a parathyroid adenoma, in the thickness of the left lobe - an isoechoic node measuring 12.2*14.0*18.6 mm and altered lymph nodes in the supraclavicular areas. A trephine biopsy of the cervical lymph node was performed, and sarcoid-type granulomas were identified. During surgery, the altered lower parathyroid gland on the right and the left lobe of the thyroid gland were removed. By the evening after surgery the level of calcium in serum decreased to 2.32 mmol/l; after 10 days, the level of calcium was above 3 mmol/l with a steady increase to 3.96 mmol/l, while the level of parathyroid hormone decreased. A diagnosis of sarcoidosis was made. The patient received methylprednisolone at a dose of 32 mg daily. A day after starting methylprednisolone, calcium levels gradually began to decrease. In the presented clinical case, a thorough analysis of clinical, laboratory and instrumental data revealed a rare combination of parathyroid hormone-dependent and parathyroid hormone-independent hypercalcemia. The patient was diagnosed with primary hyperparathyroidism and sarcoidosis with involvement of the mediastinal and cervical lymph nodes.

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A case report of a patient with severe postoperative hypoparathyroidism

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Beckgrounds and aims
The most common cause of hypoparathyroidism is postoperative, i.e., after thyroid, parathyroid, or radical neck surgery due to neoplasms, and is most often transient, whether continuous or even intermittent. The incidence of permanent hypoparathyroidism ranges from 0.8 to 3.0% in patients after total thyroidectomy. In this case report, we will present a patient with a severe form of postoperative hypoparathyroidism refractory to standard treatment regimens.
Methods
A 49-year-old patient underwent total thyroidectomy due to recurrent hyperthyroidism and diffuse goiter. Postoperatively, she received levothyroxine, cholecalciferol, and calcium carbonate. Two months after the procedure, the patient complained of tingling in her hands, feet, and face and spasms of the esophagus. Since then, lower values have been constantly observed in the findings of total and ionized Ca with immeasurably low PTH. The dose of drugs was gradually increased (cholecalciferol: 25 000 IU once a week; calcitriol: up to 4.5 mg; calcium carbonate: up to 6 g; magnesium citrate: 300–400 mg per day) with frequent applications of calcium gluconate infusion, without improvement. Since rhPTH (l-84) is not available in our country, we started with subcutaneous administration of teriparatide with a gradual increase in the dose up to 3x20 mg per day, but without improvement. After reviewing the literature, we decided to use teriparatide via an insulin pump.
Results
After the introduction of the catheter-less pump, the serum Ca values quickly normalized, and during the following 3 months, they were maintained at reference values with a stable dose of teriparatide (24 mg/24 h). On January 5 2023, the patient switched to a catheter pump, and since then, large oscillations of serum Ca have been monitored again with symptoms of hypocalcemia and the need for constant correction of the teriparatide dose. On April 28 2023, she switches again to a catheter-less pump with stabilization of the general condition and the dose of teriparatide (18 mg/24 h).
Conclusions
Although chronic postoperative hypoparathyroidism rarely occurs, in most cases it is easily resolved with the use of vitamin D and calcium supplements. In a small number of patients, it is necessary to apply replacement therapy with a parathormone analogue. In our case, the patient stabilized only after continuous use of teriparatide via an insulin pump.

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Severe hypomagnesemia: outpatient management in endocrinology and nutrition unit

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Magnesium disorders are common in clinical practice. Hypomagnesemia is seen in inherited disorders, with excessive gastrointestinal or renal losses and due to medications. Replacement of magnesium can be challenging, with oral replacement strategies being generally more effective at slowly replacing body storages and intravenous (iv) replacement being more effective at treating life-threatening and severe cases of hypomagnesemia.
Objective, material and methods
To analyze clinical history and evolution of a group of patients with severe hypomagnesemia who received treatment with iv magnesium in the Endocrinology and Nutrition day hospital center of a tertiary hospital during 2023.
Results
7 patients. 5 men. Mean age: 62.6 years. Follow-up 40.9 months. Hypomagnesemia causes: - Short intestine syndrome (5), etiology: Crohn disease (3), surgery complications (1) and radical enteritis (1). - Chronic diarrhea syndrome with Gitelman syndrome (1). - Malabsortion syndrome post bariatric surgery (1). No diagnosis of severe hypomagnesemia due to pharmacology causes. 3/7 with ileostomy. Two patients received additional treatment with iv suerotherapy weekly. One received domiciliary daily suerotherapy through PICC. 3/7 with chronic renal disease. 4/7 chronic consumers of PPIs at start of follow-up. 3/7 maintained it at the end of follow-up as part of high debit ileostomy treatment. 2/7 went to the emergency department during follow-up for neurological complications in the form of vegetative symptoms followed by distal paresthesias and dizziness. The most frequent frequency of infusion was once a week, except for one patient who received iv magnesium infusion every 4 days. As for the amount of magnesium administered, the mean was 585 mg iv per week, with a maximum of 900 mg iv per week and a minimum of 300 mg iv every 15 days. All patients received oral supplementation with magnesium, on average 745 mg/day. 5/7 received oral calcium supplementation, mean 960 mg/day. 3/7 were receiving oral potassium supplementation, mean 2400 mg/day. Magnesium levels improving during the follow-up (initial compared to last visit) [0.91 vs 1, 44 mg/dl (t -3.17 p.019)]. 3/7 treated with oral nutritional supplements because of malnutrition (GLIM criteria). No significant changes in weight and BMI during follow-up.
Conclusions
In our series, the pathology that led to treatment with iv magnesium and high-dose oral supplementation was mainly due to digestive and malabsorption causes. Close monitoring, as well as joint treatment with iv magnesium and high-dose oral supplementation, achieved significant improvements in magnesium blood levels in our sample.

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Adipsic central diabetes insipidus as a result of neurosarcoidosis

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Background
Sarcoidosis is a multisystemic disease, the cause of which has not yet been determined. It's characterized by the appearance of granulomas, which typically target the lungs, the lymphatic system and in rare cases, around 5-15%, changes in the nervous system are observed. Neurosarcoidosis leads to hypothalamus-pituitary axis dysfunction and the most common clinical manifestation is the onset of central diabetes insipidus.
Case report
We present the case of a 46-year-old female patient with neurosarcoidosis and changes in the hypothalamus-pituitary axis and clinical manifestation of hypopituitarism, along with a non-typical presentation of central diabetes insipidus. The diagnosis of neurosarcoidosis has not been confirmed with a biopsy due to its high risk and difficulty to access. However, according to the CT and MRI results and the clinical presentation, an intensive hormone replacement therapy was administered to reduce the clinical symptoms. What is notable about this case is the diagnosis for central diabetes insipidus, which could not be confirmed based on the clinical characteristics because of the absence of polydipsia and polyuria, as well as with the classic water deprivation test because of persistent hypernatremia, which was confirmed by excluding other potential causes of hypernatremia.
Conclusion
Neurosarcoidosis has a rich clinical presentation and is a challenge when it comes to diagnosis and treatment, particularly with patients with disorders in the hypothalamus-pituitary axis and non-typical adipsic central diabetes insipidus.
Keywords: neurosarcoidosis, central diabetes insipidus, hypernatremia

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