Acute pancreatitis induced by hypercalcemia due to primary hyperparathyroidism (PHPT) is a very rare condition, with the incidence estimated to be between 1.5% and 7%. Previous studies conducted in India report the incidence of PHPT between 6.8% and 12%. However, in patients with PHPT and resulting hypercalcemia, experience pancreatitis occurs 10- to 20-fold times more often than in the general population. The metabolic causes of acute pancreatitis include diabetic ketoacidosis, hypertriglyceridemia, and hypercalcemia with or without hyperparathyroidism. Normally, hypocalcemia is generally occurs during an attack of acute pancreatitis, thus hypercalcemia is a strong clue predictor for suspecting PHPT. Hence, findings of elevated serum calcium levels associated with pancreatitis should alert the physician to either be indicative of hyperparathyroidism or malignancy. The metabolic causes of acute pancreatitis include diabetic ketoacidosis, hypertriglyceridemia, and hypercalcemia with or without hyperparathyroidism. The most common etiologies of pancreatitis are gallstones and alcoholism, are the commonest etiological agents of pancreatitis. Serum calcium level is not routinely measured in all patients diagnosed with the first attack of acute pancreatitis as it is not a common etiology. Some patients suffer from two or more attacks of pancreatitis before being diagnosed with diagnosis of PHPT. Here we describe the case of a 30-year-old female patient who presented to a gastroenterology unit with severe upper abdominal pain, vomiting, and a 3-day history of fever of 3 days' duration. She had experienced a similar episode of similar symptoms 2 months previously, for which she was admitted to a civil hospital and diagnosed, where she was diagnosed as with case of acute pancreatitis. There, she was and was managed conservatively and discharged after 7 days. She had no additional risk factors causing acute pancreatitis, such as history of alcohol.
consumption, or hyperlipidemia, and gallstones were present; however, she had a history of undergoing cholecystectomy 1.5 years earlier for gallstones. After proper evaluation, she was diagnosed with a history of post-cholecystectomy acute pancreatitis was made, and the patient was managed conservatively. However, she was readmitted within the next 5 months, after experiencing dyspeptic symptoms and abdominal pain of 20 days’ duration. On physical examination, the abdomen was found to be soft with diffuse tenderness, especially in the right hypochondrium.