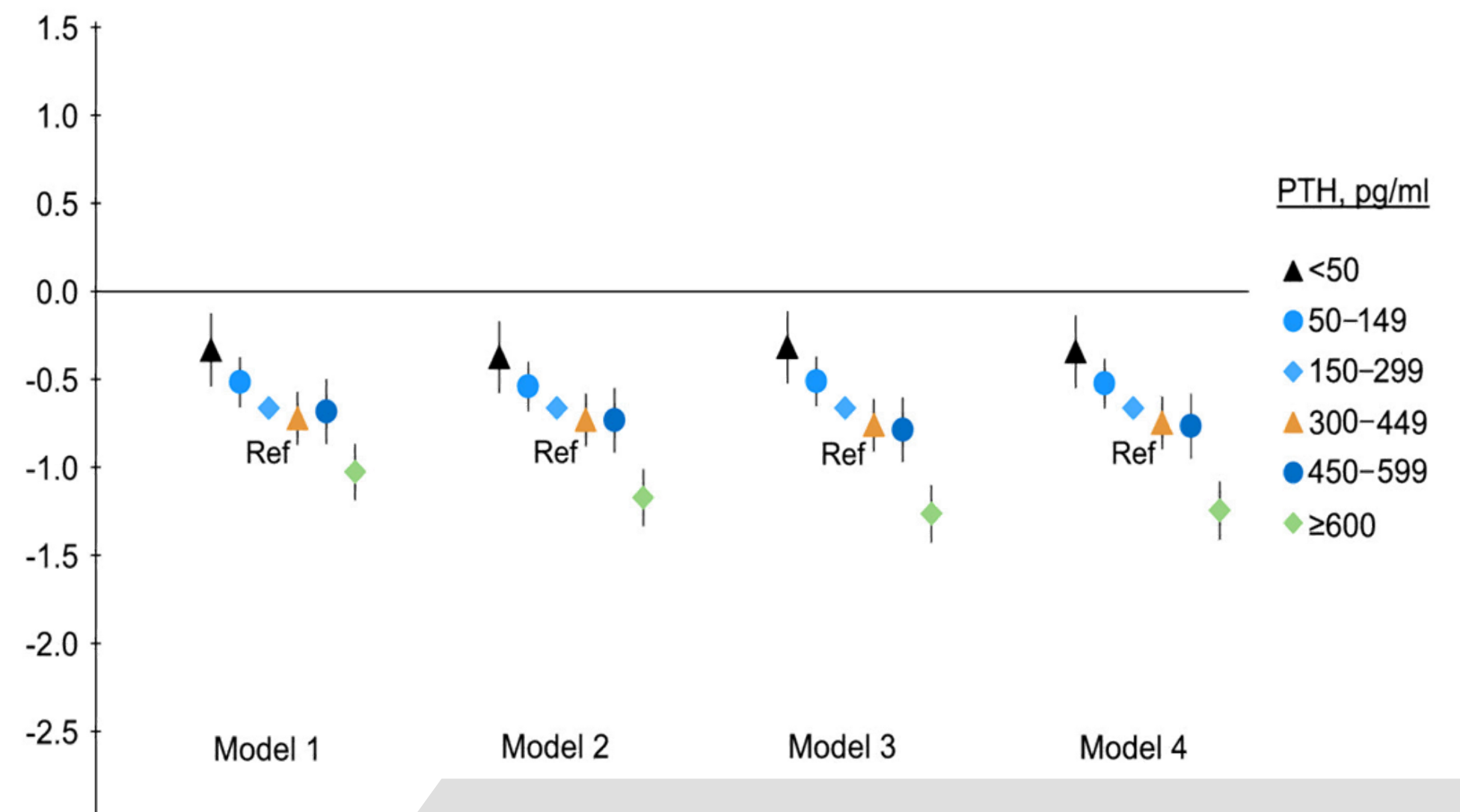


Disthabanchong S. Front Nutr. 2022 Sep 13;9:933918

WEIGHT LOSS

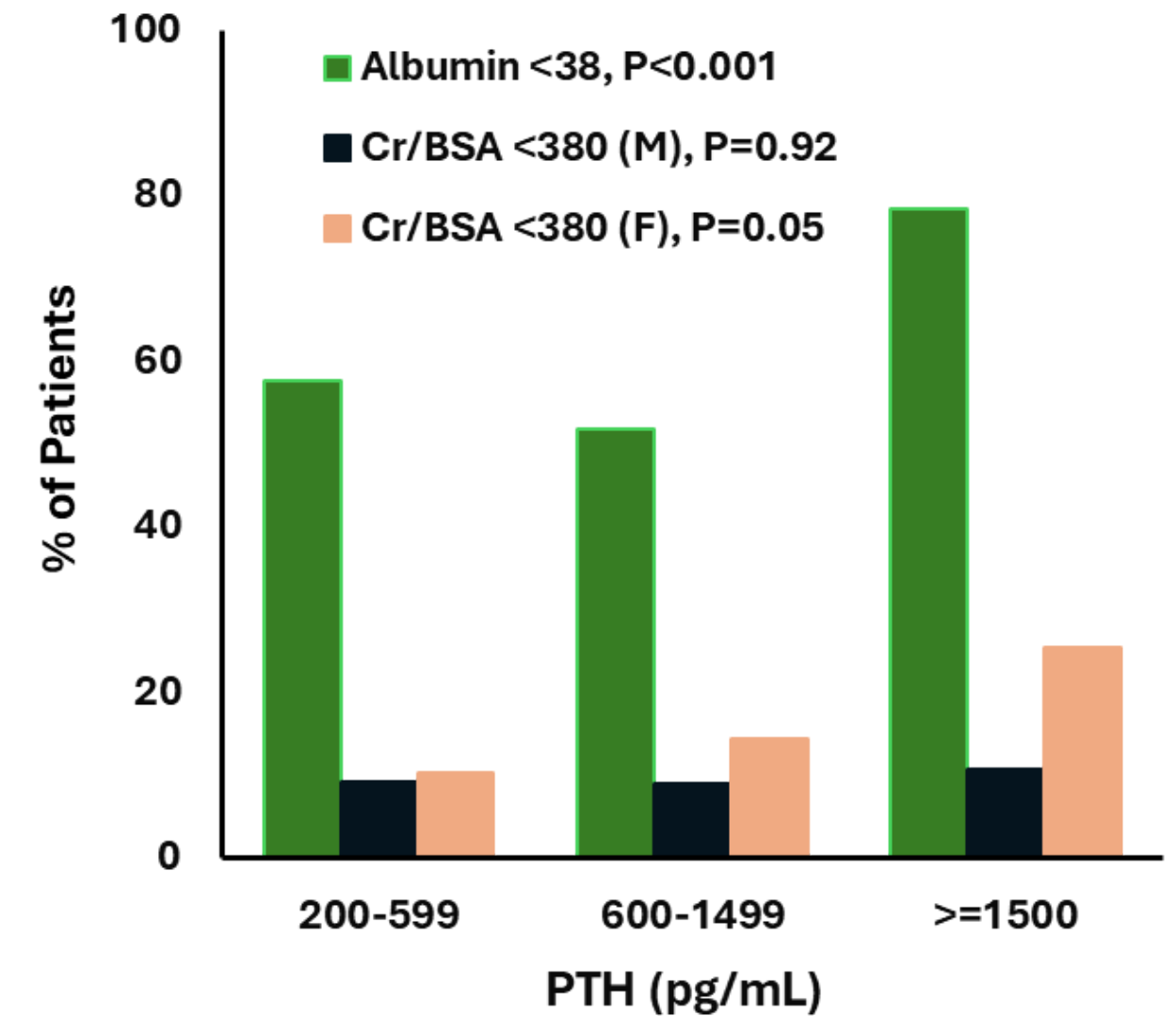
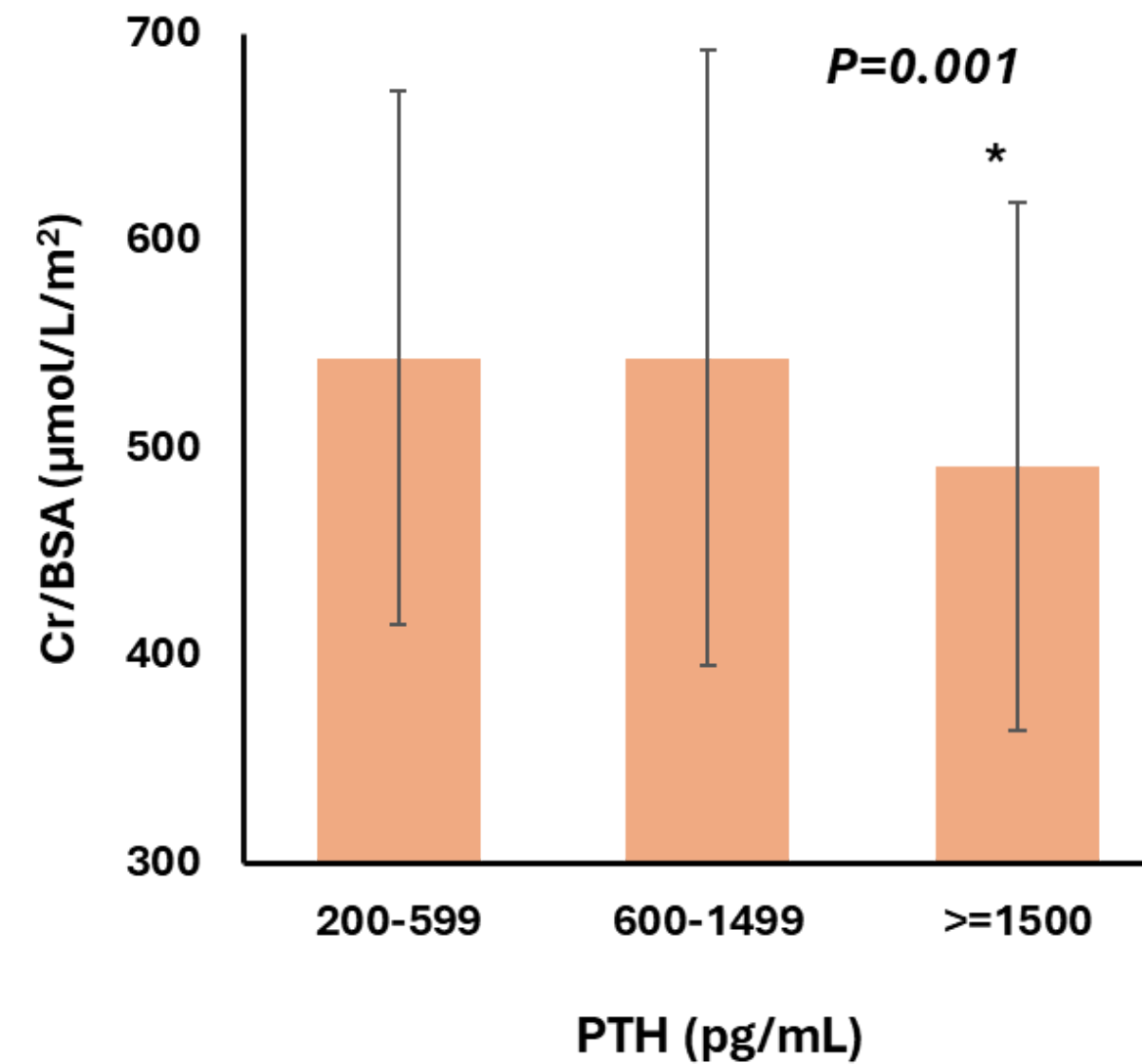
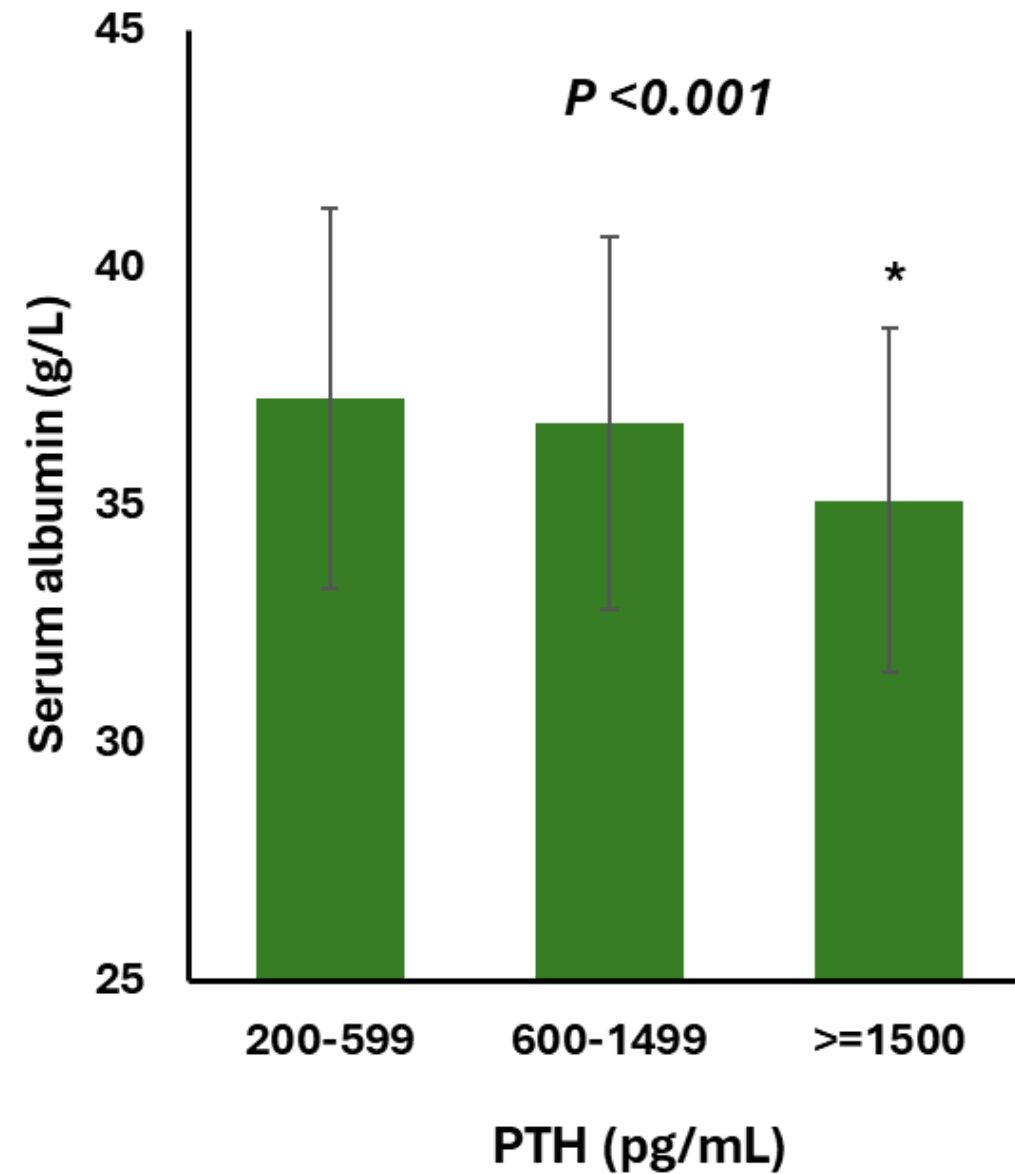
42,319 chronic HD patients from DOPPs phases 2–6
(2002–2018)

% weight change (95% CI for difference to reference group)

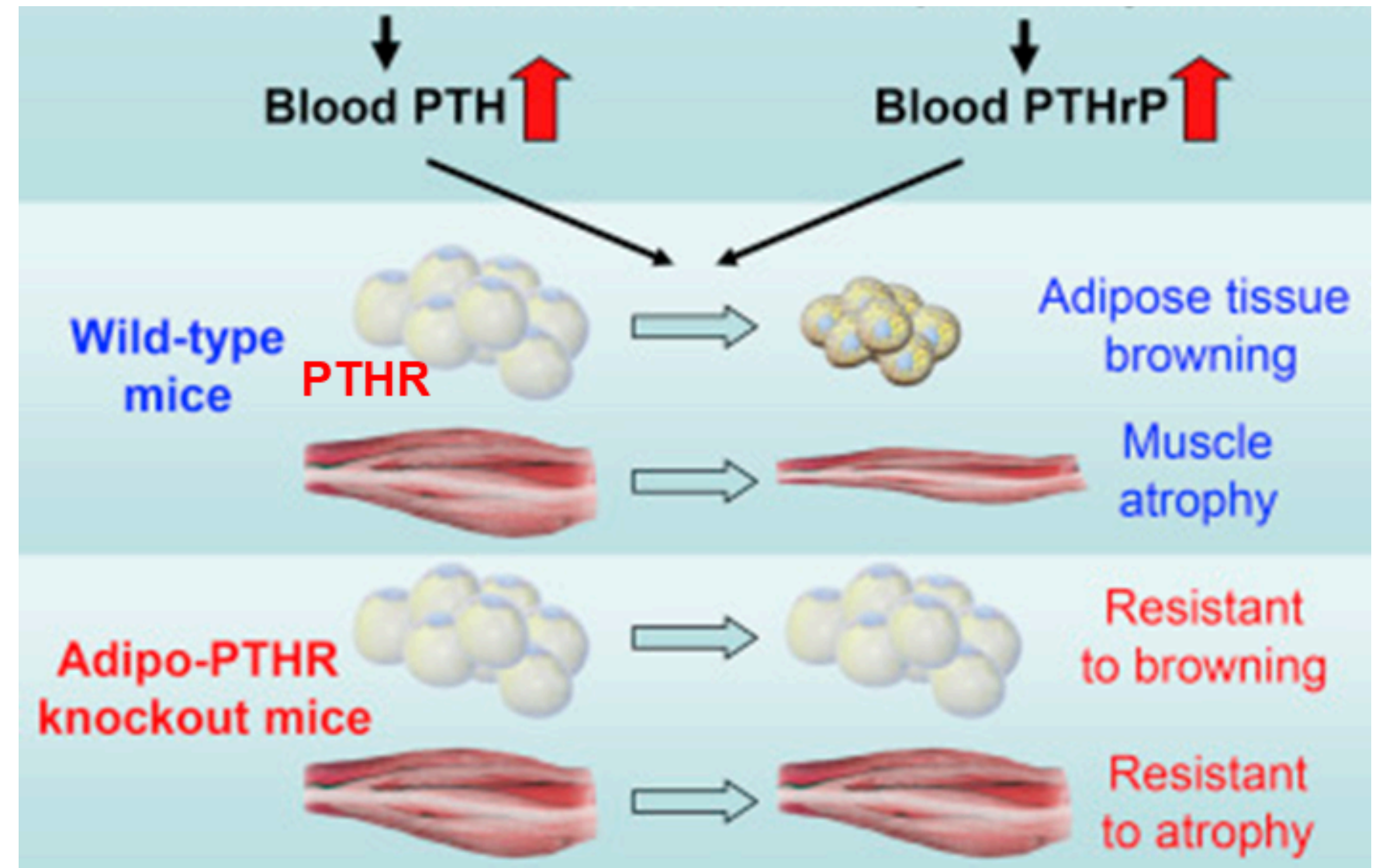
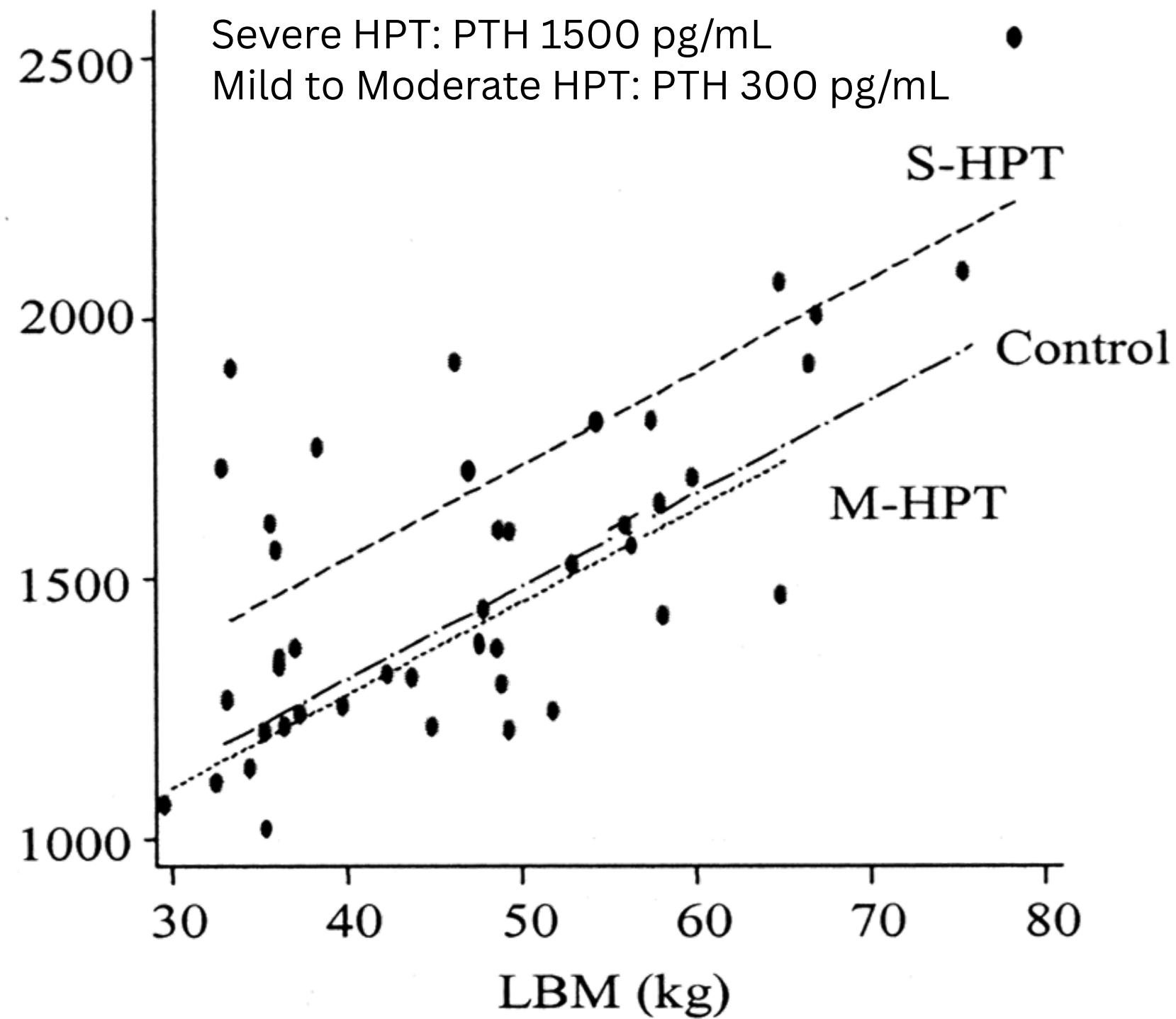


Komaba H J Cachexia Sarcopenia Muscle 2021;12(4):855-65f

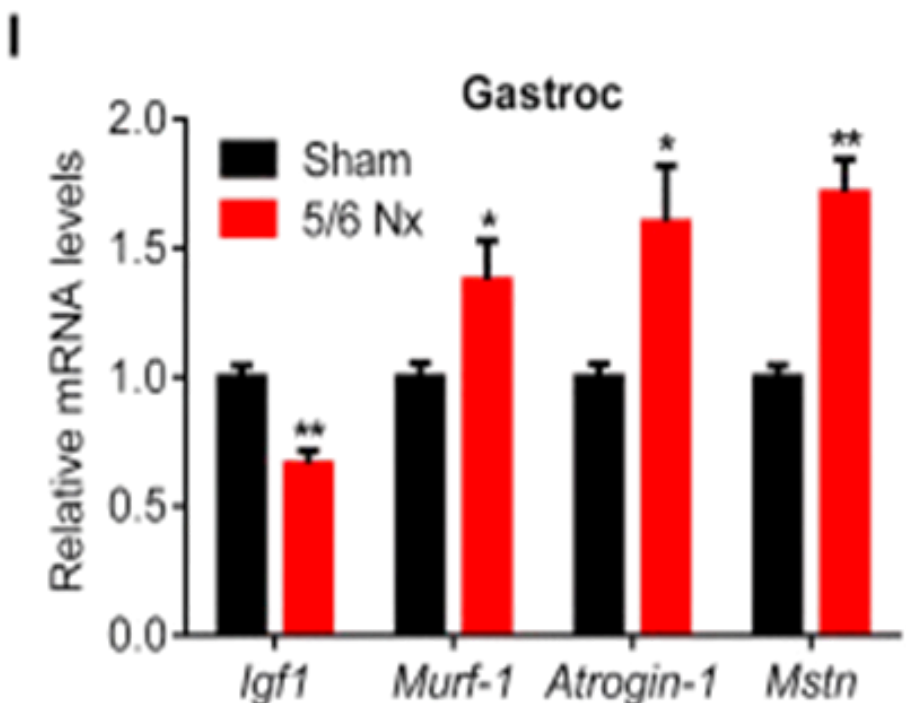
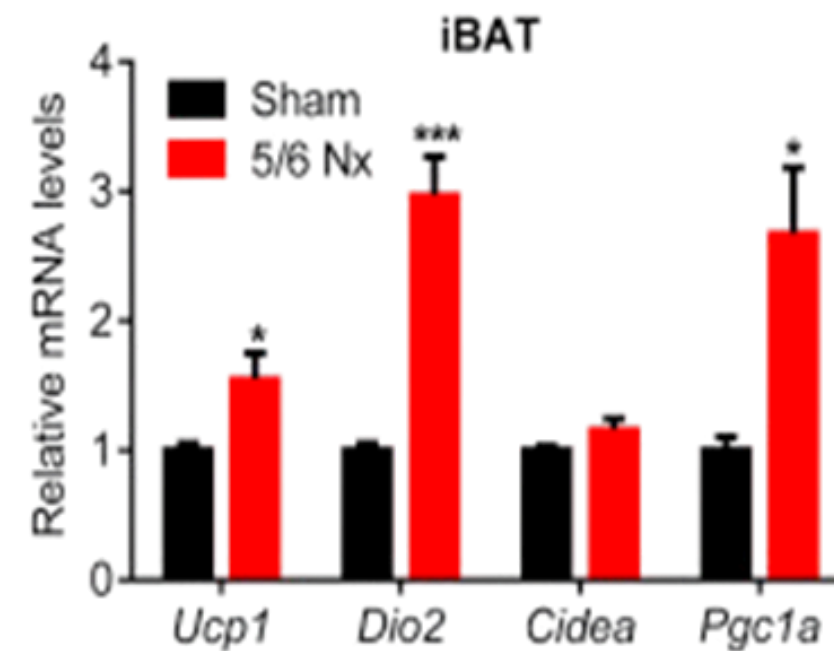
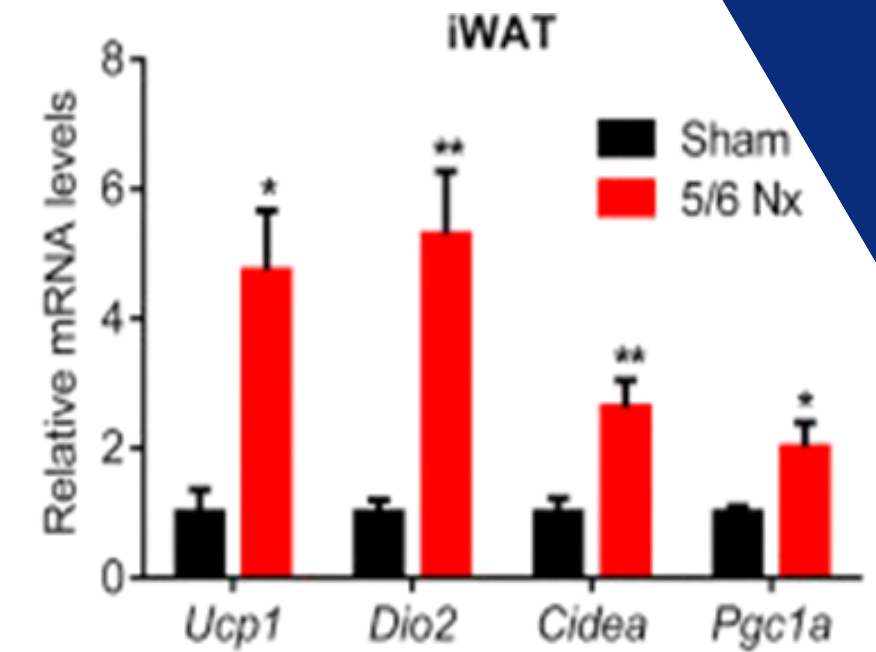
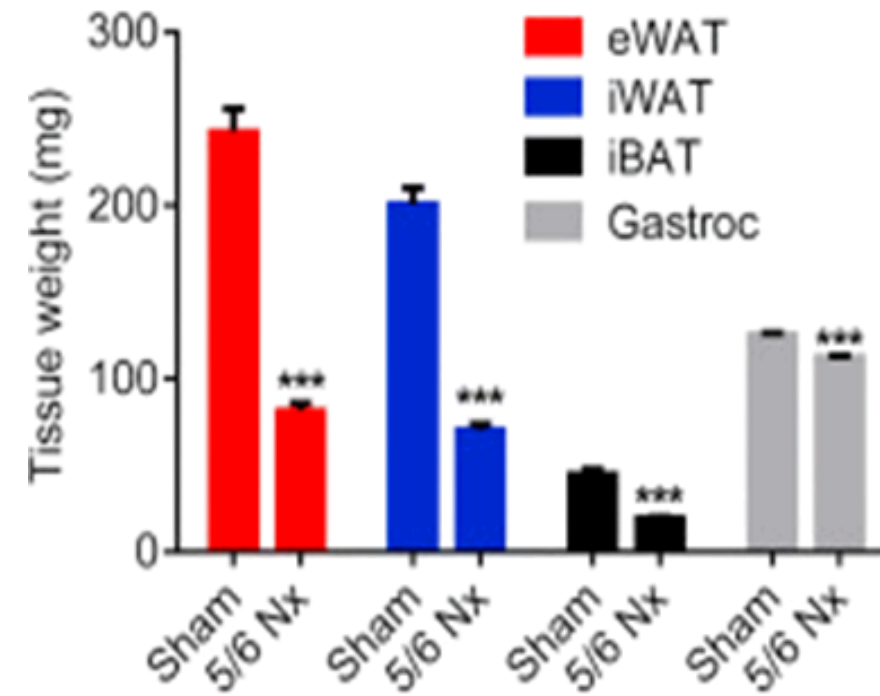
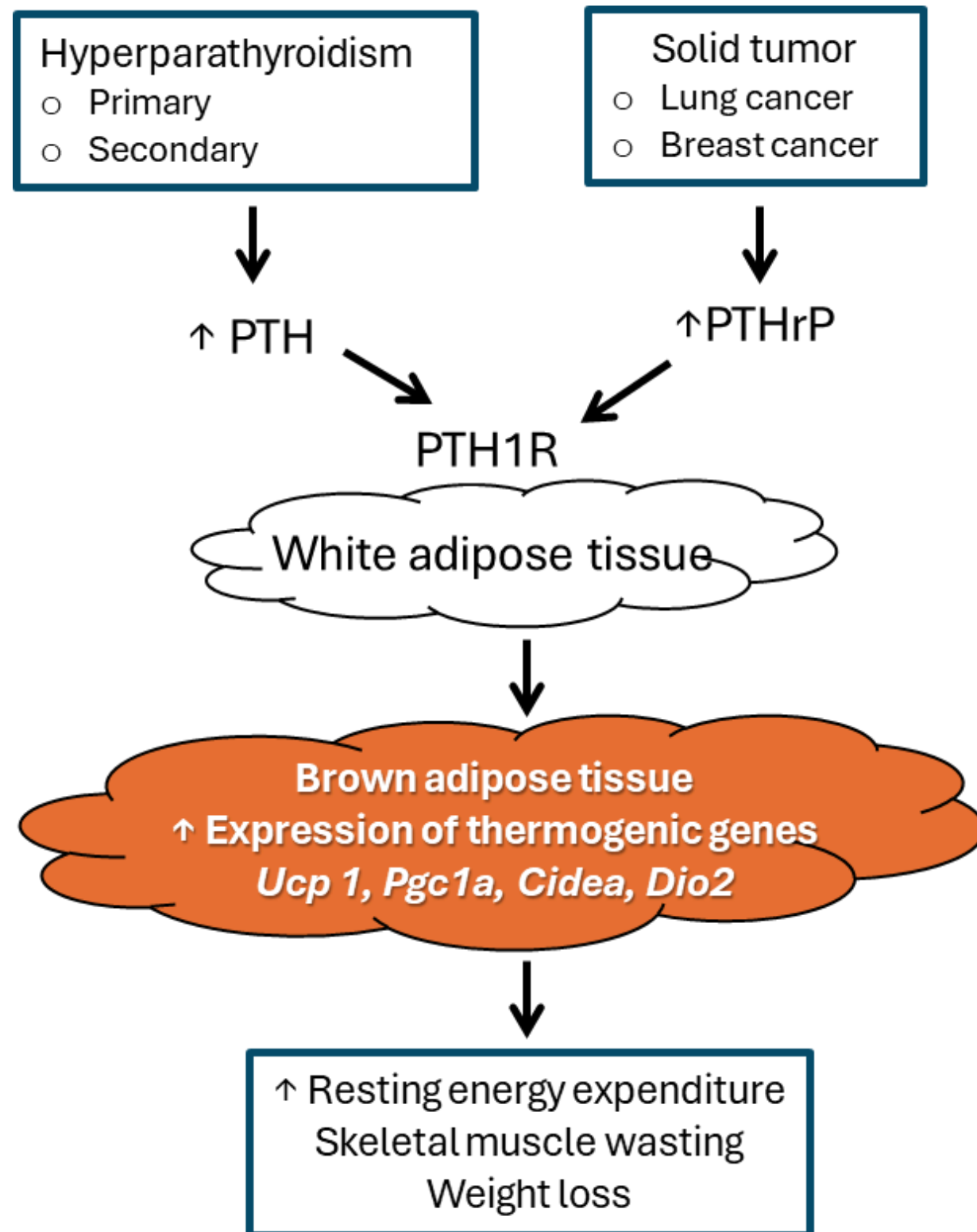
PROTEIN-ENERGY WASTING



INCREASED RESTING ENERGY EXPENDITURE IN HYPERPARATHYROIDISM

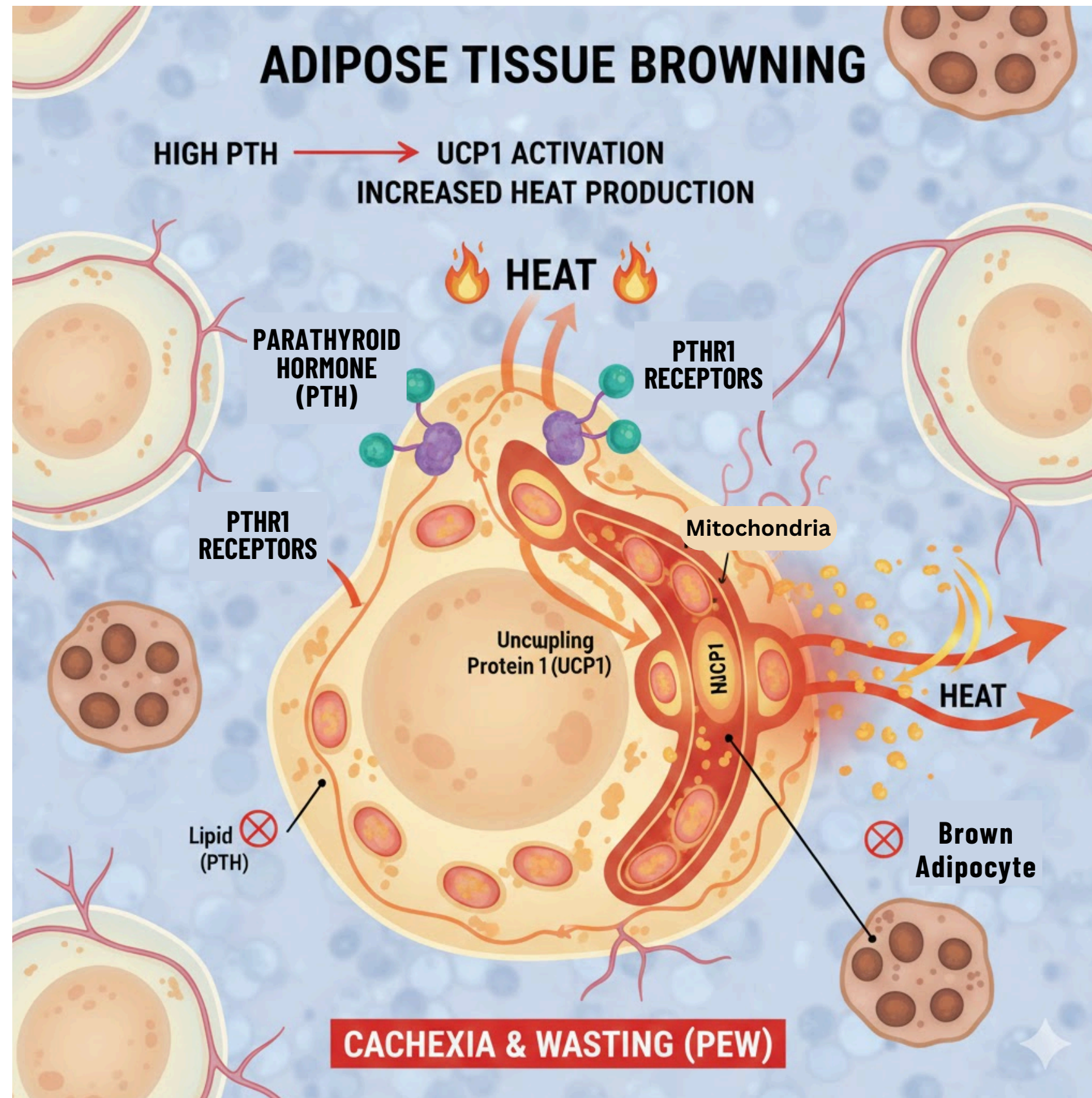


ADIPOSE TISSUE BROWNING



eWAT: Epidymal white adipose tissue (Visceral fat)
 iWAT: Inguinal white fat (Subcutaneous fat)
 iBAT: Intercapsular brown fat
 Gastroc: Gastocnemius muscle

ADIPOSE TISSUE BROWNING



White adipose tissue (WAT) is primarily for energy storage. Brown adipose tissue (BAT) are specialized fat cells that generate heat by burning energy (thermogenesis). = Browning

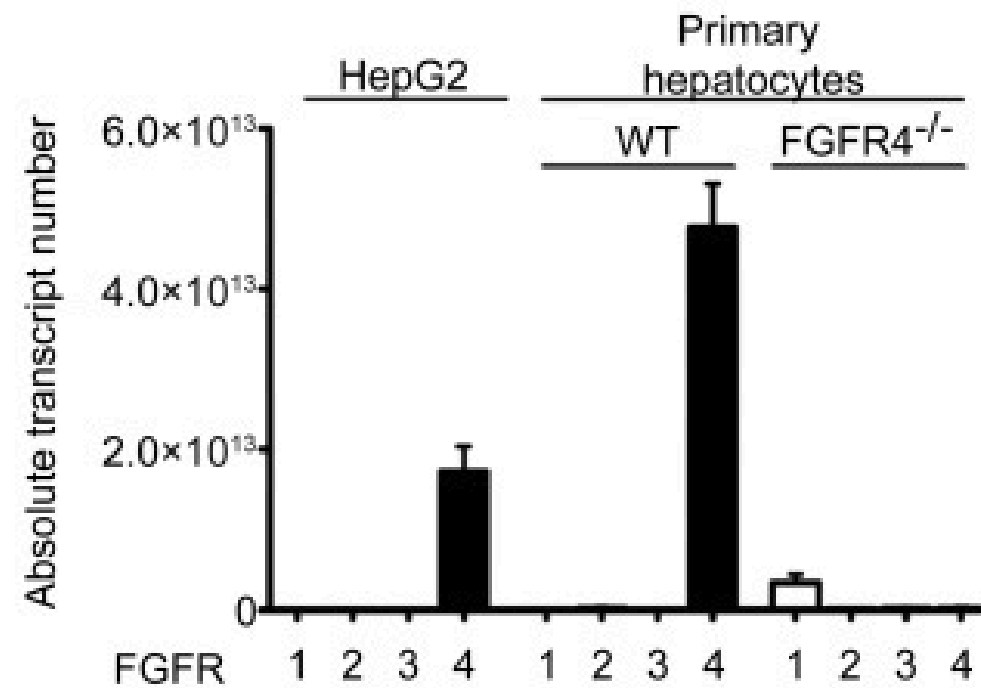
High concentrations of PTH (and related peptides like PTHrP) activate PTHR1 on the white adipocytes. This activation triggers signaling pathways that promote the expression of key thermogenic proteins, most notably Uncoupling Protein 1 (UCP1).

UCP1 uncouples the process of oxidative phosphorylation in the mitochondria, meaning the energy from food is dissipated as heat instead of being stored as ATP or converted into new fat/muscle mass.

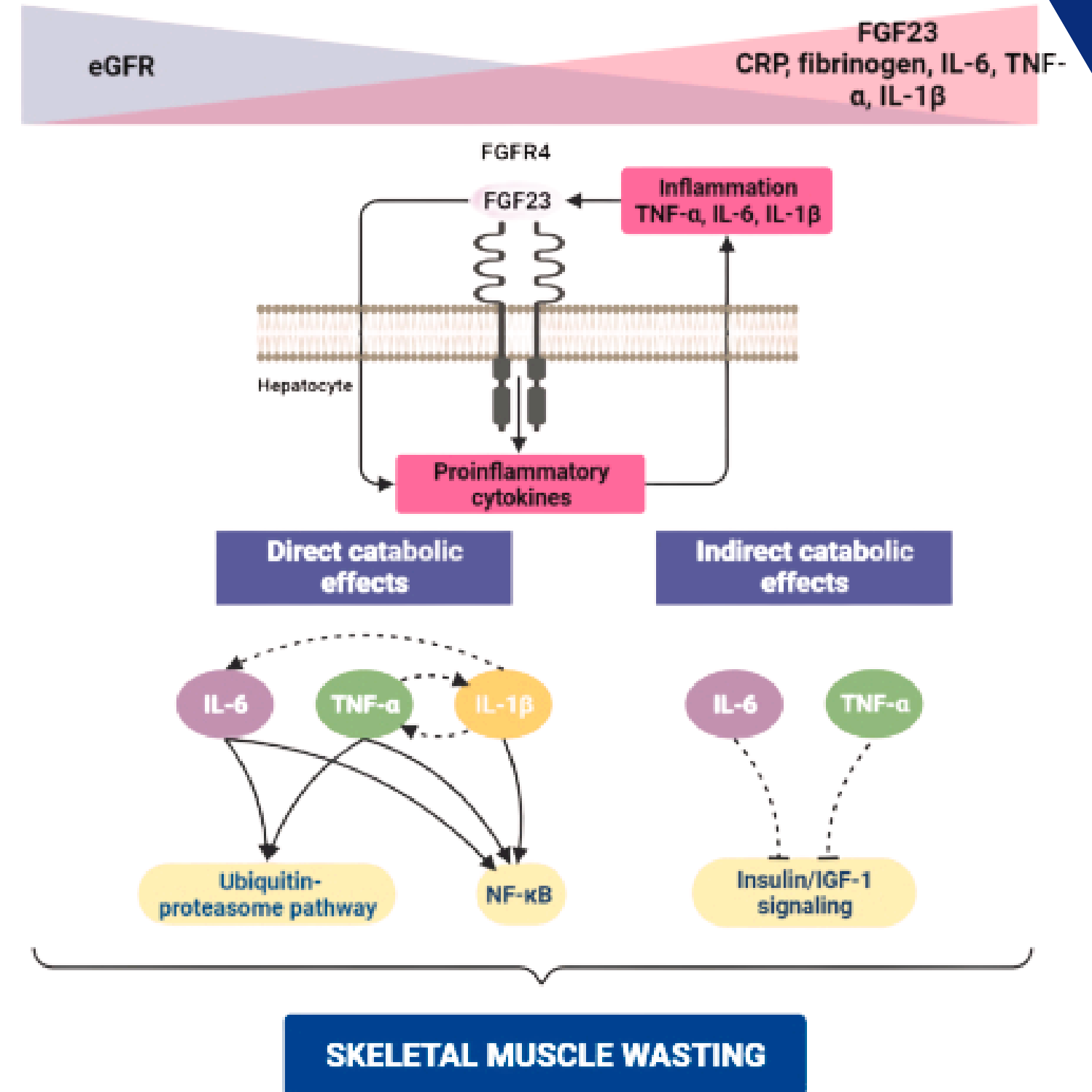
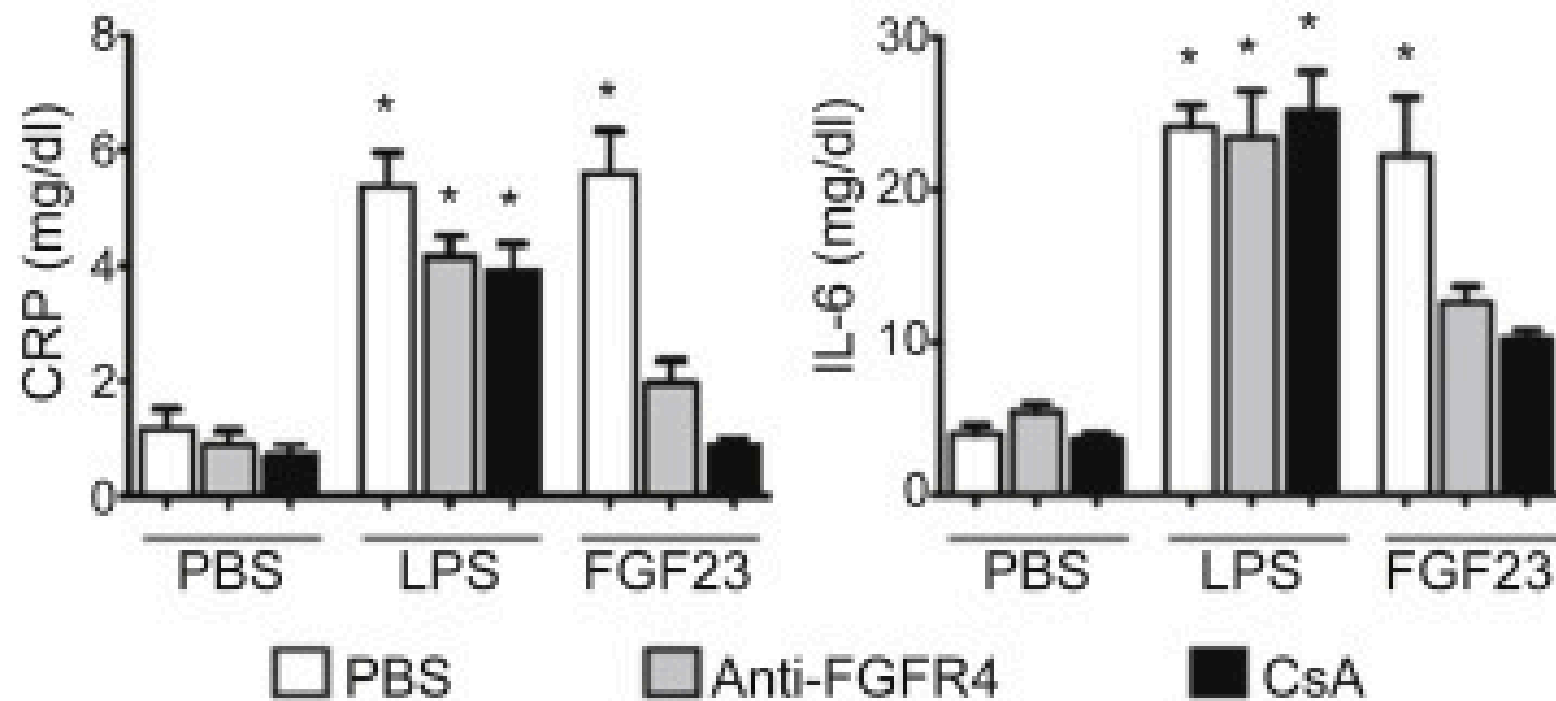
The net effect is a significant and persistent increase in the body's resting energy expenditure (REE). The body burns calories unnecessarily for heat, leading to a negative energy balance.

This high energy demand contributes directly to the breakdown of both fat and muscle stores, resulting in cachexia and wasting (PEW).

FGF-23 AND INFLAMMATION

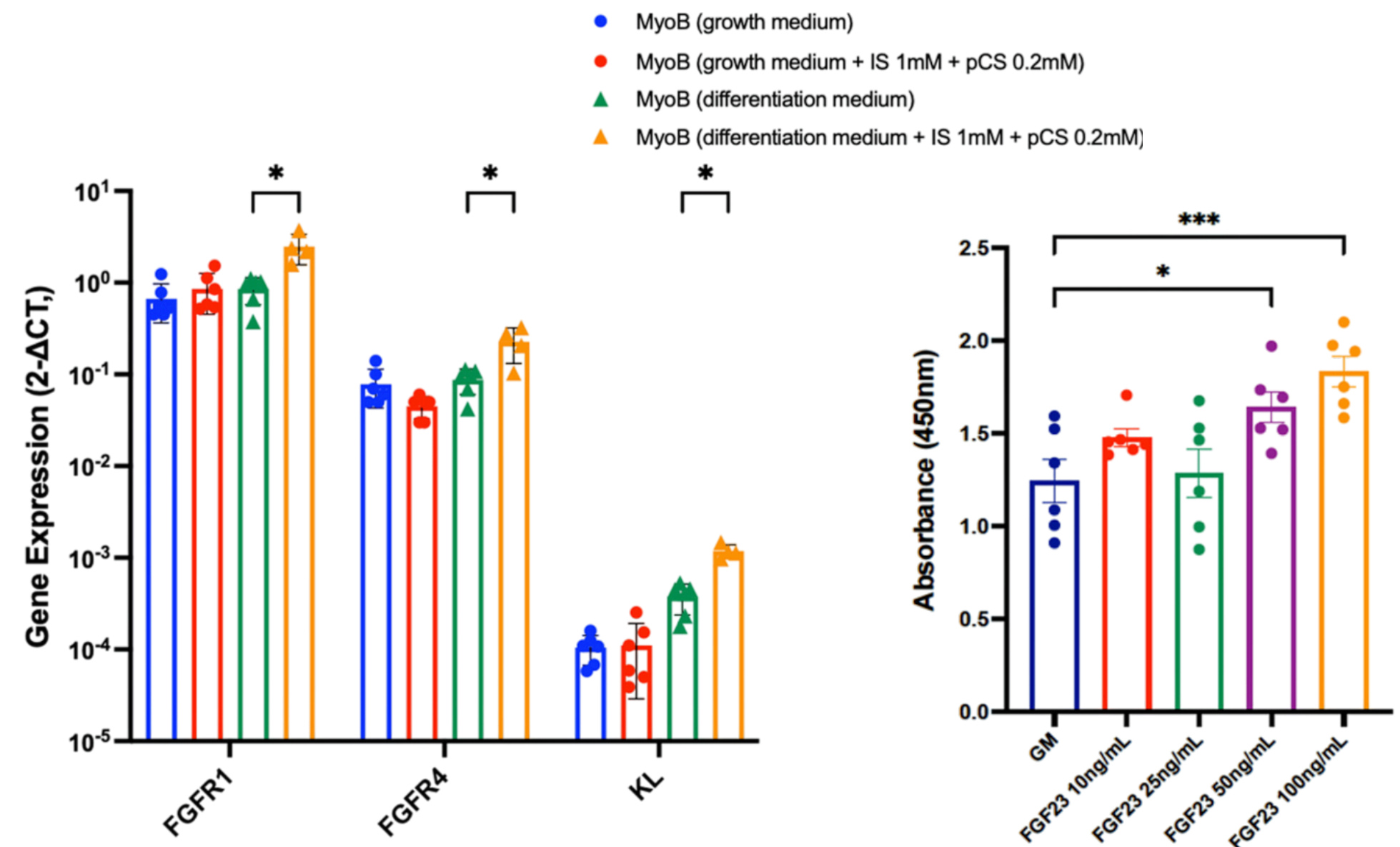
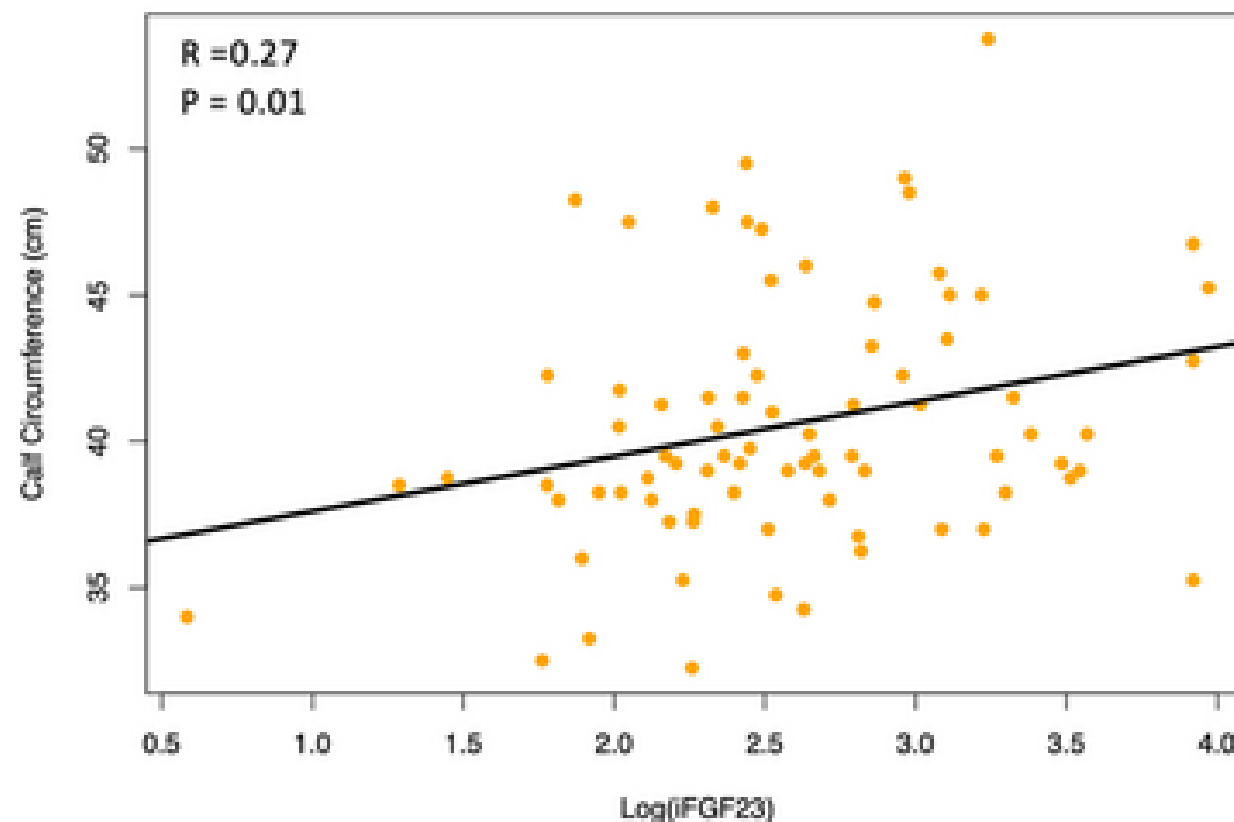
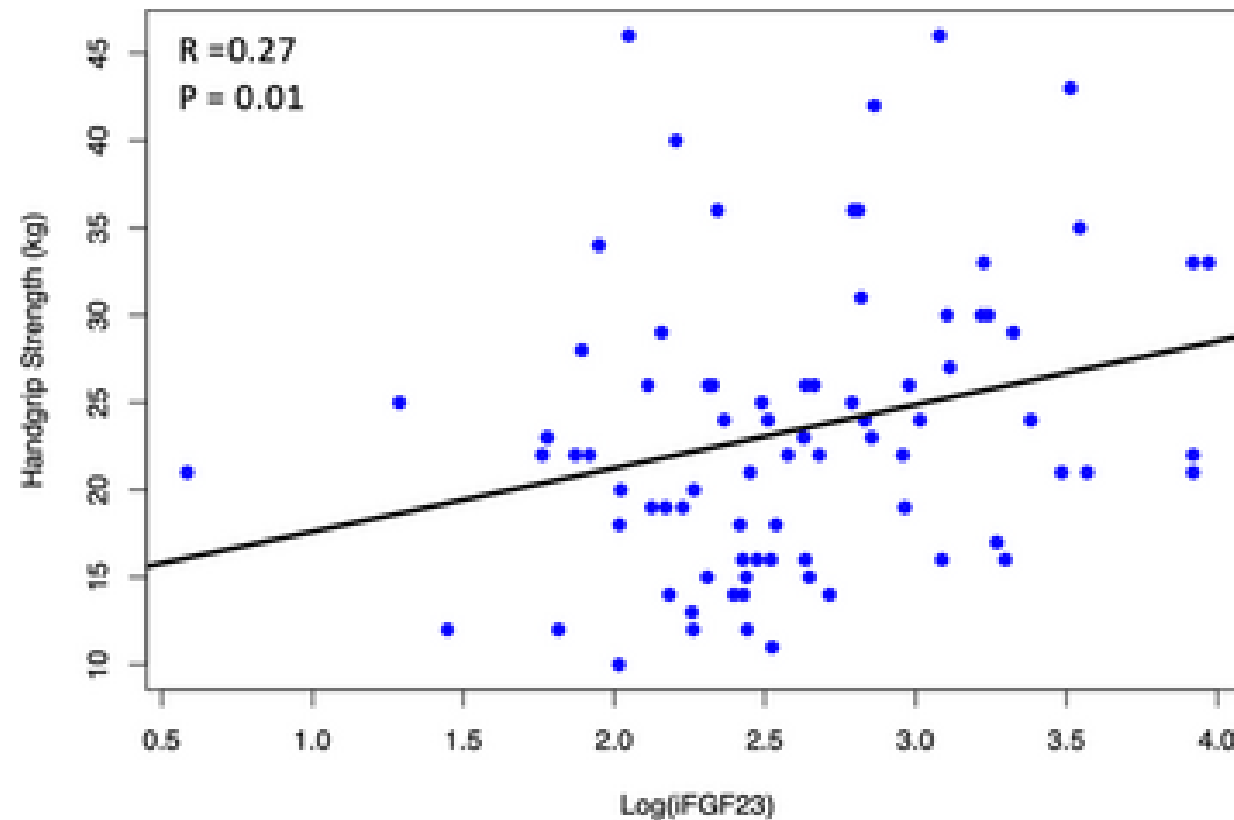


FGF23 can directly induce cytokine production from hepatocytes through activation of FGFR4 expressed on hepatocytes, through PLC-Calcineurin-NFAT pathway

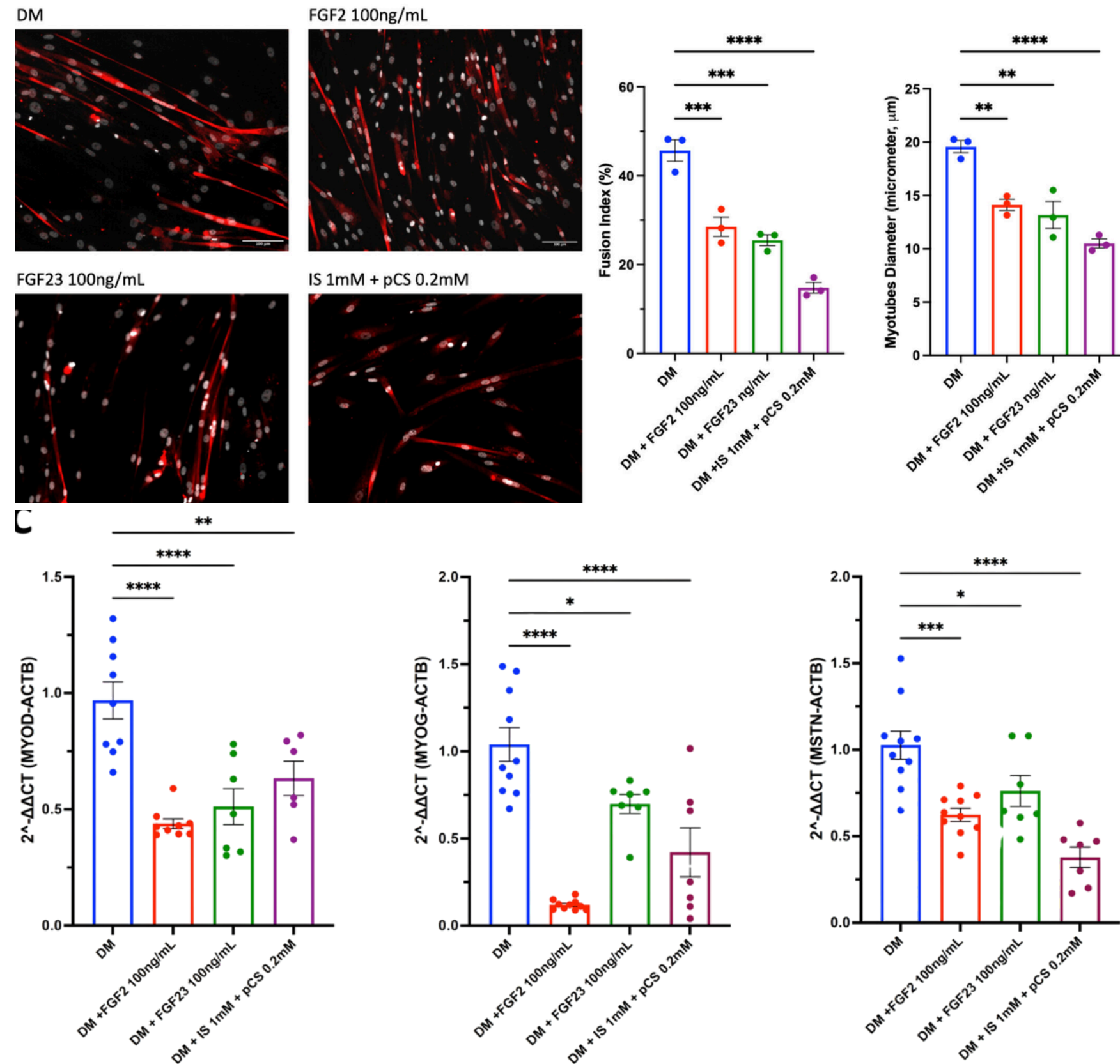


FGF-23 AND SARCOPENIA

- FGF-23 level is associated with muscle mass and strength in HD patients
- FGFR1, FGFR4, and klotho are present in adult human skeletal muscle myoblasts
- Increasing dose of FGF-23 promotes myoblast proliferation but repressing myogenic differentiation

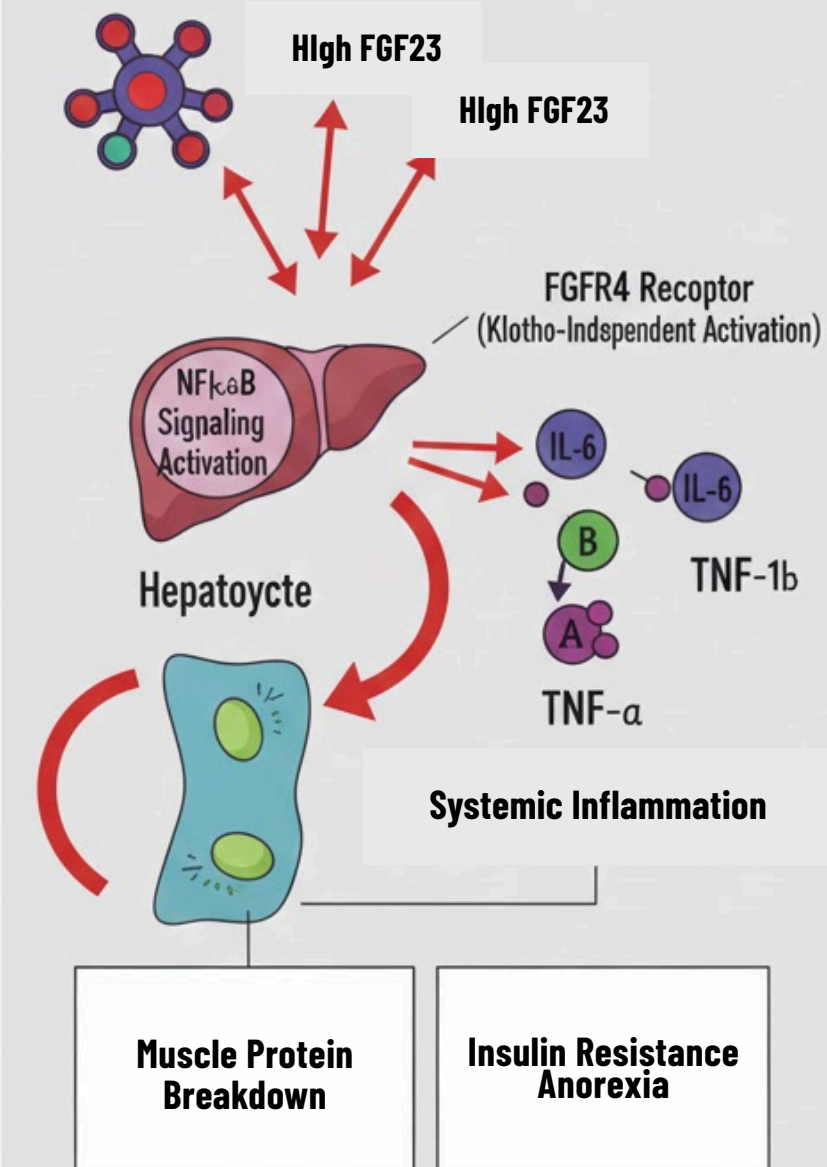


FGF-23 AND SARCOPENIA

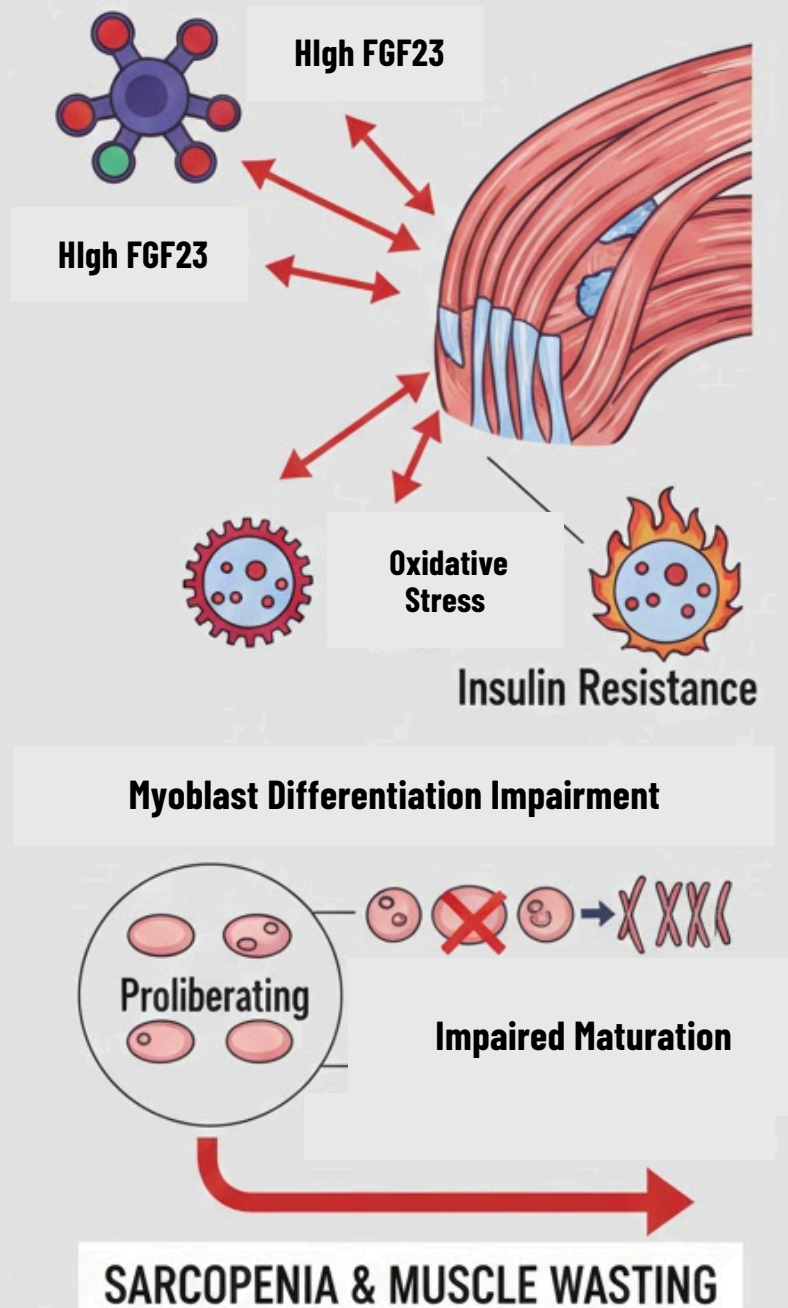


Reduced myosin heavy chain (red staining), fusion indices and myotubes diameter after FGF-23 treatment. The expressions of MYOD, MYOG and MSTN were reduced in myoblasts cultured in differentiated medium (DM) in the presence of FGF-23

1. Systemic Inflammation



2. Muscle Toxicity & Sarcopenia



HIGH FG23 DRIVES INFLAMMATION & MUSCLE DYSFINCTION, ACCELERATING PEW IN CKD-MBD.

MANAGEMENT OF HYPERPARATHYROIDISM

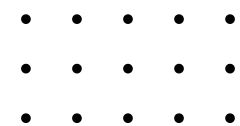
**MULTIMODAL TREATMENT IS
THE KEY TO EFFECTIVE
MANAGEMENT**

**Phosphate Restriction
Phosphate Binders**

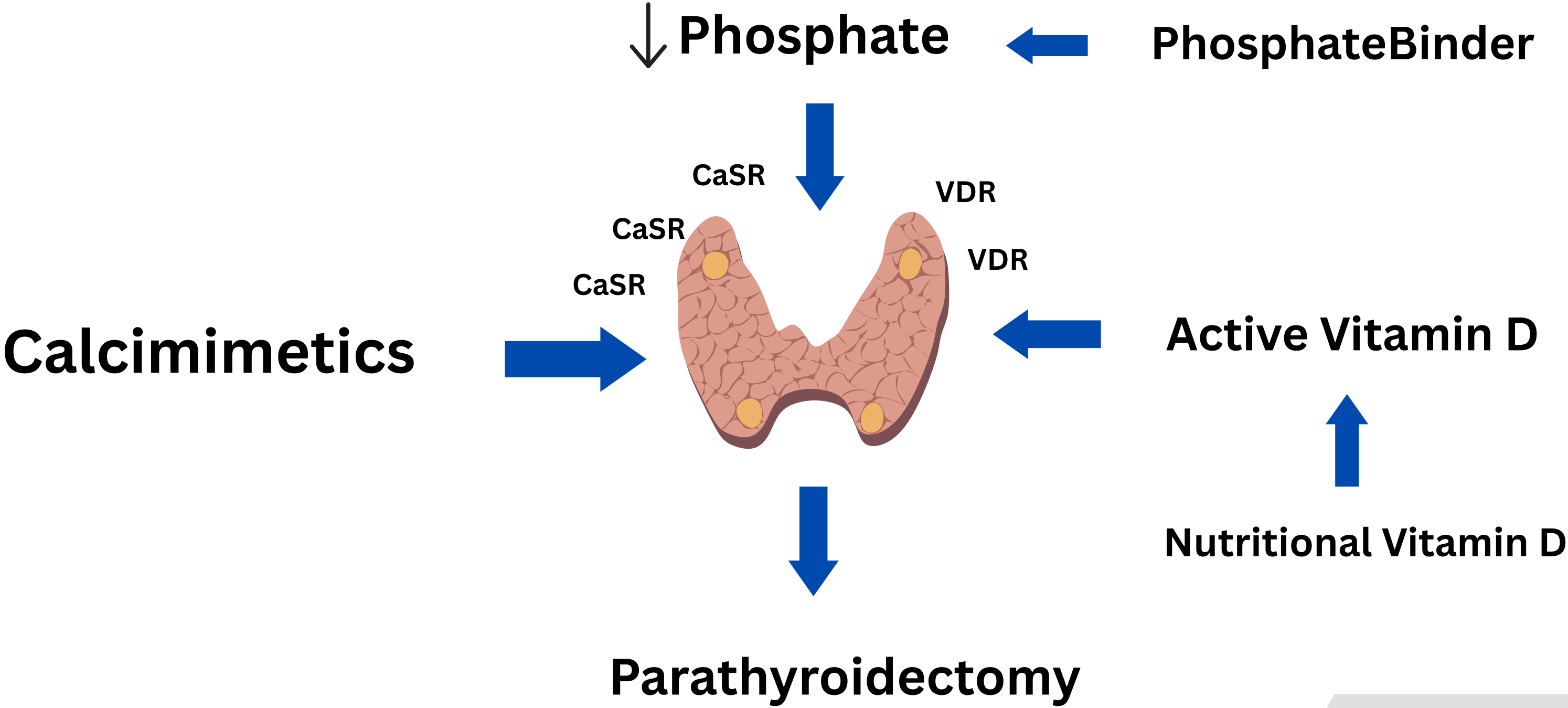
Active Vitamin D

Calcimimetics

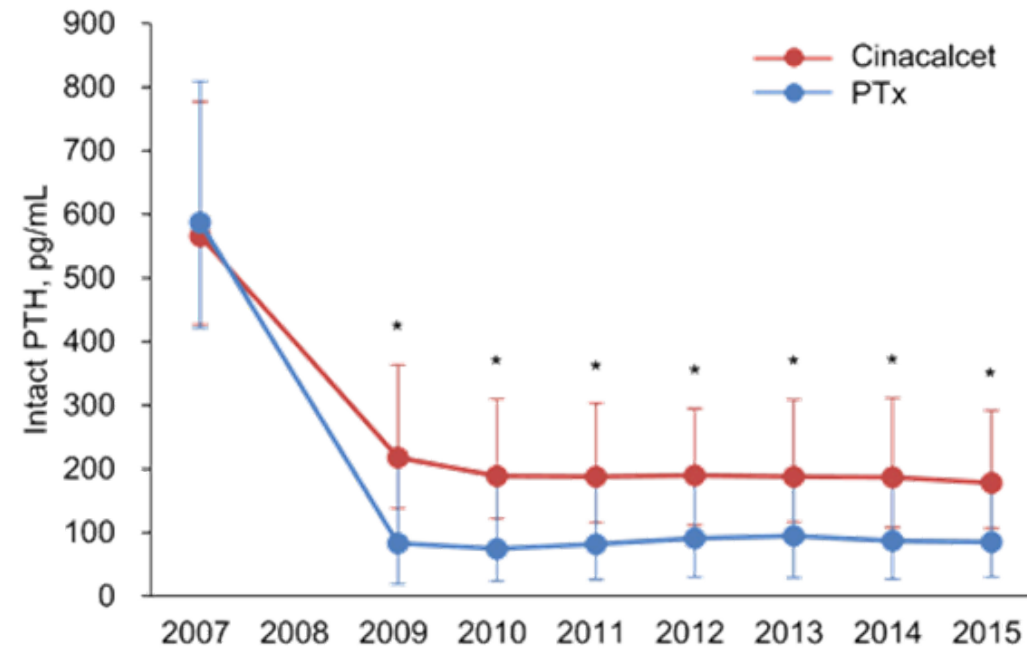
Parathyroidectomy



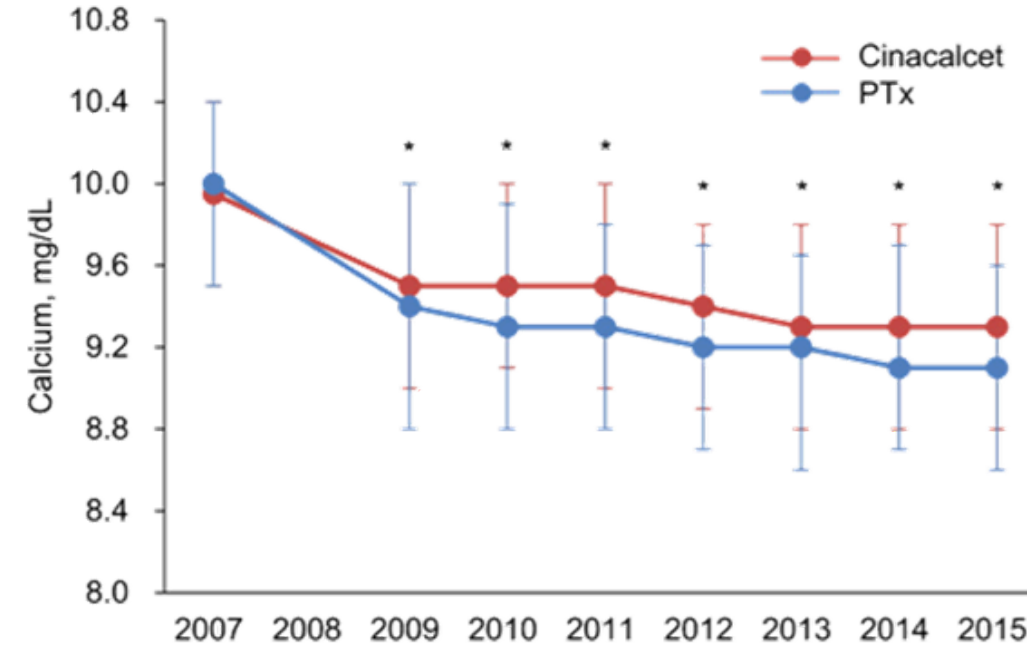
TREATMENT OPTIONS FOR HYPERPARATHYROIDISM



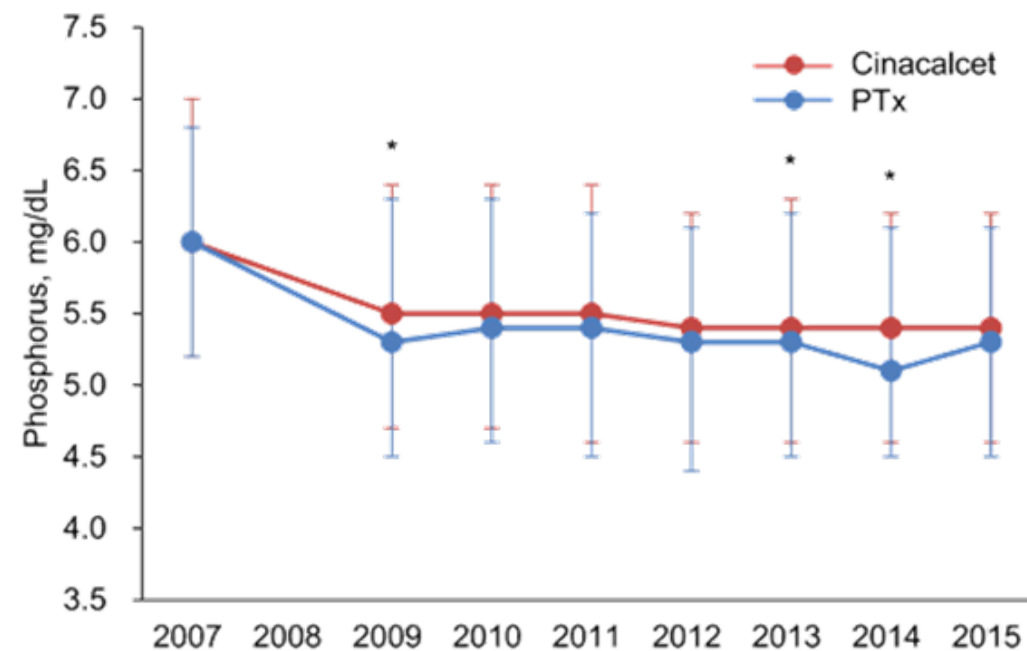
PARATHYROIDECTOMY AND NUTRITION



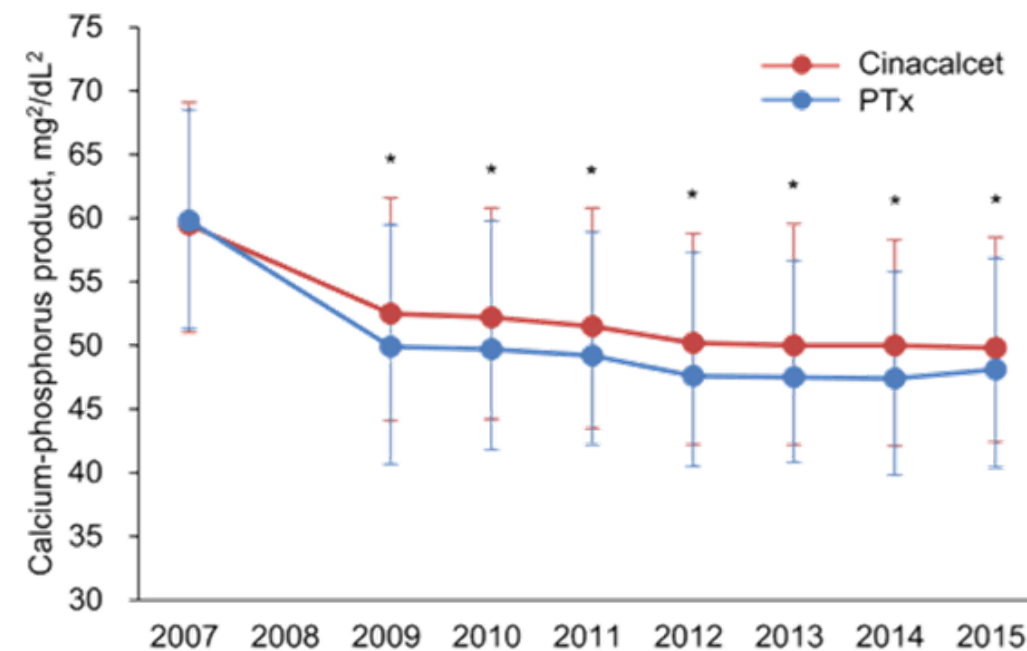
No. of patients									
Cinacalcet	2,682	NA	2,652	2,462	2,237	2,090	1,890	1,788	1,634
PTx	894	NA	872	802	753	718	681	662	598



No. of patients									
Cinacalcet	2,570	NA	2,619	2,457	2,265	2,112	1,909	1,811	1,655
PTx	863	NA	868	809	763	751	697	671	614



No. of patients									
Cinacalcet	2,675	NA	2,675	2,498	2,302	2,142	1,942	1,826	1,673
PTx	894	NA	890	825	784	756	709	678	619



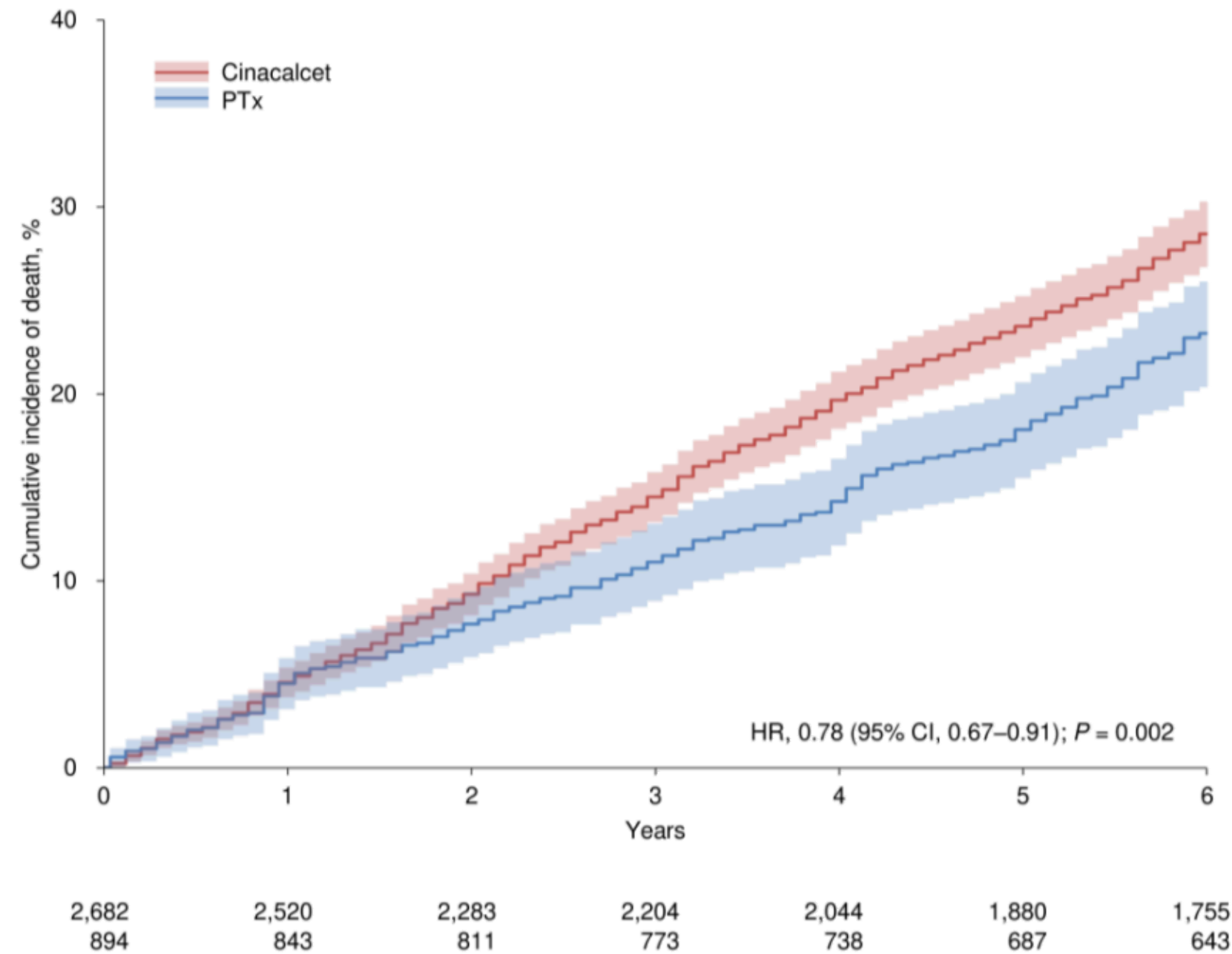
No. of patients									
Cinacalcet	2,570	NA	2,619	2,455	2,263	2,112	1,909	1,809	1,651
PTx	863	NA	868	807	763	751	697	671	614

- Patients with iPTH ≥ 300 pg/mL underwent PTx or started treatment with cinacalcet were matched by propensity score 1:3 ratio
- Those who underwent PTX had lower serum calcium, phosphate, and PTH levels

PARATHYROIDECTOMY AND NUTRITION



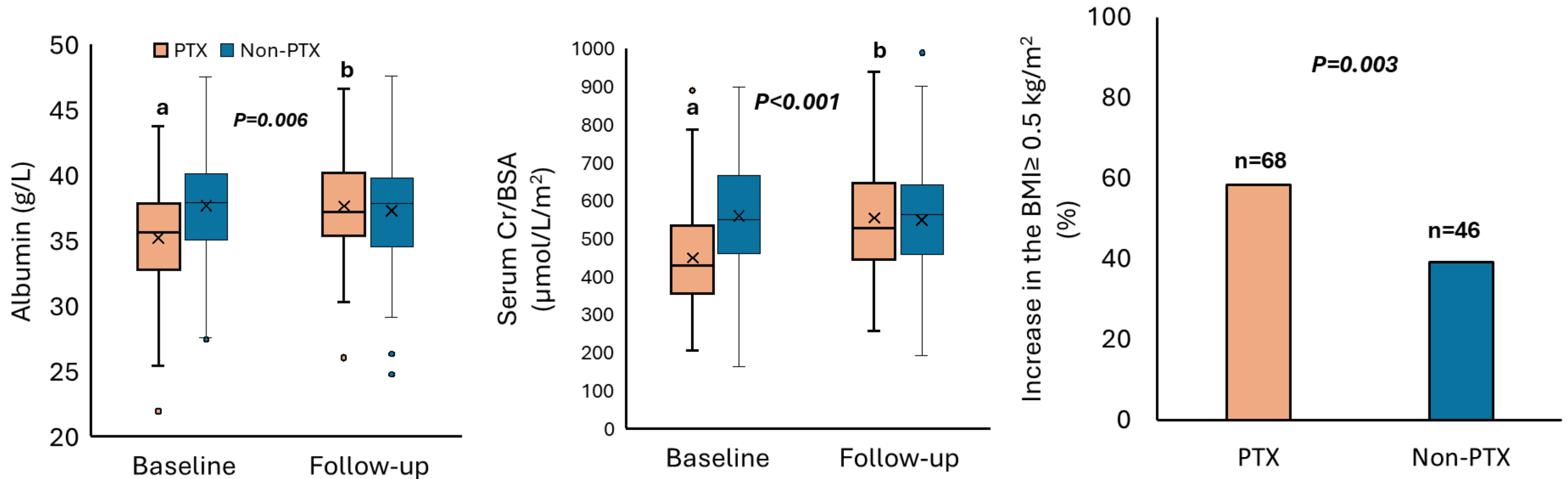
The reduction in mortality was more pronounced among patients with more severe HPT and impaired nutrition



Characteristics	No. of patients		Hazard ratio for death (95% CI)		P value for interaction
	PTx	Cinacalcet			
Overall	894	2,682	0.78 (0.67–0.91)		
Age, yr					
<60	475	1,457	0.71 (0.53–0.96)		0.60
≥60	419	1,225	0.78 (0.94–0.00)		
Sex					
Female	403	1,215	0.73 (0.57–0.92)		0.39
Male	491	1,467	0.83 (0.68–1.02)		
Dialysis duration, yr					
<15	558	1,629	0.82 (0.67–1.01)		0.96
≥15	336	1,053	0.74 (0.58–0.94)		
Cause of kidney failure					
DM	81	295	0.84 (0.58–1.24)		0.92
Non-DM	813	2,387	0.83 (0.69–1.00)		
Body-mass index, kg/m ²					
<22	559	1,735	0.79 (0.65–0.95)		0.97
≥22	335	947	0.78 (0.60–1.02)		
Cardiovascular disease					
Yes	112	337	0.63 (0.43–0.92)		0.44
No	782	2,345	0.80 (0.67–0.95)		
Albumin, g/dL					
<4.0	534	1,617	0.78 (0.65–0.93)		0.92
≥4.0	360	1,065	0.79 (0.58–1.07)		
Intact PTH, pg/mL					
<500	343	1,029	1.07 (0.85–1.35)		<0.001
≥500	551	1,653	0.63 (0.51–0.78)		
Calcium, mg/dL					
<10.0	436	1,340	1.02 (0.82–1.26)		<0.001
≥10.0	458	1,342	0.60 (0.47–0.75)		
Phosphorus, mg/dL					
<6.0	419	1,312	0.75 (0.60–0.94)		0.68
≥6.0	475	1,370	0.82 (0.66–1.02)		

NUTRITIONAL IMPROVEMENT AFTER PTX

- HD patients who underwent PTX were matched 1:1 to non-PTX and Pre-PTX HD patients
- Serum albumin, Cr/BSA, and BMI increased after PTX



SUMMARY



01

ADVERSE HEALTH CONSEQUENCES OF SEVERE HPT

Bone loss, protein-energy wasting, weight loss, vascular and soft tissue calcification, dementia, and death.

02

MECHANISMS OF PROTEIN ENERGY WASTING

Adipose tissue browning and increased energy expenditure
Enhanced muscle proteolysis and impaired energy production
Systemic inflammation and hormonal imbalance

03

MANAGEMENT

Phosphate restriction/phosphate binders, active vitamin D, calcimimetics, and parathyroidectomy when medications fail.

THANK YOU

FOR YOUR ATTENTION

