

PATIENT INFORMATION · GENERAL HEALTH

Raised calcium

an abnormal result that deserves a second test, not a shrug

Raised blood calcium is a common incidental finding on routine blood tests. The commonest cause is an overactive parathyroid gland — a condition that is curable with a small operation, and that is frequently left unexplained for years because the follow-up test is never done.

Seek urgent assessment if you have

- **confusion, drowsiness or personality change**
- **persistent vomiting** with dehydration
- **severe abdominal pain**, or a very high calcium level
- **excessive thirst and passing large volumes of urine**
- **irregular heartbeat or palpitations** with a raised calcium
- raised calcium alongside **weight loss, bone pain or a known cancer**

Severe hypercalcaemia is a medical emergency causing kidney failure, cardiac arrhythmia and coma. Raised calcium with weight loss or in someone with cancer needs same-day assessment. In an emergency call 999, or go to the Royal London Hospital Emergency Department, Whitechapel Road, London E1 1FR.

Symptoms, if any

Mildly raised calcium often causes nothing at all. When it does, the symptoms are famously vague and are routinely attributed to age, stress or the menopause. The old mnemonic is **bones, stones, abdominal groans and psychic moans**:

- **Bones** — aches, osteoporosis, fractures
- **Stones** — kidney stones, and passing large volumes of urine
- **Abdominal groans** — constipation, nausea, indigestion, occasionally pancreatitis
- **Psychic moans** — fatigue, low mood, poor concentration, irritability, brain fog
- excessive thirst, muscle weakness, and joint pain

The test that must follow

A raised calcium is not a diagnosis. The essential next step is to **repeat it, adjusted for albumin or as an ionised calcium, and to measure PTH (parathyroid hormone) at the same time**, along with vitamin D and kidney function. **A raised or even inappropriately normal PTH with a raised calcium means primary hyperparathyroidism** — a curable condition. A suppressed PTH points elsewhere and needs different investigation. Measuring calcium without PTH answers nothing, and this is where most cases stall.

What causes it

- **Primary hyperparathyroidism** — usually a single benign adenoma on one of the four parathyroid glands. By far the commonest cause in people who are otherwise well.
- **Cancer** — the commonest cause in people who are unwell, particularly with breast, lung, myeloma or kidney cancer.
- **Medicines** — thiazide diuretics, lithium, and excessive vitamin D or calcium supplements.
- **Sarcoidosis and tuberculosis**, and prolonged immobility.
- **Familial hypocalciuric hypercalcaemia** — a harmless inherited condition that mimics hyperparathyroidism and must be distinguished from it, because surgery does not help and is not indicated.

Assessment

- Repeat calcium with albumin, **PTH**, vitamin D, kidney function, phosphate and magnesium
- A **24-hour urine calcium**, which helps distinguish hyperparathyroidism from the familial condition
- **DEXA bone density scan**, since bone loss influences whether surgery is recommended
- **Kidney ultrasound** to look for stones
- Imaging of the parathyroid glands only once the diagnosis is biochemically established, to guide surgery

Treatment

Surgery

curative in around 95% of cases

Day case

for most, via a small neck incision

Monitoring

reasonable for mild, asymptomatic disease

- **Parathyroidectomy** — removing the overactive gland — cures the condition. It is recommended for symptoms, calcium above a threshold, kidney stones, reduced kidney function, osteoporosis, or age under 50.
- **Monitoring** is reasonable for mild disease without symptoms or complications: calcium and kidney function annually, bone density every one to two years.
- **Keep drinking normally** — do not restrict fluids — and stay active.
- **Do not stop dietary calcium**. Restricting it can worsen the condition by driving PTH higher. Vitamin D deficiency should be corrected, carefully and under supervision.
- Review any thiazide diuretic or lithium.

Why come to us. A raised calcium on a routine test very often goes no further than a note to repeat it sometime. We take **adjusted calcium, PTH, vitamin D, phosphate and kidney function in-house together** and explain the results in the same visit — which is what actually establishes the diagnosis. We arrange DEXA and parathyroid imaging through our CQC-registered partners, and refer to endocrine surgery where an operation would be curative. Seven days a week, no referral needed.

Calcium and PTH together, explained in one visit

The follow-up test most people never get. Seven days a week.

Book an appointment

or call 020 7916 0029

Where to get help

Tower Bridge Hospital London

97–99 Whitechapel Road, London E1 1DT

020 7916 0029

WhatsApp **07903 284 189**

info@mhwclinic.co.uk

Open 7 days, 9am–7pm

In an emergency

Call 999, or go to the Royal London Hospital Emergency Department, Whitechapel Road, London E1 1FR.

When we are closed and it is not an emergency

Call NHS 111 or visit 111.nhs.uk.

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Written and reviewed by Dr H Bolat, GP & Clinical Director Review date: 26 July 2026 Next review due: July 2028

Ref: TBH-PIL-223

This leaflet is based on current NHS and NICE NG132 guidance on hyperparathyroidism and CKS guidance on hypercalcaemia. It is general information and does not replace advice from a clinician who has assessed you. If your symptoms change or you are worried, contact us on 020 7916 0029, call NHS 111, or call 999 in an emergency.

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