Long-term Results of Subcutaneous Parathyroid Grafts in Uremic Patients

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Hypothesis: Parathyroid glands are normally surrounded (entirely or partially) by fatty tissue. Subcutaneous parathyroid grafts are thus located in a normal environment. Therefore, we postulated that the late results of subcutaneous implantation of parathyroid tissue in uremic patients should be at least as good as those reported for intramuscular grafting. We also challenged the idea that the recurrence rate of renal hyperparathyroidism after surgery depended solely on the type of hyperplasia (diffuse vs nodular) observed in the implanted tissue.

Design: A retrospective study of a series of patients without loss to follow-up.

Setting: A university hospital and 9 affiliated dialysis units.

Patients and Interventions: Fifty-nine patients (33 women and 26 men) operated on for renal hyperparathyroidism underwent the resection of at least 4 parathyroid glands followed by presternal subcutaneous implantation of parathyroid tissue. They were followed up for 12 to 130 months (median, 38 months).

Main Outcome Measures: Failure of treatment, recurrence of disease, and hypoparathyroidism.

Results: During the study period, 9 patients had to undergo another operation: 2 (3%) for persistent hyperparathyroidism due to a fifth ectopic gland and 7 (12%) for recurrence of hyperparathyroidism resulting from hypertrophy of the subcutaneous grafts. Four patients received a kidney transplant. The prevalence of hypoparathyroidism (intact parathyroid hormone serum level <1.6 pmol/L with a normal or low serum calcium concentration) was 14% (8 of 59 patients), and the curve representing the distribution of intact parathyroid hormone serum concentrations among operated on patients was shifted to the left when compared with the curve of patients who underwent hemodialysis and who had no indication for parathyroid surgery. In this latter group, the peak of the curve was situated between 1 and 2 times the upper normal limit, while it was in the normal range 12 to 130 months after total parathyroidectomy and subcutaneous parathyroid autotransplantation. No relation was observed between the recurrence rate of the disease and the histological characteristics of the parathyroid grafts. Also, their function was not influenced by the presence or absence of aluminum deposits in bone biopsy specimens that were obtained at the time of cervical exploration.

Conclusions: The late results of total parathyroidectomy and presternal subcutaneous grafting compare favorably with the published data on other surgical techniques proposed for the treatment of renal hyperparathyroidism. The ease with which the hypertrophied grafts are removed when the disease recurs warrants further use of this procedure.

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SUBCUTANEOUS grafting of parathyroid tissue after total parathyroidectomy in uremic patients has seldom been described.1-3 Resection of hypertrophied grafts is easy when hyperparathyroidism recurs after this procedure, but the published series1-3 are small with a rather short follow-up. The present study determines how the late results of this procedure compared with those reported for other surgical techniques used in the treatment of renal hyperparathyroidism. We also investigated if the recurrence rate of the disease was related to the type of grafted parathyroid tissue (nodular vs diffuse hyperplasia).

RESULTS

Fifty-nine patients (33 women and 26 men) operated on for renal hyperparathyroidism were followed up for 12 to 130 months (median, 38 months) after undergoing total parathyroidectomy and subcutaneous implantation of autologous parathyroid tissue. Five parathyroid glands were excised in 2 patients; and in all the...
PATIENTS AND METHODS

SURGICAL PATIENTS AND THE POPULATION THAT UNDERWENT HEMODIALYSIS

The patients included in the surgical series were selected from a group of patients treated by parathyroidectomy who underwent subcutaneous implantation of parathyroid tissue for renal hyperparathyroidism between November 1, 1986, and August 31, 1996. Patients in whom fewer than 4 parathyroid glands had been resected before the grafting procedure were excluded from the study. No patient was lost to follow-up. The population that underwent hemodialysis comprised patients who presented no indication for surgical treatment. Their blood calcium levels were normal, and they were treated prophylactically with cholecalciferol, calcium supplements, or both. They did not receive aluminum-containing medications. Patients with diseases interfering with calcium and phosphorus metabolism, such as myeloma, Paget disease, bone metastases, and sarcoidosis, were excluded. The sex ratio and age distribution were similar in both groups. None of the patients had diabetes.

INDICATION FOR OPERATIVE TREATMENT AND SURGICAL PROCEDURES

Surgery was performed in all patients (first procedure and subsequent operations) when prophylactic treatment with calcium and cholecalciferol supplements failed because of spontaneous or induced hypercalcemia and a high blood phosphorus level. The patients underwent the excision of all visible parathyroid glands and the subcutaneous implantation of autologous parathyroid tissue in front of the lower third of the sternum. The exact number of glands removed during the procedure was determined by microscopic examination of all resected specimens. Parathyroid glands showing diffuse hyperplasia were preferentially used for grafting. However, when the amount of diffusely hyperplastic endocrine tissue was insufficient, nodular tissue was also implanted subcutaneously. At the time of cervical exploration, some patients underwent a bone biopsy of the iliac crest performed with an 8-mm trocar.

MEDICAL TREATMENT

Hemodialysis was carried out 3 times a week for 3 to 4 hours with a dialysate made with pure water obtained by reverse osmosis and containing 2.5 or 3.0 mEq/L of calcium depending on blood calcium and phosphorus concentrations. The patients were treated with oral calcium salts and 1,25(OH)2 vitamin D3 supplements in dosages adapted to their blood calcium and phosphorus levels. Moreover, at the beginning of the study, several patients had previously taken oral aluminum-containing phosphate binders.

PARATHYROID FUNCTION

Intact parathyroid hormone (PTH) levels were obtained in all patients using an immunoradiometric assay (N-tact PTH IRMA; Incstar Corp, Stillwater, Minn) (normal values, ≤5.8 pmol/L). Hypoparathyroidism was defined as an intact PTH serum level below 1.6 pmol/L with a normal or low blood calcium level (normal, 2.12-2.62 mmol/L [8.5-10.5 mg/dL]).

HISTOLOGICAL STUDIES

During the study period, the parathyroid glands were examined by 3 senior pathologists. These specimens were recently reviewed by a fourth (I.S.) who has a special interest in endocrine diseases and who was unaware of the clinical evolution of the patients. The histological characteristics of the glands were defined according to the criteria established by Akerström et al.6 Bone biopsy specimens were stained for aluminum by the aurintricarboxylic acid method and studied by histomorphometry.7

STATISTICAL ANALYSIS

Distribution data were analyzed by the Fisher exact test. The comparison of intact PTH serum levels in different groups of patients was performed with an unpaired t test using log-transformed data. Linear regression analysis was used to study the relation between serum intact PTH concentrations and delay after operation.
of hypoparathyroidism was 7 (21%) of 33 women and 1 (4%) of 26 men, but this difference did not reach the level of statistical significance (odds ratio, 6.37; 95% confidence interval, 0.77-58.75; \( P = .07 \)). The results of bone biopsies performed at the time of cervical exploration were available for 46 patients. All the samples showed typical features of pure hyperparathyroidism or renal osteodystrophy, and 13 presented with aluminum deposits in 5% to 74% of the total trabecular surface. There was no relation between parathyroid graft function and the presence or absence of aluminum deposits in these bone specimens (\( P = .63 \)).

Precise information concerning the histological characteristics of the grafted tissue was available in 48 of the 55 patients who did not receive a kidney transplant during the follow-up period. The samples showed typical features of pure hyperparathyroidism or renal osteodystrophy, and 13 presented with aluminum deposits in 5% to 74% of the total trabecular surface. There was no relation between parathyroid graft function and the presence or absence of aluminum deposits in these bone specimens (\( P = .63 \)).

Figure 1. Distribution of serum intact parathyroid hormone (PTH) levels in 46 surgical patients (top) and in 90 other patients undergoing hemodialysis (bottom). H, serum intact PTH level <1.6 pmol/L; N, serum intact PTH concentration in the normal range (1.6-5.8 pmol/L). The figures correspond to multiples of the upper normal limit of serum intact PTH concentration. For example, 5 corresponds to a value greater than 4 times up to 5 times the upper normal limit.

The most popular surgical procedures used to treat renal hyperparathyroidism are subtotal parathyroidectomy and total parathyroidectomy with intramuscular implantation of parathyroid tissue. A small amount of abnormal parathyroid tissue is left in the patient with both techniques. As chronic renal failure persists after the operation, this glandular tissue is continually stimulated, and hyperparathyroidism may recur. Some researchers presently advocate total parathyroidectomy without grafting to avoid these recurrences. They state that the absence of PTH has no significant clinical consequence on the bones of patients who undergo hemodialysis and who are treated with calcium and cholecalciferol supplements.6-9 These conclusions are, however, questioned by other investigators.10 The ideal blood concentration of intact PTH is not known for uremic subjects. Histomorphometric analysis of iliac crest bone biopsy specimens showed that it should be elevated to maintain a normal bone turnover, but the levels advocated by different researchers11-13 varied from 1.5 to 4.0 times the upper normal limit. As some secretion of PTH seems necessary, we
were again unable to confirm the observation made by Gagné et al. The reoperation rate was the same in both groups, and the intact PTH serum levels were not significantly higher in patients with nodular grafts. The slight increase that was observed could actually be explained by their longer follow-up compared with the patients with grafts of tissue showing diffuse hyperplasia.

RECENT PUBLICATIONS have shown that a significant proportion of uremic patients treated by maintenance hemodialysis present with hypoparathyroidism that consequently could not be attributed solely to the surgical procedure used in all our patients. Therefore, we compared the surgical patients with a population of patients treated by hemodialysis and who were not candidates for parathyroidectomy. There was a shift to the left of the curve representing the distribution of the intact PTH serum levels after total parathyroidectomy and subcutaneous autotransplantation when compared with this second group. As there is no consensus concerning the adequate intact PTH levels in patients with chronic renal failure, hypoparathyroidism was arbitrarily defined as an intact PTH level lower than 1.6 pmol/L. Admittedly, this definition does not include all the patients with a PTH secretion insufficient to maintain a normal bone turnover, but it allows a comparison with previously published data. In our study, the prevalence of late hypoparathyroidism after operation was 8 (14%) of 59 patients, which was significantly higher than the 3 (3%) observed in the 90 patients who underwent hemodialysis and who were not operated on, but was lower than the 29% and 38% reported by Gagné et al for total parathyroidectomy with intramuscular autotransplantation and subtotal parathyroidectomy, respectively. The discrepancies between both studies should, however, not be attributed only to differences in surgical technique. The evolution of the function of parathyroid grafts depends on multiple other factors, among which the prescribed therapy and the compliance of the patients are of utmost importance.

At the beginning of the present study, some uremic patients had received aluminum-containing phosphate binders as part of their treatment before undergoing parathyroid surgery. This type of medication is no longer administered in our unit to patients undergoing hemodialysis. Therefore, it was necessary to investigate separately the question of aluminum intoxication. Indeed, aluminum accumulates in parathyroid glands and is known to inhibit their hormonal secretion. We found no relation between the presence of aluminum deposits in bone biopsy specimens and the function of parathyroid subcutaneous grafts. This is in keeping with the results of Berland et al, who found that the aluminum content of parathyroid glands was similar in patients with or without bone aluminum deposits and was only correlated with serum aluminum levels. Moreover, in vitro studies with dispersed bovine parathyroid cells demonstrated that the suppression of PTH secretion was not an irreversible phenomenon. The PTH production returned to normal when aluminum was removed from the culture medium. Ac-
tually, hypoparathyroidism was also observed in patients who had not been exposed to aluminum and tended to be more frequent in women, which seems to indicate that some other factors, possibly technical, hormonal, or both, could be responsible for the lack of secretion of the grafts.

Finally, the slow progressive increase of blood intact PTH concentrations with time suggests that, in the future, other patients could require excision of the hypertrophied grafts. This is not a matter of concern because the procedure is quick and simple for presternal subcutaneous implants.

In conclusion, the late results of total parathyroidectomy with presternal subcutaneous autotransplantation compare favorably with published data on other forms of surgical treatment of renal hyperparathyroidism. The present results warrant further use of this procedure.

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