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Preoperative Noncoronary Cardiovascular Assessment and Management of Kidney Transplant Candidates
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On the Cover
What’s the diagnosis?
A 58-year-old man with a history of end-stage kidney disease secondary to polycystic kidney disease on hemodialysis presented for insertion of a pacemaker. Physical examination revealed bilaterally swollen shoulders with limited range of motion. Patient’s hemodialysis is limited to 2 hours at a time to limit post-dialysis. A chest x-ray showed bilateral periarticular calcification over the glenohumeral joints. His pertinent laboratory findings were serum creatinine 7.31 mg/dl, serum calcium 8.8 mg/dl, serum phosphate 6.2 mg/dl, and parathyroid hormone 1813.3 pg/ml.

Image Descriptions:
Image 1: This is an x-ray of the left humeral joint where we can see diffuse calcium deposits over the glenohumeral region.
Image 2: This is an x-ray view of the right humeral joint showing similar depositions. Here we can see the “sedimentation sign,” which is lobulated layering of calcium deposits. This is a common finding in Uremic Tumoral Calcinosis (UTC).

Key Teaching Points:
UTC occurs in 0.5-1.2% of hemodialysis patients and presents as painful nodular cystic growths around large joints. It is more common in the acetabular joint than the glenohumeral joint and is typically seen in patients with a GALNT3 mutation, which reduces phosphate breakdown. A hallmark of UTC is normocalcemia and hyperphosphatemia. Tumoral calcinosis was termed based on appearance of multiple well-defined tumors. While UTC is not a malignant condition, it can cause severe discomfort and limited motion. The best management is fine-needle aspiration for small UTC and surgical removal for larger UTC. To prevent recurrence, it is best to identify and treat the underlying pathology.

(Images provided by Vikas Yellapu, St. Luke’s University Health Network - Orthopedics, Bethlehem, Pennsylvania, and Sudip Nanda, St. Luke’s University Health Network - Cardiology, Bethlehem, Pennsylvania)