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CLINICAL CASE OF A CHILD N. WITH A DIAGNOSIS: DIFFUSE TOXIC GOITER OF II DEGREE, MODERATE SEVERITY. SECONDARY (THYROTOXIC) CARDIOMYOPATHY. CHRONIC KIDNEY DISEASE 1 ST. HORSESHOE-SHAPED KIDNEY WITH DOUBLING OF THE TUBAL AND PELVIS SYSTEM, RIGHT HALF (ECHOSCOPICALLY). CYST OF THE RIGHT OVARY. MASTOPATHY.

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Introduction: Diffuse toxic goiter is a disease caused by excessive secretion of thyroid hormones under the influence of thyroid-stimulating antibodies of diffusely enlarged thyroid gland.

Purpose of work: Description of the clinical case of the child N. with the diagnosis: Diffuse toxic goiter of II degree, moderate severity. Secondary (thyrotoxic) cardiomyopathy. Chronic kidney disease 1 st. Horseshoe-shaped kidney with doubling of the tubal and pelvis system, right half (echoscopically). Cyst of the right ovary. Mastopathy.

Clinical case: Child H. delivered to the Regional Children's Clinical Hospital with complaints of tearfulness, irritability, heart palpitations, fast fatigue, a feeling of "coma" in the throat, tremor of hands, tremors of the whole body, weight loss, hair loss, increased blood pressure to 140/50, consciousness, headaches.

Anamnesis of the disease: The above complaints appeared 2,5 years ago. It is known that the girl was consulted by an endocrinologist in 2015, where it was revealed: a hypothalamic syndrome of the pubertal period, diffuse goiter 1-2 st. Despite the revealed changes in the hormonal examination: thyroid-stimulating hormone -0,05 MME/ml (N 0,23-3,4), ant. to thyroid peroxidase - 46,5 U/ml (N to 30), the child did not resort to the endocrinologist again. The child's condition deteriorated sharply 2 months ago. The girl was hospitalized in the Central Regional Hospital, where she received treatment for autonomic dysfunction, without the proper

effect. Later he was sent to the Regional Children's Clinical Hospital for examination and treatment.

Objectively on admission: heart rate 130 beats per minute, arterial pressure - 110/50. The general condition is severe. Physical development is disharmonious, asthenic. Skin covers pale, white striae on the mammary glands, thighs, diffuse hyperhidrosis, periorbital hyperpigmentation, pastose of the eyelids. Attention is paid to the pastosity of the feet. Choreoid twitching of the muscles of the hands. Thyroid gland enlarged to 4 degrees (according to Nikolayev), dense, palpation painless, mobile. The submandibular lymph nodes are enlarged. Cardiac tones are marked tachycardia. Stool 3-4 times a day. Sexual formula: Ax3 P5 Ma4 Me3 (hypermenorrhoea).

The results of the conducted studies: Ultrasound of the thyroid: sharp hyperplasia of the 4th degree, increased parenchymal echolarsity, parenchyma linear fibrosis septa (with the «central thyroid gland» phenomenon, ultrasound signs of autoimmune thyroiditis, hypertrophic form); Ultrasound of the abdominal organs, kidney: horseshoe-shaped kidney with signs of doubling of the right side of the tubal and pelvis system. Cyst of the right ovary; Ultrasound of the mammary glands: minor fibrotic changes in the parenchyma of the mammary glands from both sides; ECG: sinus tachycardia, hypertrophy or hyperfunction of the left ventricle and atrium, Ps 109 beats per minute, a blood test for hormones: thyroid-stimulating hormone - 0,12 MME/ml (N 0,23-3,4); T3 - 9,98 Pmol /ml (N to 2,5-5,8); ant. to thyroid peroxidase - 496,6 U/ml (N to 34); T4 - 49,8 Pmol /ml (N to 10,0-23,2); ant. to the thyroid-stimulating hormone receptor – 13,84 ME/l (N to 1,75).

Received treatment: espa-carb (20 mg/day, then - 25 mg/day), anaprilin, cardonate, glycine, aspartame. Against the background of ongoing therapy, the state of the child has significantly improved.

Conclusions: On the example of the presented clinical case, we see a combination of different symptoms, which manifests itself under various types of «masks». In connection with this, regular preventive examinations should be

conducted for the early detection of thyroid pathology and the timely start of drug therapy.

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CLINICAL CASE PRESENTATION OF PATIENT WITH HIV-ASSOCIATED PRIMARY CENTRAL NERVOUS SYSTEM LYMPHOMA

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Topic: HIV-associated primary central nervous system lymphoma (PCNSL) is a diffuse, large-cell non-Hodgkin lymphoma (NHL) of B-cell origin that usually occurs in the brain in the late stage of infection. Epstein-Barr virus (EBV) is identified in almost all cases. PCNSL accounts for up to 15 % of NHLs in HIV-infected patients. Even with early treatment the prognoses is poor. There is no strongly recommended guidelines for management of this patient. We report a case of successfully treated adult with PCNSL.

Materials and methods: A 39-year-old female presented with fever, headache, feelings of weakness, numbness and paraesthesia in the right limbs, loss of coordination, lethargy and dizziness for 1-month period. It is known that patient had been HIV-1-infected from 2013, and doesn’t take HAART. Last CD4 cell count was at the level of 26 cells/ml.

On examination: the patient was lethargic with decreased mood and with Glasgow coma scale score of 15. Meningeal signs and mental disorders were negative. She had had left lower motor neuron facial palsy and right hemiparesis (hypotonia, hemihypesthesia, hyperreflexia on the right limbs plus pathological Babinski and Oppenheim's sings). The other systems were normal.

The CSF was with a protein concentration of 0.9 g/l, cells count of 3/mm3 due to lymphocytes, and a glucose concentration of 3.2 mm/l. PCR of CSF was positive on EBV DNA. MRI revealed 3 lesions located in the deep and juxtacortical regions of the white matter in the frontal lobe and in the right middle cerebellar peduncles.