**Summary**

1. In literature declared and in our material recorded unreliability of immunofluorescent examination in comparison with the results of IRMA method has structural character. The worst findings (bad agreement) are observed in cases with low positive of IIF on one ( + ) or two ( ++ ). Excellent agreement is found in cases with negative immunofluorescent findings (agreement 99,1 % for thyroglobulin and 99,3 % for thyroperoxidaze ). Relatively very good agreement is observed in the second extreme with the highest value of immunofluorescent examination on three ( +++ ) and it is 83,3 % for thyroglobulin and 67,5 % for thyroperoxidase.

2. In cases, where immunofluorescent screening examination for detection of antithyroid antibodies ( TgAb a TPOAb ) was evaluated on one ( + ) or two ( ++ ), is useful immunofluorescent examination revise beyond a certain date, or carry out examination by quantitative method such as IRMA.

3. Small claim on instrumental equipment for carrying of immunofluorescent detection is possible even in a small pathological department. All method dependent on industrial elaboration of sera need such equipment, that they are suitable only for big departments.

4. Valuable feature of the immunofluorescent examination is its flexibility and operativeness – the examination is possible to carry out as statim – it does not require accumulation of the demands – not to wait from the economic reasons for utilization of the whole capacity of the testing set as it is in other methods.

5. Except currently applied demands (daily including of negative and positive controls) is useful to ensure evaluation of immunofluorescent findings (especially their semiquantitative aspect) by the same evaluator.

6. Circumstance that the autoantibodies do not lost binding ability even after the week of preservation at room temperature, allows to solve problematic cases (disagreement of the immunofluorescent examination with clinical condition and others findings ) by sending the sera samples to the central referential department by post.

7. It is necessary to keep the condition so the source of the tissues for the detection of autoantibodies has the blood group 0, otherwise unreliable immunofluorescence of some tissues structures occurs bearing also izohaemagglutinogens as are lining of blood-vessel – endothelium.

8. Examined serum standard dilute in the rate of 1:10 with phosphate buffered saline solution ( PBS ) usually this dilution is enough for background clarification, but also for attenuation of non-specific antibodies bindings.

9. Percentage representation of autoantibodies against thyroglobulin and thyroperoxidase is in diffuse lymphocytic thyroiditis higher than in focal lymphocytic thyroiditis and it is proportional with stage of damage of thyroid gland.

10. In shows in our study that comparison of morphological findings and serological date makes from the immunofluorescent techniques useful examination, which confirms morphologically suspected immunological disease. It corrects unreliable cytological findings of thyroid gland there, where cytology itself fails (especially in case of false negative and false positive results) in the patients with clinical diagnosis of autoimmune lymphocyte thyroiditis.

11. Cytodiagnostic accuracy of FNAC in Hashimoto´s thyroiditis in followed group is 75 % and in focal lymphocytic thyroiditis is 20 %. Surprising cytological inaccurancy (disagreement), in the frame of FLT diagnosis can have double reason. One source of the inaccuracy is interpretative problem – small cluster of lymphocytes was by mistake considered for the manifestation of Hashimoto´s thyroiditis. On the other side wrong aim is the source of errors and mistakes, in which the small foci of the focal lymphocytic thyroiditis could imitate cytological negative finding.