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ABSTRACTS
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degree - very high risk. Prescribed: glimepiride-4 mg, levothyroxine-125 mg, amlodipine-2.5 mg, bisoprolol-2.5 mg, aspirin-75 mg, atorvastatin-10 mg.
The patient was discharged due to improvements. BP was stabilized while angina and dyspnea decreased. However, leg pain, lower extremities seizures, toe numbness, impaired vision and reduced memory persisted.
Conclusion. Complications of DMT2 combined with hypothyroidism on the background of compensation of the glycemic curve and TSH is seen to progress faster and proves more difficult to treat. This creates a difficult clinical task in managing patients with combined endocrine pathology.

SILENT CORONARY HEART DISEASE IN PATIENT WITH DIABETES MELLITUS TYPE 2

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Introduction. The severity of hyperglycemia in diabetes mellitus (DM) Type 2 is not high enough for the development of a typical clinical picture, so the disease is asymptomatic for a long time and leads to the development of various vascular complications, among which coronary heart disease (CHD) plays the main role. One of the important causes of CHD in patients with DM is autonomous cardiovascular neuropathy, including silent myocardial ischemia.
The aim of the study. To study a clinical case of a patient with DM and silent CHD. The goal is to raise awareness of the prevalence of DM and silent CHD and also the influence of DM on the progression of CHD, focusing on diagnostic investigation and treatment strategies.
Clinical Case: Patient N. men is a 72 years old, admitted to the hospital with such complaints: increase blood pressure up to 160/100 mm.Hg, moderate shortness of breathing during walking, pain in the muscles of both legs during walking, numbness of low extremities, general weakness. From the anamnesis- DM Type 2 on insulin since 2008, hypertonic disease, obliterating atherosclerosis of the lower extremities arteries (endovascular stenting of the right common iliac artery in 2018), gallstone disease, chronic calculous cholecystitis and chronic pancreatitis in remission, duodenal ulcer (operated in 1981). CHD was suspected. Different laboratory and instrumental tests were made in the hospital.
Electrocardiography: left ventricular hypertrophy, diffuse disturbances of repolarization processes. Echocardiography: cardiosclerosis, diastolic dysfunction of the left ventricle, left ventricular hypertrophy, moderate decrease myocardial contractility. Ultrasound examination of the vessels of the lower extremities: signs of obliterating atherosclerosis with decompensation of peripheral blood flow. Daily monitoring of the electrical activity of the heart: the rare episodes of reversible disorders repolarization ischemic type, manifested horizontal segment ST depression. Coronary angiography: pronounced coronary calcification. The left coronary artery is an extended section with critical subocclusions, an extended chronic occlusion of the envelope of the artery, the