**A1:** ‘?Hypocalcaemia secondary to magnesium deficiency (blunted PTH response). See <http://nww.lhp.leedsth.nhs.uk/common/guidelines/detail.aspx?ID=2105> for guidance on Mg replacement before repeat Ca.’

**A2:** ‘Hypocalcaemia with low PTH suggestive of primary hypoparathyroidism, suggest referral to Endocrinology.’

**A3:** ‘Hypocalcaemia with low PTH suggest repeat with Mg’

**B1:** ‘?Hypocalcaemia secondary to magnesium deficiency (blunted PTH response). See <http://nww.lhp.leedsth.nhs.uk/common/guidelines/detail.aspx?ID=2105> for guidance on Mg replacement before repeat Ca.’

**B2:** ‘Hypocalcaemia with inappropriately normal PTH suggestive of primary hypoparathyroidism, suggest referral to Endocrinology.’ however if borderline low calcium suggest repeat in the first instance.

**B3:** Hypocalcaemia with inappropriately normal PTH suggest repeat with Mg.

**C1:** ‘Secondary hyperparathyroidism due to vitamin D deficiency/insufficiency

**C2:** ?historical vitamin D deficiency/?Mg.’

**C3:** ?Vitamin D status

**D:** ‘Normal calcium with low PTH unlikely to be significant.’

**E:** Normal profile

**F1**: Secondary hyperparathyroidism due to vitamin D deficiency/insufficiency

**F2:** ?normocalcaemic primary hyperparathyroidism, suggest repeat in the first instance before considering referral to Endocrinology.

**F3:** ‘Calcium within reference range and borderline raised PTH likely not significant. Unless primary hyperparathyroidism is suspected no follow up required.

**G:** ‘Non-PTH dependant hypercalcaemia suggest further investigations’.

**H:** ‘Hypercalcaemia with PTH in the reference range consistent with primary hyperparathyroidism, suggest referral to Endocrinology.’

**I:** ‘Hypercalcaemia with raised PTH consistent with primary hyperparathyroidism, suggest referral to Endocrinology’