ine 50 mcg in the morning). First hormonal studies conducted in the early 2000s. There was revealed a high level of TSH, but replacement therapy was continued despite the manifestations of thyrotoxicosis. Free T4 Episodic study revealed increased rates of medical and regarded as thyrotoxicosis. Clinically, the patient had symptoms of hyperthyroidism DC with lesions predominantly cardiovascular system, since 2007 atrial fibrillation, mitral and tricuspid insufficiency, replacement of heart valves. The first pair of hormones (TSH and FT4) on a clean background was investigated in 2016. In the repeated trial (which excluded a laboratory error) at the same time an elevated level of TSH (20.8 mMe/ml) and FT4 (34 pmol/l). The differential diagnosis with resistance to thyroid hormone. The study of the brain and pituitary MRI with dynamic contrast. Pituitary adenoma was found 0.2 cm in diameter. Exhibited a clinical diagnosis of TSH-producing pituitary adenoma. The patient was operated in neurosurgical center of Far Eastern federal university's medical centre. Performed transnasal transsphenoidal adenomectomy with endoscopic video navigation in January 2017. According to the results of immunohistochemistry. According to the results of immunohistochemistry: Ki-67, Alpha ingiban — negative expression. Chromogranin — weak expression in 10—20% of the cells. TSH — strong expression in 90—100% of the cells, prolactin expression severe 80—90% of the cells. **Conclusion.** IHC tumor profile best fits multigormonalnoy pituitary adenoma with minimal formation of proliferative activity of cells. When hormonal study TSH decreased to 3.45 mMe/l, retained a higher level of St. T4 30.4 pmol/l. The patient was recommended treatment with somatostatin analogues (octreotide Long 40 mg of p 1 to 28 days/m) and dopamine agonists (cabergoline 0.5 mg 2 p per week) - on 6 months follow-up examination. The patient entered into the register of entities gipotalyamo pituitary region of Primorsky Krai. This case is the second in the coastal region.

KEYWORDS: pituitary adenoma, endocrine pathology, prolactinoma, somatotropinoma.

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SECONDARY AND TERTIARY HYPERPARATHYROIDISM: CASE REPORT

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Introduction. In the treatment of secondary hyperparathyroidism of chronic kidney disease, allosteric modulators of the calcium-sensing receptor — inhibit glandular hyperplasia, reduce parathyroid hormone (PTH) levels, impact on bone turnover and mineral density (BMD). But the use of calcimimetic did not reduce the need for parathyroidectomy for refractory hyperparathyroidism. Tertiary hyperparathyroidism is a state of excessive secretion of PTH after a long period of secondary hyperparathyroidism and renal transplantation. **Case report.** We present the case of a 43-year-old caucasian male undergoing chronic hemodialysis since 2006. Laboratory investigations showed elevated levels of phosphorus 1.95 mmol/l, calcium 2.6 mmol/l, CaxP 5.07 mmol2/l2, iPTH 817 pg/ml, CTx 3.1 ng/ml, OC >300 ng/ml, ALP 469.6 U/L, vitamin D deficiency 7.9 ng/ml. Ultrasound revealed multiple enlarged parathyroid glands: right superior 1.08 cm3; right inferior 0.04 cm^3; left superior 0.3 cm^3 and left inferior d=0.6 sm. DEXA revealed osteoporosis (Z-sc): Rad 33% –4.0; L2—L4 —1.1; total femur —2.2 SD. We have recommended dialysis with low calcium (1.25 mmol/L) and cinacalcet 30 mg/day. Laboratory investigations were done during the treatment. After normalization of serum calcium and phosphorous concentrations we have added cholecalciferol. Six months later mean iPTH and Ca×P levels decreased by 60.2 and 20.4%. Bone markers decreased by CTx 19.4%; OC 1.4%; ALP 16.8%. 25-D levels increased by 123.4%. The dynamics of BMD from baseline: L2—L4 +5.4%; Rad 33%: +9.3; total femur +6.4%. On ultrasound 3 parathyroid glands (right inferior, left superior and inferior) involute to normal size, but right superior enlarged 1.9 cm^3 (+75%). Patient underwent renal transplantation in 2010 (CKD stages 1—2). After successful kidney transplantation right superior parathyroid gland did not involute. One months later he developed the tertiary hyperparathyroidism with an iPTH 815 pg/ml, calcium 3.4 mmol/l. Was recommended cinacalcet initially in dose 30 mg, then was dose-increased to 180 mg/day in 2011 (calcium 2.4 mmol/l, iPTH 634 pg/ml), added alfacalcidol 6 mcg/week, but did not control hyperparathyroidism. In 2011 performed a right superior-gland parathyroidectomy to treat severe hyperparathyroidism refractory to cinacalcet and alfacalcidol treatment. **Conclusion.** Our case study shows that cinacalcet treatment is an effective therapy of hyperparathyroidism. But enlarged gland (larger than 0.5 cm^3 or 1 cm in diameter) became refractory to medical therapy and patient need for parathyroidectomy.

KEYWORDS: hyperparathyroidism, mineral density, bone, chronic hemodialysis, chronic kidney disease, parathyroid hormone.

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LONG-TERM MANAGEMENT OF RESISTANT ACROMEGALY WITH PASIREOTIDE LAR IN A PATIENT FROM AN AIP MUTATION POSITIVE FIPA FAMILY

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Introduction. AIP-related somatotropinoma patients with active acromegaly after surgery tend to be resistant to adjuvant medical therapy with somatostatin receptor