Overview

Useful For
Aiding in the evaluation of patients with hypercalcemia of unknown origin
Aiding in the evaluation of patients with suspected humoral hypercalcemia of malignancy

The test should not be used to exclude cancer or screen tumor patients for humoral hypercalcemia of malignancy.

Method Name
Immunochemiluminometric Assay (ICMA)

NY State Available
Yes

Specimen

Specimen Type
Plasma EDTA

Specimen Required
Collection Container/Tube: Ice-cooled, lavender top (EDTA)
Submission Container/Tube: Plastic vial

Specimen Volume: 0.7 mL

Collection Instructions:
1. Centrifuge specimen in a refrigerated centrifuge or in chilled centrifuge cups.
2. Aliquot plasma into plastic vial and freeze.

Forms
If not ordering electronically, complete, print, and send a General Request (T239) with the specimen.

Specimen Minimum Volume
0.25 mL

Reject Due To

<table>
<thead>
<tr>
<th>Gross hemolysis</th>
<th>Reject</th>
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<tbody>
<tr>
<td>Gross lipemia</td>
<td>OK</td>
</tr>
<tr>
<td>Gross icterus</td>
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Specimen Stability Information
Test Definition: PTHRP
PTH-Related Peptide

<table>
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<tr>
<th>Specimen Type</th>
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<th>Time</th>
<th>Special Container</th>
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<tbody>
<tr>
<td>Plasma EDTA</td>
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Clinical and Interpretive

Clinical Information

Parathyroid hormone-related peptide (PTHrp) exists in several isoforms, ranging in size from 60 to 173 amino acids, which are created by differential splicing and post-translational processing by prohormone convertases. PTHrp is produced in low concentrations by virtually all tissues. The N-terminus and the secondary structure of multiple isoforms of PTHrp resemble parathyroid hormone (PTH), allowing PTHrp to bind to the same receptor as PTH. The physiological role of PTHrp can be divided into 5 categories: 1) transepithelial calcium transport, particularly in the kidney and mammary gland; 2) smooth muscle relaxation in the uterus, bladder, gastrointestinal tract, and arterial wall; 3) regulation of cellular proliferation; 4) cellular differentiation and apoptosis of multiple tissues; and 5) as an indispensable component of successful pregnancy and fetal development (embryonic gene deletion is lethal in mammals).

Hypercalcemia of malignancy (HHM) is a common complication of cancer. Elevations of PTHrp are the most common cause of malignancy-associated hypercalcemia. PTHrp leads to hypercalcemia by stimulating calcium resorption from bone and reabsorption in the kidneys. It also plays a significant function in osteolysis in bony metastases, particularly in breast cancer, and has been postulated to play a role in malignancy-associated cachexia through induction of orexigenic peptides.

Various malignancies secrete PTHrp resulting in HHM. PTHrp production is most commonly seen in carcinomas of breast, lung (squamous), head and neck (squamous), kidney, bladder, cervix, uterus, and ovary. Neuroendocrine tumors may also occasionally produce PTHrp. Most other carcinomas, sarcomas, and hematolymphatic malignancies only sporadically produce PTHrp, with the exception of T-cell lymphomas and myeloma. In HHM, the typical laboratory presentation includes elevated calcium (Ca) and PTHrp, decreased PTH, and suppressed serum 1,25 dihydroxyvitamin D3 levels. Patients with HHM may have increased PTHrp values before treatment. PTHrp level decreases and PTH level increases, accompanied by decreased serum calcium values, are observed with successful treatment.

Reference Values

< or =4.2 pmol/L

Interpretation

Depending on the patient population, up to 80% of patients with malignant tumors and hypercalcemia will be suffering from humoral hypercalcemia of malignancy (HHM). Of these, 50% to 70% might have an elevated parathyroid hormone-related peptide (PTHrp) level. These patients will also usually show typical biochemical changes of excess parathyroid hormone (PTH)-receptor activation, namely, besides the hypercalcemia, they might have hypophosphatemia, hypercalcuria, hyperphosphaturia, and elevated serum alkaline phosphatase. Their PTH levels will typically be less than 30 pg/mL or undetectable.

In patients with biochemical findings that suggest, but do not prove, primary hyperparathyroidism (eg, hypercalcemia, but normal or near-normal serum phosphate, and a PTH level that is within the population reference range but above 30 pg/mL), HHM should be considered as a diagnostic possibility, particularly if the patient is elderly, has a history of malignancy, or risk factors for malignancy. An elevated PTHrp level in such a patient is highly suggestive of HHM as the cause for the hypercalcemia.

Cautions
Parathyroid hormone-related peptide (PTHrP) can be elevated in pregnant and lactating women and in newborn infants. Nonmalignant conditions that have been described in association with elevated plasma PTHrP levels include systemic lupus erythematosus, HIV-associated lymphadenopathy, lymphedema of chest or pleural cavities, and with benign tumors of the ovary, kidney and the neuroendocrine system.

Because of the complexity of PTHrP isoforms, the differences between various PTHrP assays and the lack of a common calibration standard, PTHrP measurements performed with different assays cannot be compared easily.

The complex isoform mixture of PTHrP can occasionally lead to pronounced nonlinearity on dilution of patient specimens. In these situations an accurate measurement of PTHrP concentrations might be impossible.

Like all immunometric assays, PTHrP assays are susceptible to false-low results at extremely high analyte concentrations ("hooking") and to rare false-positive results due to heterophile antibody interference. Therefore, if test results are incongruent with the clinical picture, the laboratory should be contacted.

Clinical Reference


Performance

Method Description
The parathyroid hormone-related peptide (PTHrP) assay is a plate-based chemiluminescent assay utilizing an anti-PTHrP rabbit-polyclonal antibody for capture and an acridinium ester anti-PTHrP goat-polyclonal antibody for detection. The assay targets 1-86 PTHrP.(Unpublished Mayo method)

PDF Report
No

Day(s) and Time(s) Test Performed
Monday through Thursday; 2 p.m.

Analytic Time
2 days

Maximum Laboratory Time
5 days

Specimen Retention Time
3 months

Performing Laboratory Location
Rochester
Fees and Codes

Fees
- Authorized users can sign in to Test Prices for detailed fee information.
- Clients without access to Test Prices can contact Customer Service 24 hours a day, seven days a week.
- Prospective clients should contact their Regional Manager. For assistance, contact Customer Service.

Test Classification
This test was developed and its performance characteristics determined by Mayo Clinic in a manner consistent with CLIA requirements. This test has not been cleared or approved by the U.S. Food and Drug Administration.

CPT Code Information
82397

LOINC® Information

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