

VAQ 2009.2.6 (Bloods)

A 65 year old woman with a history of osteoporosis and depression presents with two weeks of increasing confusion and malaise.

Observations on arrival:

GCS	13	
HR	100	/min
BP	130/85	mmHg supine
Temperature	36	°Celsius

Serum biochemistry

Reference Range

Na+	144	mmol/L	134-146
K+	4.2	mmol/L	3.4-5
Cl-	98	mmol/L	98 - 106
HCO ₃ ⁻	38	mmol/L	22-32
Urea	17.2	mmol/L	3-8
Creatinine	58	micromol/L	45-90
Glucose	5.4	mmol/L	3.5-5.5
Calcium	4.47	mmol/L	2.1 – 2.5
Phosphate	0.92	mmol/L	0.75 – 1.4
Albumin	40	g/L	35 - 50

Describe and interpret her investigations (100%)

The significant abnormalities are hypercalcaemia, metabolic alkalosis, and uraemia, with an insidious onset of confusion. The normal creatinine suggests against renal failure as a cause of hypercalcaemia, and the normal phosphate suggests against hyperparathyroidism but does not exclude it. These abnormalities in a depressed osteoporotic patient are concerning for deliberate overdose of prescribed calcium and bicarbonate (i.e. the milk alkali syndrome), but the commonest causes are of hypercalcaemia are malignancy and hyperparathyroidism.

Abnormalities

markedly raised bicarbonate

suggests metabolic alkalosis (or chronic respiratory acidosis – check ABG if suspected)

upper GI losses (vomiting not mentioned in history unless concealed)

addition of base (ingestion – may be on calcium carbonate for osteoporosis/dyspepsia)

mineralocorticoid excess not supported by normal potassium

markedly raised urea with normal creatinine

hypovolaemia / pre-renal impairment

supported by raised hypercalcaemia

GI bleed / protein load not suggested by history

normal glucose

not cause for confusion

severe hypercalcaemia

could explain symptoms and confusion

commonest causes in ED - malignancy

history and exam +/- imaging may suggest

primary hyperparathyroidism

serum parathyroid hormone

other causes - ingestion of calcium

normal phosphate/albumin

calcium does not need correction

suggests against hyperparathyroidism