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Infectious skin diseases

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Infectious skin diseases

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ANNOTATION

Infectious skin diseases are conditions caused by pathogenic microorganisms such as bacteria, viruses, fungi, or parasites that infect the skin, leading to a variety of lesions, rashes, or other dermatological symptoms.

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LIST OF ABBREVIATIONS

Ig - immunoglobulin

RW - Wasserman reaction

HIV - human immunodeficiency virus

H.P.V. is herpes simplex virus.

WHO - World Health Organisation

CHD - coronary heart disease

ELISA - enzyme-linked immunosorbent assay

STDs are sexually transmitted infections

TTD - Skin and Genital Dispensary

CLS - clinical and serological control

CEB - classical serological reactions

FFP - false positive reactions

Physical exercise treatment - therapeutic physical therapy

ICD - International Classification of Diseases

NSAIDs are non-steroidal anti-inflammatory drugs.

PCR - polymerase chain reaction

RIBT - immobilisation reaction of sores treponema

IGF - immunofluorescence reaction

MR - micro-precipitation reaction

PGR - passive haemagglutination reaction.

CBD - complement binding reaction EHT - erythrocyte sedimentation rate

UHF - ultra-high frequency currents

UGC - urogenital chlamydia

UTT - ultrasound therapy

EEG - electroencephalography.

Glossary: Infectious Skin Diseases

Term	Definition
Infectious disease	A disease caused by pathogenic microorganisms that can spread from person to person.
Skin infection	An infection that affects the skin, caused by bacteria, viruses, fungi, or parasites.
Bacteria	Microscopic organisms; some can cause skin infections like impetigo or cellulitis.
Virus	A tiny infectious agent that can cause skin conditions like herpes or warts.
Fungus (Fungi)	Microorganisms like dermatophytes and yeast that cause infections such as ringworm or candidiasis.
Parasite	An organism that lives on or in a host; can cause skin diseases like scabies or lice infestations.
Impetigo	A contagious bacterial skin infection, common in children, causing blisters or sores.
Cellulitis	A deep bacterial skin infection causing redness, swelling, and pain.
Herpes Simplex	A viral infection causing cold sores or genital sores.
Warts	Small skin growths caused by the human papillomavirus (HPV).
Tinea (Ringworm)	A fungal infection that forms ring-shaped, red, itchy patches on the skin.
Candidiasis	A fungal infection caused by <i>Candida</i> species, often affecting moist areas of the skin.

Introduction

For students of higher educational institutions of applied medicine the problems of diagnostics, treatment and prevention of common skin diseases are solved. Special importance is given to the dependence of skin diseases on the general condition of the patient's organism, his labour, personal and social activities. In addition, students' attention was drawn to the detection and reception of sexually transmitted

diseases. The principles of preliminary diagnosis, classification of diagnosis and prevention of such patients are presented. *Manzur kullanma* is intended for medical students, specialists in skin diseases and other specialists.

Examination of a patient with skin diseases

All skin diseases are a disease of the human body. Therefore, the symptoms of the disease are manifested not only on the skin, and various general symptoms are accompanied by disorders in the work of internal organs, nerves and other systems. It can have subjective and objective signs. Subjective signs - complaints of the patient: pain, itching. Cramps, paresthesias - decreased sensitivity, brokenness in the body, increased body temperature, insomnia, nervousness.

Diagnosis of a skin disease requires a thorough examination of the patient's skin and starts with a skin check. Attention should be paid not only to pathologically altered areas of the skin, but also to areas without rashes. This may affect some functional changes caused by factors predisposing to the development of this disease (for example, excessive oiliness of the skin and, conversely, its drying). When performing a skin examination, a general examination of the patient should also be performed. A patient with a skin disease should be examined in a warm and bright room, preferably in daylight.

If possible, the entire skin of the body should be visualised, not limited to the areas of skin that are of concern to the patient. Most skin changes that are not bothersome but may help to detect disease can be overlooked, such as scars, moles, etc. from past diseases.

Objective changes manifest themselves in the form of rashes on the skin. They are morphological elements of the clinical picture, reflecting pathological processes in

the skin, the alphabet of specific skin diseases. Knowing the morphological signs, it is possible to closely represent their origin, the significance of the developed pathological process and clinical diagnosis. These are primary and secondary elements. Primary is the breed that first arises in response to any exogenous or endogenous influence. Secondary element - arises as a result of evolution of primary elements. By the nature of the secondary elements we can often tell what the primary element was. There are 8 types of primary element: spot, nodule, nodule - in filtrate elements, bubble, blister, bubble, pus, bulge (bump) - in exudative elements.

When determining skin rashes, attention is paid to their greater or lesser distribution, location, symmetry and significance for each other, the nature of the boundaries of the location, colour, swelling and all other features. Particular attention is paid to the skin changes characteristic of each disease, the favourite areas of rashes, some skin diseases morphological elements are increased in typical locations, and diagnosis is not difficult. For example, nodules are often located in the area of the shins and shins of the scrotum. In vesicular gland, the vesicles are tense, as a group in foci, and in surrounding gland are arranged in a single line on one side of the body. Signs important in the diagnosis of the disease can sometimes be detected only with the aid of a magnifying glass or with specific tests. A very broad and deep semantic analysis of the patient's complaints should be made when studying the history of the disease. If the patient complains of itching and rashes, it is necessary to determine whether they are pain, soreness, desensitisation or when and under what factors they appear. Careful identification of factors associated with the disease or causing its exacerbation or improvement, or the patient's personal and family relationship to the disease. In particular, this includes the sequential development of skin changes, what medications were taken, the presence of such changes in close relatives - descendants, etc. In some cases, only histological examination helps to make a correct diagnosis.

Major pathological elements and conditions of the skin.

Primary morphological elements of the skin rash

A *spot (macula)* is a primary proliferative morphological element that does not rise above the skin level and has a clear border. Spots can vary in size from small (e.g. petechiae, freckles) to large foci. The spots are vascular, pigmented and artificial depending on their origin, inflammatory and non-inflammatory, depending on their size they are called roseola (up to 2-3 cm in diameter), erythema (like a palm) and erythroderma (when large areas of skin are affected). These spots disappear when pressure is applied because the wall of the dilated blood vessel is not damaged. Vascular spots are divided into hyperaemic, telangiectatic and haemorrhagic.

A *nodule (papula)* is a primary cell-free cellular overgrowth rising above the skin surface, formed as a result of deposition of exogenous substances, having a viscoelastic consistency, up to 1 cm in size, leaving no scar after resorption. Nodules are divided by size and shape: miliary - in the form of a lump, in the form of a lentil, nummular - in the form of a coin.

Tuberculum - primary cavity-free formation, rising above the skin surface, located in the reticular layer of the dermis, have a dense or doughy consistency, ranging in size from 3-5 mm to 2-3 cm, subsequently ends with necrosis, ulceration and scarring of the proliferative element. The tubercle is observed in wounds, tuberculosis, leprosy, syphilis and other diseases.

Node (nodus) is a primary cavity-free formation in a fat cell under the skin, elevated above the skin level, a large infiltrative element that is harder than a nodule. A

nodule differs from a papule by its large size, from 2 to 10 cm or more, and later heals with ulceration and scarring. It is observed in skin tuberculosis, leprosy, leishmaniasis and other diseases. The blister leaves no trace and disappears within a few hours.

Vesicle (vesicula) - a primary cavity containing serous and serous-haemorrhagic fluid and a porous element rising above the skin level, up to 1.5 to 5 mm in size. The vesicle has a wall, cavity and bottom filled with serous fluid. Vesicles are observed in eczema, dermatitis, blisters, herpes and other diseases.

Blister (bulla) - a primary limited formation, 0.5 to 0.7 cm or more in size, consisting of a wall, cavity and bottom, filled with serous fluid and serous-haemorrhagic fluid and rising above the skin level, oval in shape, sharp border. Vesicles may be located on the inflammatory base (e.g. in vesicular vesicles vulgaris, Duhring's dermatitis herpetiformis), the cavity is located intraepidermally - in the leaf-shaped form of vesicular vesicles.

Pustule (pustula) - primary cavity formation, containing pus, pus exudate may be pus or pus-haemorrhagic exudate rising above the skin surface. The pustule is conical in shape and usually pierced by a hair in the centre, and may be follicular or non-follicular. After healing it leaves a temporary de - or hyperpigmentation.

Blister (urtica) is a primary cavity-free morphological element with a flat surface, arising from oedema of the upper papillary dermis. They have a smooth surface and are round, circular, annular or irregular in shape.

Formation of secondary morphological elements as a result of transformation of primary rashes.

Dyschromia (*dyschromia cutis*) - pigmentation disorder remaining on the skin after the primary or secondary rash, corresponding to the size and shape, secondary hyper- and hypopigmentation disappear without trace.

Damage to the superficial layers of the skin

Erosion (*erosio*) is damage to the superficial layers of the epidermis. It moisturises, does not bleed and does not leave scars (e.g. at the site of a burst chickenpox blister).

Ulcer (*ulcus*) is a lesion of the deep layers of the skin (dermis or hypodermis) that may bleed and subsequently end in scarring (e.g. hypertensive ulcers on the calves, wounds, skin tuberculosis, leishmaniasis, leprosy ulcers). Ulcers always heal to form a scar.

A **crack (*fissura*)** is a linear defect formed as a result of a violation of the elastic properties of the skin. A distinction is made between superficial and deep cracks.

Crusta - formed by the drying of clear purulent or bloody fluid in rashes such as scabs, blisters, pus and deep wounds (e.g. impetigo).

Scales (*squama*) - migrating cells of the scaly layer, clinically the formation of small, scaly or medium to large coins, that is, a process in the form of flaking.

Lichenisation (*lichensatio*) is a change in the appearance of the skin in the form of thickening and coarsening. This results in the appearance of obvious normal skin strictures (e.g. atopic dermatitis, neurodermatitis).

A **scar (*cicatrix*)** is fibrous connective tissue that forms irregularly in deep skin defects. A scar can be hypertrophic (thick pink) and atrophic (thin pale).

Atrophy (*atrofio*) - thinning of the skin and loss of characteristic lines. The skin becomes shiny and clean (e.g. atrophy of some skin areas as a result of impaired arterial blood supply).

Vegetation (vegetationes) - overgrowth of dermal papillae and thickening of the spinous layer of the epidermis on the surface of various pathological elements.

An abrasion, or Excoriation (excoriatio) is a **linear** skin lesion caused by mechanical impact or irritation .

A **comedone** is one of the manifestations of acne or pimples. They are simple black dots caused by clogged sebaceous ducts.

Telangiectasias are small red or bluish dilated blood vessels. They can form on their own or be a sign of other diseases.

A **nevus** is a structure slightly raised above the surface of the skin, rounded in shape and unicoloured (called a holdover in marriage), but the appearance of some nevi can vary.

Basics of general and local treatment

are clinical manifestations of complex processes occurring throughout the body, as well as disorders of the central and autonomic nervous system, endocrine system, internal organs and metabolic activity. Therefore, it is very important to use complex methods of treatment of skin diseases, including quality nutrition, prescription of necessary drugs, relaxation and physiotherapeutic methods.

A patient suffering from a skin disease is recommended to avoid products that cause hypersensitivity, and taking into account the specifics prescribe antihistamines, sedatives, purifying blood and gastrointestinal tract, fighting power, angioprotective, membrane-fixing, anti-inflammatory and other pathogenetic, symptomatic drugs. peculiarities of each person.

In this case, local remedies occupy a special place in the treatment process and have a general effect. The purpose of local treatment in skin diseases is to eliminate the cause of the disease, e.g. in purulent, fungal, parasitic infections, or to protect and heal the damaged skin from the external environment. Symptomatic, i.e. local

treatment directed at a given symptom, is prescribed to resorb skin rashes or to eliminate subjective sensations associated with them.

To get a positive result from topical treatment, it is necessary to know how to correctly choose not only the necessary pharmacological agent and its amount, but also its type used in this case. First of all, the type of drug is chosen depending on the degree of inflammation on the skin.

In acute inflammation, preparations in the form of an aqueous solution (moistening or hydrating dressing) are recommended. If there is no hydration process in acute inflammation, in addition, upu (powder or powder) or throat rinses are prescribed.

Topical preparations are used in the form of creams or pastes, in the process of subacute inflammation, you can also compress, lotions.

Apply **lotions** - prescribed during the acute, subacute inflammatory periods of the disease, even when the skin surface is moist or not moistened. This shrinks blood vessels, reduces swelling on the skin surface, reduces the level of inflammation, itching and pain disappear. In wetting method, 1-2% resorcinol, 2% boric acid and other solutions are used. To do this, gauze or bandages are folded into 6-8 layers and moistened with medicine, a little squeezed and tied to the affected area of the skin. It is moistened every 10-15 minutes so that it does not dry out. Perform the soaking method for 1 hour, then return after another 1.5-2 hours. To make a wet and dry bandage (it can be called the method of long-term moistening), 6-8 layers of gauze are folded and soaked on the damaged area of the skin, and then impregnated with a layer of thickness of more than 1 cm, these solutions on the surface of it put clean white cotton wool, then tie all layers of bandages. The bandage is changed every 3-4 hours without drying.

Powders are used in acute inflammation after the hydration process has stopped. Due to its moisture-absorbing properties, powder sprinkled on the skin dries it, cools

the skin due to increased heat exchange and narrows superficial blood vessels. Indifferent in the form of upa (for example - talc, white clay, alcohol oxide, starch), mineral and vegetable substances are used in disinfectant powder. Oupa must not be applied to skin folds.

Ointments - are a mixture of water and glycerin (alcohol, petroleum jelly, etc.). It reduces inflammation, cools and dries the skin. The liquid contained in the cream evaporates quickly, leaving only powder on the skin. Claims it is used in the acute inflammatory process after the hydration process has stopped. Ointments are used in chronic inflammation of the skin. Ointments contain an active drug, the basis of which is oil or oily substances. The ointment evenly covers the surface of the skin and protects it. After the ointment is absorbed, the fluid contained in the sweat exiting the skin remains under the ointment, reduces heat exchange and warms the skin by dilating the blood vessels. The moisture under the ointment softens the mucous layer and allows the absorption of pharmacological agents contained deep in the skin. In addition, the oily base softens crusts and scales and removes them from the damaged skin surface.

Pastes - consist of equal amounts of oil and fatty substances, e.g. in the form of indifferent powdered forms. Pastes are used in acute subinflammatory conditions after the hydration process has stopped. The fatty substances in the paste soften the ice layer and allow the penetration of drugs. Due to the desiccant powder included in the paste, it dries the skin, cools it and constricts blood vessels. It is not recommended to apply to skin areas with a large number of hair fibres.

Cream - used for subacute inflammation. The cream usually contains equal amounts of lanolin, vegetable oil and water. The evaporating water of this cream cools the skin, softens it, reduces itching, and the oily base protects it from the external environment.

Warming compresses are used in chronic inflammations. The compresses act with moist heat, increase metabolic processes in the damaged skin area, warm the skin and ensure resorption of the inflamed infiltrate.

Medicines that can be heated (poultices) are used for chronic inflammatory processes. For this purpose, 4-5 layers of gauze are folded, dipped in boiling solution and applied to the skin area. When cooling gauze wetting occurs in the opposite direction. Procedures are carried out for 10-15 minutes and repeated 2-3 times a week.

PURULENT SKIN DISEASES (PYODERMITIS)

The causative agent of pyoderma is most often different types of staphylococci and streptococci, in rare cases - other microorganisms (Proteus, Pseudomonas and Escherichia coli, mycoplasmas, etc.). Staphylococci depending on the etiological factors (osteofolliculitis, folliculitis, furuncle, carbuncle, hidradenitis). It is divided into streptoderma (impetigo, ecthyma) and streptostaphylococci. Depending on the localisation at the skin level - superficial and deep, depending on the course - distinguish between acute and chronic types.

Staphylococci live in front of the hair follicles of healthy skin and in the crevices of the sebaceous glands, while streptococci live in most skin folds. The pathogenicity and virulence of microorganisms are of great importance. Secondly, local factors that allow the entry of microorganisms into the skin: skin pollution, mechanical damage to the skin (superficial injuries at home and at work, scratches, burns, friction), changes in the pH of the skin environment, peeling and drying of the skin, abrasions in pruritic diseases, frostbite or heat stroke and other causes. In many cases, pyodermitis can become chronic due to common causes: immunodeficiency, metabolic disorders, including carbohydrate and fat metabolism, thyroid, pituitary 1 kidney, nervous,

circulatory, gastrointestinal systems, hypovitaminosis, alimentary factors. Pyoderma may also develop in patients receiving corticosteroids and cytostatic drugs.

Osteofolliculitis (staphylococcal impetigo)

Location: most often on the face, neck, arms, calves. At the beginning of the disease, redness and pain appear near the hair follicle or sebum. A 1-2 mm pustule is formed with a hair fibre protruding from the centre, surrounded by a heat ring. After resorption of the pus, no scar remains. Osteofolliculitis usually occurs as a result of various impacts on the skin . For example, shaving, moustache hair removal, chemical and physical factors, warming compresses, the use of various oils, etc. Treatment is local. Apply sulfur-containing rinses, Bactroban, Dalacin T, ointments and ointments with antibiotics, ultraviolet rays. With purulent skin diseases, the patient should not take a bath or shower. If the pus on the areas with a lot of hair if they are located, they can not be rubbed or swept away. hair is better to cut it short with scissors to make it easier to apply the medicine.

Folliculitis

Acute purulent inflammation of the hair follicle, in which a painful pale pink nodule of 3-5 mm in size appears, with a pustule forming on top of it. When the pustule ruptures, pus is released and an erosion is formed, or the substance hardens with pus and turns into a scab. In the deep type of folliculitis, a pitting scar may remain. The course of the disease is 5-7 days .



The treatment process consists of lubrication of foci with aniline dyes (1-2% methylene blue, genzianviolet, Castellani liquid), application of disinfectants, antibacterial agents. The skin is wiped with 1-2% solution of boric acid and salicylic alcohol.

Boil

It is popularly known as "chipcon". It is an acute purulent-necrotic inflammation of the hair follicle and surrounding tissues. Initially begins with folliculitis, as the inflammatory process spreads to the surrounding tissues, the diameter reaches 3 cm. pink-pink painful nodule is formed. After the development of necrosis in its centre and rupture, thick pus is released. The resulting deep wound ends with a scar.



Complications: lymphangitis, lymphadenitis, abscesses. In the face: thrombophlebitis of eye veins, meningitis, septicaemia. When developing a furuncle

infiltrate, "ashes" of ichthyol (ichthyol and a layer of white cotton wool fixed with a leukoplasty) are laid. When bursting the furuncle - a bandage moistened with hypertonic solution, then the solution of aniline dyes on the erosions. Physiotherapeutic treatment: UHF, soluks - until rupture. In complicated furuncles - broad-spectrum antibiotics, sulphonamides, in case of abscess - surgical treatment. When the boil is located on the face, the patient should be transferred to a surgical ward and begin early administration of antibiotics, even in the absence of complications. When complications develop, when the boil is localised in separate areas (head, face, hands) and with a large number of boils, the patient is temporarily incapacitated.

Furunculosis

Chronic recurrent disease with frequent furuncles. Furunculosis can be localised and widespread. Pathogenic immunodeficiency states, disorders of carbohydrate metabolism. The endocrine glands are important. Therefore, it is necessary to check the state of the patient's martial forces, antibodies to HIV , blood sugar level .



The treatment process is carried out depending on the general condition of the patient and pathogenetic factors. Specific immunotherapeutic drugs are prescribed, increasing the fighting power - vaccine against staphylococci, anatoxin, antiphagin. Along with them prescribe non-specific means and procedures - autohemotherapy, pyrotherapy (pyrogenal proligiosan), immunomodulators (thymalin, thymogen, T-activin, immunomodulin), vitamins. With frequently recurring furuncles, it is recommended to give antibiotics for 1-2 months, without stopping the medication.

In children, differential diagnosis should be made with false furunculosis (multiple abscesses - inflammation of eccrine sweat glands), epidemic neonatal herpes (develops from the day of birth to 7-10 days), neonatal ulcerative herpes. In adults, furuncles are compared to anthrax, hidradenitis and deep trichophytosis.

Carbuncle

purulent-necrotic inflammation of the deep layers of the dermis and hypodermis. In the course of the pathological process, the hair follicles located nearby are also damaged. The patient is bothered by a "throbbing" pain, sometimes severe,



sometimes mild. The diameter of the damaged area is 5-8 cm, its colour is dark blue-black, in several places it grows, necrosis is formed in the centre. Pus-necrotic substances are separated from several holes formed. At the bottom of the wound, which has irregular edges, green-yellow necrotic nuclei can be seen. From the nucleus to the furuncle it migrates somewhat slowly. The general situation is much worse. The wounds end in a rough scar. Complications: abscess, phlegmon, septicaemia.

Treatment is carried out by a surgeon. The patient is prescribed general and local strong antibiotic therapy, neutralising and cleansing agents. In severe cases, anti-staphylococcal plasma and immunoglobulins are administered. Complications are treated surgically, with large necrosis - necroectomy. The patient is temporarily incapacitated. If the general condition has changed and complications arise, the patient is transferred to the department of purulent surgery.

HYDRADENITE

Acute purulent inflammation of the apocrine sweat glands. Location: in the axilla, scrotum and anus, on the tips of nipples in women. Painful nodules 0.5 - 2 cm in size are formed. The skin over them and around them is red, bluish-reddish. The fumes merge with each other, and the inside is filled with pus and hangs down. When the smoke breaks out, yellow-reddish thick pus begins to come out of several holes. Sometimes the disease can recur and become chronic. Children before puberty and the elderly do not get hidradenitis, because they do not work apocrine sweat glands. Complications: lymphadenitis, abscess, phlegmon.



Care. In acute isolated nocturnal hidradenitis, the same local remedies as in the treatment of furuncles are sufficient. In the development of purulent cysts - surgical method is used. In chronic course - antibiotic therapy, means of specific and nonspecific immunotherapy, immunomodulators, determining sensitivity to the pathogen. With the development of complications or the formation of a large number of foci, the patient becomes incapacitated. Deterioration of the general condition and the development of complications are indications for transfer of the patient to the purulent-surgical department.

Streptococcal Impetigo

Children are often ill. Course: characterised by the formation of a serous and serous-purulent, fluid-filled, flat, friable blister surrounded by a rim of erythema, pus (phlyctena). Contagious. When drying, they form a thick, layered yellowish-brown crust.



Some hyperaemia, itching and pigmentation persist even after removal of the crusts. It is most often located on the face and palms. To the place Conditionally impetigo is divided into types: lip bite - superficial paronychia in the corners of the lips - in the lesions of tissues around the nails - in large folds (axillary , axillary). Complications are rare. In case of cutaneous spread and dissemination in the body, symptoms of bacterial intoxication may develop.

Phlyctenes are dissolved, bark remnants are cut off, aniline dyes are applied to the erosions, antibacterial ointments (dermatol, streptocide, Lorinden C and others) are applied to the bark. Healthy skin around the planes is wiped with 1% borate or 1% salicylic alcohol. A 1% alcoholic iodine solution is applied to the base of the nails every day. Clothing - clothes are changed and boiled every day. It is forbidden to give children to kindergartens and schools. Treatment is carried out on an outpatient basis. In cases where the pathological process has spread and the general condition has changed greatly, antibiotics are prescribed, and if necessary, hospitalisation in a children's infectious diseases department.

Simple lichen planus

The superficial flaking of the skin is called dry streptoderma. It mainly affects children. It is characterised by the formation of round pink spots on the skin of the face and upper parts of the body, covered with small oozing granules. The disease is characterised by slow progression and relapses.



The skin is wiped with 1-2% salicylic alcohol and ointments containing antibacterial substances are applied for 10-15 days.

Swelling of the skin

Superficial cellulitis caused by beta-haemolytic group A streptococcus. The main morphological element is erythema. The disease begins with a change in general condition, an increase in body temperature and the formation of red swelling of the affected skin. Foci of erythema have a clear border, look like several tongues. On palpation, the patient feels a strong pain. This can be repeated. In this case, the movement of lymphatic fluid is disturbed and leads to the development of elephantiasis.

Treatment: Penicillin 1 million units intramuscularly every 6-8 hours or erythromycin - 500 mg 4 times a day for 2 weeks. This is the reason for antibiotics at low sensitivity prescribe cephalexin, claforan or others. Symptomatic treatment. Locally - a compress of 10% solution of ichthyol, ointments with antibiotics. During the disease the patient is temporarily unable to work. When the general condition of the patient has changed significantly, blisters are formed on the damaged skin, the patient is hospitalised in an infectious or purulent-surgical department. The disease is compared with allergic dermatitis, eczema, chronic disseminated streptoderma.

PARASITIC SKIN DISEASES

Scabies. The most common parasitic skin disease of humans. The causative agent is the scabies mite *Sarcoptes scabiei*. The source of the disease is a sick person. Infection occurs through contact with a sick person by touching various parts of the body, sexual contact, handshake, massage or through infected clothing, towels, towels, toys. Having attached to the skin surface, the female mite begins to pierce the uterine layer of the epidermis and after 1 hour reaches the granular layer. The incubation period of 8-12 days is associated with the complete development cycle of the adult mite. The cycle begins with the laying of eggs and ends with the birth of the adult mite. The main location - between the fingers and the surface of the palm, wrist, chest, abdomen, genital area. Scabies is characterised by papulovesicular elements (from 0.3 to 1.0 cm), slightly swollen, separating from the skin surface, among which is the nucleus of the scabies mite. The patient is bothered by itching, intensifying at night, may be complicated by purulent infection.



Diagnosis and treatment is carried out by a dermatologist. Sick children are isolated. An urgent notification is sent to the health control for each case. A general practitioner makes the initial diagnosis and examines family members. A highly effective and convenient treatment is 20 per cent benzyl benzoate suspension or ointment for adults and 10 per cent suspension for children. Only freshly prepared benzyl benzoate suspension should be used. On the first day of treatment, the patient washes in a bath and applies benzyl benzoate suspension to all parts of the body, except for the scalp and head, 2 times 10. per minute, with a break of 10 minutes. the application is repeated on the 2nd or 4th day. It should be remembered that for

complete administration benzyl benzoate must remain on the skin of the patient for 6 days (the same duration as in the treatment of rabies). Therefore, even if the patient washes his hands during treatment, he should immediately apply the drug to them. On the second day, the patient washes with soap and water and changes clothes.

A 20% sulphur ointment can also be used for treatment. On the first day after washing in the bath, the patient applies sulphur ointment to the entire skin, except for the scalp and head, for 15-20 minutes, and then changes clothes - night clothes and sheets - blankets.

On days 2, 3, 4 and 5 apply 20% sulphur ointment to the skin without washing off the previous ointment. If necessary, some areas of the skin can be washed with water during treatment, but immediately afterwards apply 20% sulphur ointment to these areas. On the 6th day the patient does not apply the ointment, but does not wash off the previously applied ointment. On the 7th day the patient takes a bath and changes clothes - the night before and sheets. If severe itching occurs, corticosteroid ointments containing 0.1% fluoride can be used, the itching disappears after 1-2 weeks. Bacterial infections may require broad-spectrum antibiotics . Secondary streptoderma may lead to the development of rheumatism.

Disinfection, especially in kindergartens and schools, is carried out to prevent the spread of the disease. Disinfection can be carried out by the patient himself or a family member during treatment: sheets, towels, clothes can be disinfected by boiling them in a 1-2% solution of soda or washing powder for 5-10 minutes. The top is ironed on both sides with a hot iron. The rest of the clothes are disinfected by hanging them outdoors for 5 days. The room is washed every day with a 1-2% soap and soda solution. Final disinfection SES from After hospitalisation of the patient and outpatient treatment by staff of the Department of Health ! and in kindergartens and schools it is carried out twice: after diagnosis of the disease and after recovery of the patient.

Paediculosis

on human skin, on the head, on clothing and in the genital area.

Head pediculosis - the causative agent is head lice (located in the growing part of long hair). The bite is located at the mouth of the hair follicles. Itching from lice bites results in scratches, which can then be complicated by secondary infection. Secondary infection results in serous purulent crusts.



Paediculosis of the groin area. Caused by lice (they are located in the growth of scaly hair). Damages the abdomen, chest, thighs, armpits, beard, moustache and eyebrows. They attach tightly to the skin of the mouth of the hair follicle. The bitten areas develop livid spots, itching, abrasions, and secondary infection is also possible.

They live and lay their eggs in the folds of clothing. From there, they spread to the skin through the skin contact area. Predominantly in the waist, chest, neck area, i.e. clothing (especially seams). Lice bites are observed in the form of pigmentation and thickening of the skin in the areas where the skin is most in contact with the body. Scratches may appear as a result of intense itching, sometimes with secondary infection. Live lice and mites are found on clothing.

Head and head lice are applied 3 times (1st, 4th, 7th days) with soap emulsion of benzyl benzoate for 15-30 minutes. It is then washed with hot water and soap. Clothing change. Trigger removal consists of hair removal. If wardrobe lice are found, clothing is disinfected. Para Plus and Nittifor can also be used for treatment

DERMATITIS

Inflammation of the epidermis and dermis layers of the skin is called dermatitis. Dermatitis is formed as a result of negative effects from external and internal sources. Sources of external influence can be conditional and unconditional. Inflammation of the skin occurs when unconditional (obligatory) sources affect the skin with a certain force and at a certain time. An example of this is acute inflammation of the epidermis and dermis layers caused by droplets of sharp acids and alkalis coming into contact with the skin. These types of dermatitis are called simple dermatitis. Conditional (facultative) sources of exposure cause skin inflammation only in the presence of a number of pathogenetic conditions.

Due to this, such dermatitis appears only in persons with hypersensitivity of the organism to this active substance.

Therefore, no skin inflammation is observed with a single exposure to conditioning agents. This is because the phenomenon of skin hypersensitivity has not yet developed. An example of this is skin inflammation caused by repeated application of "Vietnamese balm" to the skin. These types of dermatitis are called allergic dermatitis. While the formation of normal dermatitis is due to external sources, internal sources are of great importance in the formation of allergic dermatitis. In particular, diseases of the digestive organs (hepatitis, gastritis, enterocolitis, etc.) accelerate the development of allergic dermatitis.

In patients who have not yet suffered from these diseases, especially young children, an important pathogenetic role is played by a decrease in the process of absorption in the intestine. Also important are disorders of the nervous system and glands of internal secretion, metabolic changes, and immunological disorders. In applied dermatology, the concepts of simple and allergic dermatitis are widely used. Simple dermatitis.

In normal (artificial) dermatitis, skin lesions are only observed in the area affected by external influences. Depending on the degree of exposure to the factors that caused the inflammation, there may be redness and swelling of the affected skin (erythematous dermatitis), and blisters and blisters may appear on the reddened area (bullous dermatitis). Also, the inflammatory process may be accompanied by ulceration and dying (necrosis) of the skin (necrotising dermatitis). In other words, the inflammatory process in simple dermatitis is usually acute. However, in young children, simple dermatitis is also formed as a result of prolonged exposure to clothing and footwear, as well as low and high temperatures. Such simple dermatitis is chronic.

Even simple dermatitis that runs chronically presents with symptoms such as redness, swelling and wetting of the skin, blisters, blisters, crusting and erosions. Careful history taking, including identification of factors affecting the skin, can help differentiate it from chronic allergic dermatitis. Allergic dermatitis. The clinical symptoms of such dermatitis are defined by an initial polymorphism. In this case, the inflammatory reaction of the skin takes place with the formation of inflamed spots (erythema), vesicles, nodules and watery areas. Depending on the type of factor that caused the inflammation of the skin, the type and nature of rashes may be different. For example, allergic dermatitis caused by food sensitisation often has pink erythema and blisters, while allergic dermatitis caused by drugs often has large blisters and haemorrhagic patches.

In general, two types of allergic dermatitis are distinguished: contact allergic dermatitis (CAD) and toxic allergic dermatitis (TAD). Contact allergic dermatitis results from direct exposure of the skin to allergens. In this case, substances that sensitise the skin directly cause allergic inflammation of the skin.

Toxic allergic dermatitis is formed as a result of exposure to allergens through the respiratory and digestive tracts, as well as the ingestion of various chemicals in the veins and between the muscles. Toxic allergic dermatitis is also called

toxiderma, because in TAD, a substance that enters the body in a way other than through the skin causes not only sensitisation but also intoxication (poisoning).

It is known that a substance causing sensitisation should be administered two or more times. Thus, asking about the suspected allergic substance in the patient's history helps to determine the nature of the disease. The diagnosis of allergic dermatitis can be confirmed by allergy testing. In the treatment of simple dermatitis, the factor causing the inflammation must be eliminated. Then external topical anti-inflammatory agents are applied. It is necessary to take into account the signs of inflammation: opening of vesicles and release of inflammatory fluid; washing with bactericidal solutions (manganese, rivanol); application of zinc, icstiol and other similar antiseptic ointments; moistening of watery skin areas with silver nitrate or tannin solution; use of steroid ointments; Fucorsin, methylene biscuit liquid should be used.

In the treatment of allergic dermatitis, the first requirement of treatment is to identify the allergen causing sensitisation and eliminate it. Gastric and intestinal lavage and diuretics are important in toxiderma with profound intoxication.

After that, desensitising and anti-inflammatory drugs are used: a) antihistamines (a) antihistamines (dimedrol, tavegil, zaditen); b) calcium preparations (calcium chloride, calcium gluconate); c) vitamins (ascorbic acid, rutin). Among the drugs used in local treatment, corticosteroid ointments (prednisolone, fluorocort, lorinden, etc.) give good results. In severe forms of allergic dermatitis, intravenous administration of sodium hyposulphite or Ringer's solution and the use of glucocorticoids saves patients from unpleasant consequences.

VIRAL SKIN DISEASES

Infectious molluscum contagiosum - social morphological element - smoke. Methods of washing - direct contact with the sick person, including sexual contact, through objects and by using a shared bath, towel, flannel. Children are often sick. More face, neck and chest; in adults appears in the genital area, on the skin of the body round hemispherical or flat shape. wet and yellow-pink nodules with a diameter of 1-5



mm . will In the centre of the node you can see a depression resembling the navel. If the nodule is squeezed from the sides, it will flow from the bottom, and if squeezed from the sides in a swim, the horse will separate from the bottom. There is almost no subjective sensation.

Excretions from the node are removed with tweezers, scraped with two pointed spoons, then apply 5-10% iodine solution, 3% oxolin, 3% gocipol - 3% merozin ointment. The most effective methods are diathermocoagulation and cryodestruction (cauterisation with liquid nitrogen). Comparative diagnosis is made with scaly, scaly and cutaneous tumours.

Warts

The causative agents are DNA-containing viruses transmitted by direct contact or through the patient's objects. Warts 0.2-1.0 cm high or vulgar warts (hyperkeratotic papules located on the palms and fingers without pain, with a



tendency to secondary infection due to frequent trauma and bleeding); 0.2-0.3 cm flat or juvenile warts (slightly raised above the skin level on the face, neck, chest and palms, with smooth rounded bipolygonal shape, flesh-coloured or slightly

numerous nodules of yellowish colour); 0.2-0.3 cm flat or juvenile warts (nodules with a thin tip on the face, neck, chest and palms, with smooth rounded bipolygonal shape, flesh-coloured or slightly numerous nodules of yellowish colour); fibrous (nodules with a thin tip on the face, neck, trunk and especially under the arms with a sharp tip, faces slightly deformed and hardened) on the soles of the feet (one or more nodules up to 1 cm in size, sometimes painful when walking, flat, hard hyperkeratotic growths).

Treatment is carried out by a dermatologist or cosmetologist. Electrocoagulation, liquid nitrogen cauterisation, laser coagulation and Solcoderm are used in treatment. Common warts can be removed by scraping the surface and applying daily an elastic collodion containing 17% salicylic acid and 17% lactic acid. Unaffected elements may also disappear during treatment. Hypnosis and suggestion are widely used in the treatment of wounds .

Acute condylomas

Human papillomatosis is referred to as a virus containing DNA. This virus has been shown to be important in the development of malignant neoplasms of the cervix in women and prostate gland in men



But it can also be passed from mother to child during pregnancy. Symptoms: It can take from 3 weeks to 8 months from conception to the appearance of warts. Condylomas are wart-like growths that can be located in the genital area, on the skin around the anus and on the genital mucosa. These growths can multiply and increase in size and gradually take the shape of a cauliflower or remain flat and inconspicuous. They are noticed to be numerous or multiple. Sometimes very large tumours develop, causing excessive discomfort to the patient. Condylomas with a

sharp tip rub and peel, produce pus, and the tumour-like structures turn into erosions and ulcers if not properly cared for.

Diagnosis is based on clinical signs. The causative virus can be detected using modern laboratory methods. If a malignant neoplasm is suspected, a special study is performed by taking a slice from these tumours.

Treatment is carried out by dermatovenerologists, urologists. Treatment consists of electrocoagulation, cryodestruction and Solcoderm. Acute condylomas often recur. Before treatment, the patient is examined for peptic ulcer disease (the most common condylomas in secondary lesions are characterised by a copper-reddish base with extensive infiltration, there are no lumps).

Herpes simplex

The main morphological element is the blister. It can then crack and collapse or dry up and turn into a scab. On the surface of erythematous spots formed in pathological foci, which are accompanied by itching and painful sensations, blisters appear in groups,



first transparent and then filled with turbid fluid. The fluid in the blisters dries up and turns into a brownish crust. When the blisters burst, small, silent erosions are visible, the edges of which are covered with crusted skin. After the erosions are covered with epithelium, brownish-red spots remain in their place. On average, the rashes resolve within 10-14 days

In secondary pyococcal infection, nearby lymph nodes are predominantly affected. When the body's fighting power is reduced In the case of HIV/AIDS and other immunodeficiencies, the disease can become recurrent.

Clinically, primary herpetic infection is distinguished from recurrent localisation of the focus in one place, soreness, signs of intoxication, increased body temperature. With the recurrent type, the rash spreads along the nerve endings of the damaged branch, is caused by cold virus types 1 and 2. The source of the disease is patients with various types of herpetic infection, including primary, recurrent and latent, that is, without clinical symptoms. The pathogen can be transmitted by contact, airborne, sexually. In addition, the infection can also occur through vertical transmission from mother to child.

The main route of transmission of herpes infection is communicative. The virus can be transmitted with saliva and lacrimal fluid, regardless of whether the disease is on the oral mucosa or the mucosa of the eye, with or without clinical signs. Washing occurs through utensils, towels, toys and other objects, and by kissing.

The infection can be transmitted by contact through unsterilised medical equipment during dental or ophthalmic procedures.

Airborne herpetic infection is an acute respiratory illness. When the patient coughs and sneezes, the virus is spread to the outside environment with drops of nasal fluid. Children between the ages of 6 months and 3 years are infected with type 1 cold virus through contact and airborne droplets. Elderly people can also contract the virus. From adolescence onwards, two types of cold virus can be contracted. Antibodies to the common cold virus are found in 80-90% of adults. Chickenpox or herpes is the most common sexually transmitted infection, transmitted from mother to child in a variety of ways. The most common way for a foetus to become infected is through the genital tract of a mother infected with chickenpox. In such cases, the risk of the child contracting the disease is 40%. The genital herpes virus affects the growing foetus by penetrating through the cervical canal into the uterine cavity. With viraemia, the virus can be transmitted to the fetus from a pregnant woman who has all types of herpes infections. The viraemic state creates the possibility of parenteral transmission.

The virus can remain in the body for a long time in the nerve ganglia and periodically become active. This condition can occur as a result of various influencing factors, such as excessive exposure to sunlight, cold, heat, acute infectious diseases, taking certain medications, stressful situations with a temporary decrease in fighting strength. Skin lesions caused by the herpes simplex virus have the following clinical forms: Herpes simplex vesicular themirrhoea, Kaposi's herpes simplex eczema (often develops in children with eczema and atopic dermatitis, with increased body temperature, worsening of the general condition, widespread skin lesions). passes the skin and mucous membranes); shingles-like cold (the difference from shingles is the absence of pain sign and is confirmed by serological studies); ulcerative-necrotic type (under the influence of HIV infection or unrelated immunodeficiency); abortive type (absence of vesicular rash).

Acute herpetic stomatitis can develop due to lesions on mucous membranes (often in young children). At the same time, the cold virus - ophthalmic herpes - can cause genital, visceral and disseminated herpes (characterised by joint involvement of the skin, mucous membranes and internal organs).

According to the location of the genital area, a comparative diagnosis is made with a hard chancre in the primary wound. The difference is that the borders of the lesion area in herpes are silent (polycyclic), the base is soft. It is distinguished by signs of pain. Kaposi's tuberculous eczema should first of all be distinguished from streptococcal and streptostaphylococcal impetigo. Unlike tuberculous eczema, the general condition of the patient in impetigo does not change significantly, the temperature reaction of the body is less developed, there is no umbilicus-shaped depression in the centre of the rashes, purulent black spots are not large haemorrhagic, but rapidly moving yellow-grey.

In the primary type of herpes simplex, topical treatment is sufficient. Vesicles are wiped with aniline dyes. When large blisters are formed, 3% oxolin, 0.5% bonafton, 3% merozin, zovirax, epigen and spray ointments are used. Sometimes the

use of cream with acyclovir helps well. The patient is advised to use soap and water very sparingly, but keeping the affected areas moist can aggravate the inflammatory process.

General treatment of recurrent herpes - zovirax (acyclovir) 0.2 - 5 times a day - during the day or Bonafton 0.1 g 3 times a day, interferon preparations, immunomodulators (gazalidone, timolin, etc.), herpes vaccine (0.1 - 0.2 ml 5 times every 3 days, 5 injections for 2 cycles). A mouth rinse with calendula, red marrow root, KMnO₄ is prescribed.

Shingles

The main morphological element is a vesicle. It may then crack and collapse or dry up and become a scab. The disease is caused by the Varicella zoster virus, the causative agent of chickenpox. It damages the skin and nervous system. Chickenpox is a disease of children, while smallpox is considered a disease of



adults and the elderly, and this condition depends on the peculiarities of the macroorganism. The disease is more common in spring and autumn. People aged 40-70 years are often affected by the disease. The course of the disease worsens with age, and the elderly develop postherpetic neuralgia as a major complication. The disease is more common in men than in women. The disease develops as a result of activation of latent virus. It is caused by various and exogenous factors that reduce the fighting forces of the organism: somatic diseases, chronic infections, cold, exposure to light, etc. Before the skin lesion develops a prodromal state, typical for common infectious diseases, i.e. increased body temperature, headache, weakness, sometimes nausea and vomiting. Unilateral neuralgia develops, characteristic of specific innervation of the brain. The clinical course is characterised by

polymorphism. Vesicles appear after neuralgic pain on reddened and slightly swollen skin along the nerve and its branches, who feels the disease from the first days.

The affected areas may be located in different places. Rashes can be on all areas of the skin and mucous membranes: along the course of intertubular nerve fibres in the body (if there was pain earlier, and then a rash appeared between the fifth ribs on the left side, such a condition is similar to myocardial infarction, may go), on the skin of the extremities, head, face along the course of the fibres of the trigeminal nerve (it should be remembered that the development of herpetic meningitis is possible).

When the ear is affected, it is accompanied by a hangover, paralysis of the fibres of the facial nerve and rashes in the external auditory canal, auricle, soft palate (Hunt's syndrome). Eye involvement is characterised by pain associated with the trigeminal ganglion and blistering along the optic fibres of the fifth nerve, sometimes with paralysis of the third nerve. Such cases are often unilateral. Spot-nodular papules on erythematous areas are often arranged in a single line. After a while the fluid of the blisters becomes turbid, pustules are formed, and then erosions and scabs remain in their place. After they fall off, a trace of secondary spots remains. Sometimes an abortive type of the disease develops. In this case, only erythema, oedema and papular rashes may occur, are associated with the neurotropism of the virus and are expressed by strong, heating aggria due to the lesion of the sympathetic nervous system in the pathological process.

Neuralgic paresthetic symptoms are associated with a specific lesion of the ganglia and in some cases appear in the prodromal period, and then the skin and mucous membranes. it accompanies trauma and persists long after the patient has recovered. In these areas, sympathalgia usually begins at the resorption of the vesicles. Subsequently, tachycardia occurs, coronary vessels, bile ducts, and intestinal smooth muscle are often contracted.

The ophthalmological type of tinnitus is characterised by sharp shooting pains occurring along the course of the rash. It can have different clinical manifestations (as a result of lesions of the cornea, conjunctiva, white of the eye, coloured membrane of the eye, ciliary bodies) and severity (fear of light, blepharospasm, tears). These signs are associated with the anatomical features of the optic nerve of the trigeminal nerve. The first fibre of the trigeminal nerve extends beyond the skin to the eyeball, the upper part of the mucous membrane of the nasal cavity, palate and pharyngeal cavity. The varicella-zoster virus can spread from the eye to the subarachnoid and various brain structures, causing the clinic of meningoencephalitis.

When the nodes of the vagus and lingual-thoracic nerves are affected, unilateral herpetic rashes are observed on the surface of the mucous membranes of the attic and soft palate, pharynx, pharynx and back of the tongue. The shell of the blisters quickly ruptures and small painful silent erosions are formed, prodromal period diagnosis of the surrounding glands is difficult. In general medical experience, the first manifestations of herpes zoster were mistakenly seen in place of bullous type of herpes, influenza, hepatocholecystitis, food poisoning and other diseases.

Acyclovir is used as an etiotropic agent. Its amount depends on the age and weight of the patient: from 200 mg 2 times to 200 mg 5 times for 7-10 days, adults - 10 mg intravenously for each 1 kg of weight every 8 hours for 7 days, alpizarin 0.1- 0.3 g per day for 7-10 days, etc.,

The pathogenetic basis of sphincter neuralgia is oedema and compression of the nerve body in narrow bony spaces. To eliminate them and reduce pain, analgesics, salicylates (aspirin 650 mg in combination with an additional 15-60 mg codeine, sodium salicylate 0.5 g 1-3 times a day), diacarb, hypertonic glucose solution (40% in 20 ml) are used. , magnesia (5-12 ml 25%). Dehydration treatment in the first days of the disease, and sometimes in the first hours, significantly reduces pain, provides rapid resorption of the inflammatory process and the transition to the abortive type,

while preventing complications of neuralgia and skull. spine Prevents compression of nerve trunks in the bone marrow. If the pain persists, antidepressants such as amitriptyline may help.

At the beginning of the disease curantil (in order to correct disorders of microcirculation and intravascular coagulation of blood) apply 0.025-0.05 g 3 times a day for 5-7 days. To increase combat strength, immunoglobulin, vitamins (B1, B12, C), viucid, thymolin, biogenic stimulant, adaptogens are prescribed. Local treatment with antiviral, antibacterial, keratoplastic means: aniline dyes, fucorcin, solution of brilliant blue; ointments interferon, heliomycin, gossypolovaya, megozinovaya; Corticosteroid ointments are used in gangrenous and necrotic types. Physiotherapeutic methods (ultraviolet rays, solux, ultrasound) help in the recovery period.

In case of pronounced neuralgic symptomatology and treatment measures, especially in case of poisonous iron contamination of the elderly, they should undergo a comprehensive examination, consultation of a therapist, neurologist and other specialists in order to detect oncological disease.

SKIN FUNGAL DISEASES

Among skin diseases, these diseases are second only to pyoderma. Fungi are widespread in nature, and only some of them are pathogenic for humans and animals. The main group of pathogenic fungi are protozoan plant microorganisms. They parasitise plants, animals and humans. Anthropophilic are called only those that damage human skin and organs. Zoonotic fungi cause human disease from domestic animals . If they are found on the skin of humans and animals, they are called zooanthrophilic fungi.

The routes of transmission are mainly from a sick person or animals through various objects or direct contact. Many fungal diseases can intensify and worsen depending on the season, e.g. mycosis of the feet in spring and summer.

All exogenous and endogenous factors are important in the development of fungal diseases. Exogenous factors are excessive skin moisture, pH shift to alkaline state, scratches, chemical changes in sweat gland secretion. Endogenous factors are human age, dysfunction of internal secretion glands, immunodeficiency states (HIV/AIDS, corticosteroid and cytostatic drugs. prolonged intake, hypovitaminosis, acute and total infections, etc.), changes in the autonomic nervous system, disorders of external circulation. (venous insufficiency).

KERATOMYCOSIS

These diseases are characterised by epidermal lesions only, with no signs of inflammation and mild severity.

Pityriasis versicolor (Pityriasis versicolor)

The pathogen, *Malassezia Furfur*, lives in the epidermis, in the royal layer. Only people get the disease. The main morphological element is a spot. Among the factors that cause the disease, there are abundant sweating, seborrhea, violation of the chemical



composition of sweat , violation of the physiological processes of hair loss, inadequate nutrition, diabetes mellitus, thyrotoxicosis, diseases of internal organs. For example, vitoneurosis is often found in patients with tuberculosis.

According to recent data, it is also rapidly being detected in persons infected with HIV/AIDS. Although the disease occurs in young boys and girls, it is not highly contagious. The disease is chronic and often recurs. Non-inflamed spots appear on

the skin of the neck, chest, shoulders, with peripheral overgrowth up to 1 cm in size and tendency to merge. The colour of the spots varies from pinkish-yellow to dark brown, often the colour of coffee and milk. The surface of the spots is marked by a scaly skin. This is done by applying a 50% iodine solution to the skin. Because the density of the skin layer is very poor, the particles on the surface of the spots absorb the iodine a little better, and the spots are very different from healthy skin. (Balser's test). When examined in the short-wave ultraviolet light of a Wood's lamp, the damaged areas of skin turn brown. Sometimes the scalp may also be affected. Subjective symptoms may be absent or a mild tingling sensation may be bothersome.

The disease - wound roseola (the colour of the roseola is pruinous, does not peel, disappears on pressure, the result of serological reactions specific to the wound), pink Gibert fever (spots of this colour are located along the Langer lines on the skin of the chest, the shape is rhombic or elongated-flat in the centre and itching in the form of a medallion, "papyrus paper") should be compared with true wound leukoderma.

Daily 3% iodine solution, 3-5% alcohol solution of salicylic acid and resorcinol, 1% clotrimazole solution, as well as Nizoral, Mycoseptin, Travogen, Mycosolone and other fungicidal drugs in the form of solutions and ointments for 3 weeks. Subsequently, the short-term treatment process is repeated 2.3 times with a break of one month (3 days).

In cases of spread of the pathological process and relapses it is recommended to take antimycotic drugs (for example: Nizoral 200 mg daily for 2-4 weeks; Lamisil, Terbisil, Terfalin preparations). For the purpose of prevention, the clothes of the patient are disinfected. To prevent recurrence of the disease, the skin of the patient should be treated with 1-2% salicylic acid and 2% alcohol solutions of salicylic-boric acid once a day.

ERITRASMA.

The main morphological element is a spot. The causative agent is *Corynebacterium minutissimum*. False mycosis. It only traumatizes the person, it is less contagious. The development of the disease is influenced by increased sweating, the chemical



properties of sweat, humidity, individual characteristics of the patient's body. It can also be saprophytic in healthy skin. In natural large folds of skin (thighs, armpits, female breasts) the size of the palm of the hand dark red or pinkish-red (burnt brick) in colour, clear silent non-inflammatory spots appear at the edges. They are scaly. There are no subjective symptoms or mild itching, pinkish-purple in colour, when viewed with a Wood's fluorescent lamp.

The disease tends to recur frequently in obese people who sweat a lot. Comparative diagnosis is made with Hov's epidermophytosis, seborrhoeic eczema, latent rubeophytosis, erythrasma, ringworm.

It is recommended to avoid excessive sweating, observe the rules of hygiene, 5% Erythromycin ointment is prescribed for 2-3 weeks. Depending on the course of the disease, erythromycin is prescribed 0.25 g 4 times a day for 7-10 days. The patient's clothes and legs are disinfected. After treatment, the patient is recommended to wipe the foci with a 2% alcohol solution of salicylic acid.

Inguinal epidermophytosis

The main morphological element is the spot. The fungus damages skin folds and nails. The disease is more common in hot humid climates and in men. The development of the disease can be caused by increased sweating, violation of carbohydrate metabolism, high ambient temperature. Washing predominantly occurs in bathrooms, public baths in direct contact with the patient or through his belongings (rags, hair, clothes).



The pathological process involves the skin of large folds, most often in the thighs. On the surface of the affected area, large inflamed spots of pink colour, covered with scales, are visible. The border of the planes is clear, red, mature, elevated above the level of the skin and consists of blisters, crusts and granules. The patient is bothered by a sensation of itching, especially at the edges of the foci. The diagnosis is confirmed by microscopic and bacteriological methods.

Topical treatment: clotrimazole, mycosolone, lamisil, terbamil, travogen, mycoseptin are prescribed. In cases of acute inflammation, alcoholic or aqueous solution of aniline dyes, ointments with anti-inflammatory and antifungal properties - mycosolone, triderm, exoderil, etc. are used. Treatment is carried out for 3-4 weeks. If the result is not noticeable, prescribe systemic antimycotic drugs, including griseofulvin 0.25 g 2-4 times a day for 1 month (taken with 1 teaspoon of fatty food or vegetable oil) or Nizoral 0.2 g 1 time a day for 3 months. Antimycotic drugs are prescribed depending on the age of the patient, the state of internal organs and general condition, weight.

Epidermophytosis of the feet

It is an infectious disease. It often starts in adolescents and young adults. The causative agent of the disease is mainly *Tr.rubrum* (80-85%). The main morphological element is scales. Often the skin between the soles and paws is affected. In rare cases, the skin of the palms and large folds may become infected. In relatively many cases, nails are affected. Infection through direct contact with a sick person (washing in bathrooms, swimming pools or through shoes used by the patient). Hyperhidrosis of the feet, flat feet, inadequate nail hygiene and tight footwear create favourable conditions for the development of the disease.

Penetration of fungus into the epidermal layer can be caused by skin damage (scratching, rubbing, chafing), prolonged use of shoes made of rubber products, angiopathies of the blood vessels of the legs, disorders of the nervous, endocrine and immune systems. There are several clinical types of foot mycosis: The latent type is characterised by mild itching between paws III-IV feet without subjective sensations. With the squamous cell type, the skin is slightly reddened and scaly flakes are formed, the mucous layer of the soles of the feet is thickened, the process is accompanied by a slight sensation of itching. In the intertriginous type, maceration (an enlarged layer of the royal layer of white colour) and fissured erosions surrounded by remnants of epidermis are formed between the feet (especially II and IV). The patient is bothered by itching and pain. With the dyshidrotic (eczematized) type, blisters and blisters in groups of multichambered blisters filled with serous fluid are formed on the soles of the feet. When they crack, erosions appear, the edges of which are surrounded by remnants of withdrawn epidermis. Dyshidrotic type is often complicated by lymphangitis, lymphadenitis, seroma due to the attachment of bacterial infection. As a result of a prolonged latent stage of foot mycosis, there is an increased sensitivity to the fungus and the formation of mycides on the skin. They have the form of polymorphic spotty-nodular, vesicular elements and are often

located on the surface of the feet, shins, palms, and sometimes on other parts of the body.

Treatment is carried out by local therapy tincture of iodine 2-3% alcohol on the skin 1-2 times a day. solution, apply mycosolone, terbisis, clotrimazole.for 2-4 weeks, then for prophylactic purposes 1-2 times a week apply fungicidal drugs.

The dyshidrotic form of foot mycosis is treated by a dermatologist. Local anti-inflammatory drugs (alcoholic solution of aniline dyes - Castellani dye) are prescribed. After the cessation of the acute inflammatory process, means that enhance the regeneration of the epithelium are used. Then fungicides are prescribed. General treatment should be used in acute exudative forms of foot mycosis, accompanied by allergic rashes. Antihistamine (dimedrol, pipolfen, lordes, loratal), anti-inflammatory and hypoallergenic (sodium thiosulfate, calcium chloride, calcium gluconate) drugs are prescribed. If pyococcal infection is attached, antibacterial drugs are prescribed. Systemic fungicidal treatment is performed in case of damaged hair.

Nizoral, Lamisil, Terbisis, Terbisis, Orungal can also be used as effective preparations. Foot hygiene is very important after curing the disease. After washing the feet, it is recommended to wipe between the toes until dry, remove dead epidermis, use soothing, drying and antifungal ointments (ointment "Mycosolone", ointment "Borozin"). Most patients find it useful to walk barefoot.

Onychomycosis

In mycosis of the feet, fungal lesions of the nails are very common. The nail change is started from the open edge until it covers the entire nail. A distinction is made between normotrophic, hypertrophic and atrophic types of nail lesions.



In the normotrophic type, the nail retains its shape. Yellow, white, grey spots are formed on the surface of the nail, it becomes cloudy. With the hypertrophic type, the nail thickens, thickens, acquires a dark grey colour, there are pains from the impact of shoes. With the atrophic type, the nail is thinning, often completely destroyed and undergoes lysis. In place of the nail, a nail bed is formed, covered with cuticle. When making a diagnosis, microscopic and bacteriological examination is necessary.

Medicines control growth and complement the treatment process at the stage of topical fungicide treatment. The most effective method of treatment is to prescribe topical treatment together with systemic antifungal drugs (Lamisil, Terbisol, Orungal). Antifungal drugs are prescribed for long-term use for 4-6 months or more, until healthy nails grow. Local treatment begins with the removal of the damaged part of the nail using keratolytic ointment, plaster, collodion, and then fungicidal drugs are applied to the nail bed. In many cases, relapses occur after treatment.

In order to prevent foot mycosis and onychomycosis, shoes should be disinfected. To do this, the inside of the shoe is wiped with a tampon moistened with formalin, all put in a polythene bag and tightly closed, then kept outside for 8 hours. Then the shoes are taken out of the package and put on again, having previously ventilated it in the open air. During treatment, the shoes should be disinfected once every 2 weeks. A comparative diagnosis is often made with nail injury with a coin iron.

MICROSPORIA

The causative agents of microsporia are subdivided according to etiological features into anthropophilic, zoophilic and geophilic fungi, sometimes causing epidemics. The main morphological elements are spots, scales. The source of the disease is a sick person, cats and puppies.



Transmission through direct contact with the patient or objects used by the patient (clothing, headgear, comb, razor, hair clipper). Children are most often affected, and the number of adults is about 10% of the number of microsporia patients. The development of the disease is caused by hypovitaminosis, systemic changes, skin surface lesions, high humidity, high ambient temperature, chronic diseases (chronic tonsillitis, viral infections) and failure to observe the rules of personal hygiene. Hair and smooth skin are damaged. In the scalp, several foci of a distinct rounded shape of 2-5 cm in size are formed. The skin is covered with scaly, sometimes scaly scales. The hairs are broken at the same height (6-8 mm) and surrounded by secretions - a grey clade consisting of fungal spores. Erythematous ring-shaped foci appear on smooth skin. Their edges are slightly raised and covered with crust and scales. In the centre of the spots, a peeling process with small rounds is visible.

Treatment: Griseofulvin 0.125 mg in 2-4-6 tablets every other day for a month, after 15 days, depending on the weight of the patient. Take the dose of griseofulvin taking into account the weight of the sick child, daily until the first negative microscopy result, then every other day for a fortnight, then twice a week until two consecutive negative laboratory results at intervals of 5-7 days.

Capsule Teknazol 100 mg 1-2 times a day given for 4-5 weeks, depending on the age of the child, then microscopically examine the mycelium of the rind and spores of the fungus. If a negative result is obtained, treatment is discontinued. If during this period the disease relapses and fungi are detected, treatment should be continued. Another effective drug is lamisil and terbisil. They are prescribed to adults at 250 mg, children at 125 mg once a day for 2-4 weeks, during treatment, clinical and laboratory control is carried out. Local foci are applied 3-5% iodine, 10-20% sulphur, as well as mycosolone, terbisil, lamisil, terfalin, ointments. During treatment, hair in the foci is removed with a razor once a week. After treatment, after receiving at least two negative control laboratory results every 5-7 days, the child is allowed to attend school, kindergarten or other childcare facilities, as well as examine family members identified by the patient.

Superficial trichophytosis

The main morphological elements are papules, scaly patches. The source of the disease is only a sick person.

School-age children are often exposed to the disease. The development of the disease is caused by damage to the glandular layer, high body temperature,



humidity of the environment, changes in the endocrine system, and a decrease in the general fighting power of the organism.

In the scalp, the signs of inflammation are weaker and itchy patches are formed. The skin is covered with scaly scales, hair at a height of 1-2 mm is broken off in the form of black dots. Round itchy patches on smooth skin. Their edges are slightly raised, consisting of pinkish nodules covered with coin flakes. The itching is less

bothersome. Family members will miss . Treatment is carried out in specialised hospitals. Treatment measures are similar to microsporia.

Infiltrative trichophytosis

The source of the disease is domestic animals, mice, rarely humans. Rural residents are most affected. In recent years, the disease has spread among urban residents. Transmission is direct communication through two objects (clothes, straw, straw). The



pathological process is located in the scalp, on the face (in men in the area of the beard and moustache), as well as on smooth skin. Currently, it is also found in the genital area, that is, the possibility of sexual transmission from a sick person to a healthy person is considered. Deep follicular abscesses of 3-5 cm or more in size are formed in the affected follicles. When the vapours are crushed, drops of pus (called Kerion Celci) are released from the mouths of hair follicles. Damaged hair can be easily and painlessly removed. With the resorption of the pathological process, scars are formed on the skin, limited baldness in the scalp. The general condition of the patient changes greatly, body temperature rises, regional lymph nodes increase. Comparative diagnosis is made with vulgar sycosis, deep pyoderma, chronic disseminated granulomatous candidiasis, folliculitis, carbuncles. The pathological process in the genital area occurs with wounds, scabies, pediculosis, and of course the patient should be examined for sexually transmitted diseases.

Treatment is similar to that of microsporia in special inpatient wards. Systemic antimycotics - teknazol, lamisil, terbisil. In the treatment of acute inflammatory process in drug-induced infiltrative trichophytosis, moisturising method (1-2%

resorcinol solution) and other anti-inflammatory agents (e.g. 10% dermatol ointments) are used, and family members are not prescribed if there are no foci of lesions.

Candidiasis

The causative agents are yeast opportunistic fungi belonging to the *Candida* group. According to recent data, the number of carriers of *Candida* fungi is on the oral mucosa, 11-13% on the vagina of non-pregnant women, 80% in the last trimester of pregnancy, and on the surface of intact skin is formed up to 9.5%. In addition, 75 per cent of women have been bothered by this disease at least once in their lives. And every third



man who went to a skin hospital was bothered at least once in his life by a sign of "rider's itch", i.e. a sensation of itching in the genitals. It can be passed from mother to baby during childbirth. Sometimes yeast-like fungi settle in the colon and cause diarrhoea. Sometimes these fungi can pass through the anus to the genitals and then infect another person through sexual intercourse. Only a person with candidiasis can be the source of the disease (kissing, sex, utensils, etc.). Humid climate, maceration of the epidermis, processing of fruits and vegetables in the production of canned and confectionery products, violation of hygiene rules in kindergartens create favourable conditions for the development of the disease.

Endogenous development of the disease may depend on the increased activity of the existing candidal flora in the body. Candidiasis is caused by disorders of carbohydrate metabolism (diabetes mellitus, excessive intake of carbohydrates with food), immunodeficiency states (cytostatic HIV/AIDS, prolonged use of corticosteroid drugs), hypovitaminosis, chronic cases of dysbacteriosis developed as a result of antibiotic treatment are of great importance. A distinction is made between

candidiasis of mucous membranes of the skin, candidiasis of the nail surface, chronic disseminated granulomatosis and candidiasis of internal organs.

Candidiasis of the oral cavity and genitals produces a discharge in the form of sour milk ("thrush"), consisting of small particles of white colour on a hyperaemic base. When it is removed, erosions of pale red colour are seen, sometimes bleeding. In women, the mucous membranes of the genitals and the surrounding skin may be affected.

Rashes and erosions often appear on the penis of men. The patient is bothered by heartburn, pain when eating, decreased taste sensations. This yeast can cause the male sperm to stop working. Large folds in the skin are often affected. On their erythematous surface livid-coloured cracks erosions are formed, surrounded by macerated epidermis. Erythematous spots, nodules, blisters and purulent small foci appear on the background of the thickened epidermis. On the hands, the fold between the third fingers is often traumatised. The affected foci on the skin are accompanied by itching and burning sensation.

Nail candidiasis starts with inflammation of the skin around the nails, swelling and pain. When pressed, oozing pus is released. The nail plate is damaged secondarily. Starting from the damaged side, the nail becomes duller, thickens, and wrinkles form on the surface.

Complications. Candidiasis of mucous membranes and skin can occur together with candidiasis of internal organs. Gastrointestinal and urogenital candidiasis often develop.

Care. After diagnosis and laboratory confirmation (microscopy and culture), full treatment is carried out by a dermatologist (except for urogenital candidiasis). In internal candidiasis, serological reactions and skin allergy tests for candida allergens are performed. Great attention should be paid to the elimination of pathogenetic factors. Diffuse candidiasis in species that are indicated for treatment. prescribe

antibiotics: levorin, nystatin 500000 U 4-5 times a day for 10 days. They are especially indicated in lesions of the oral cavity and warm layers of the gastrointestinal tract, since they are poorly absorbed. New effective drugs Diflucan, Mycosist, Lamisil Orungal can be used for candidiasis lesions of the skin, mucous membranes, internal organs and nails. Candida yeast fungi are particularly sensitive to drugs containing fluconazole (Mycocystis, Diflucan, Diflazon), and treatment can achieve high results.

Topical therapy: aniline dyes, rasvor : methylene blue, as well as creams, ointments : travogen, triderma, exoderil, mycospora.

TOXICODERMIA

The main morphological elements are erythema, nodules, blisters. The disease develops as a result of the impact of chemical substances on the skin. The cause of toxicoderma is drugs, food products, industrial and household



chemicals that have allergic or toxic properties. They often enter the body through the gastrointestinal tract and respiratory tract. Drugs can develop toxicoderma when administered intravenously, intramuscularly, subcutaneously, vaginally, urethrally, and by local application to the skin through friction. Toxicoderma can also be caused by inhalation of small drug particles . Toxicoderma usually develops a few hours after exposure to the acute etiological factor, more often on the 2nd or 3rd day. The clinical course is usually characterised by a rash consisting of diffuse, symmetrically arranged patches, nodules, fumes, vesicles, blisters, substance and nodular, moderate pruritic elements. Patients suffering from toxicoderma complain of general weakness, headache, dizziness: their body temperature rises, there is leukocytosis of the blood, eosinophilia, moderate anaemia. In severe cases - toxicoderma with

thrombocytopenia, agranulocytosis, allergic and toxic visceropathies need to be in hospital. Development of allergic myocarditis due to the use of drugs : general condition (fever, chills, body cramps). Skin lesions resemble second-degree burns.

The diagnosis of toxicoderma must be confirmed by a dermatologist. A comparative diagnosis is made for a painful wound, followed by coin-shaped eczema, red flat lice, and erythema multiforme exudative erythema.

In the treatment of toxicoderma it is necessary to eliminate the factor affecting the body, stop the introduction of the drug, release the patient from harm in work, stop communicating with household chemicals, recommend diet and abundant drinking, fluids. Treatment of toxicoderma consists in the use of diuretics (furosemide, hypothiazide, lasix), salt laxatives (25-30% magnesia), intestinal sorbents, activated charcoal, antihistamines, ascorbic acid. If severe general changes develop, the use of corticosteroid drugs, haemosorption in combination with haemodez or reopolyglucin is indicated. The amount of prednisolone prescribed for severe toxicoderma can reach 150-350 mg. Treatment is carried out in the intensive care unit. If the internal organs are not damaged, if the necessary procedures are carried out in time, the disease will pass safely.

When treating patients with drugs that develop hypersensitivity (antibiotics, sulfonamides, analgesics, barbiturates), it is recommended to use antihistamines and calcium preparations.

Seborrhoea (Seborrhoea)

In seborrhoea there is a violation of the secretory activity of sebaceous glands in the form of increased and qualitative changes in sebum secretion. The disease appears during puberty (increased secretion of androgens) and is associated with disorders of the



digestive system. It occurs on the skin of the face and hair, chest and upper back; dark and mixed types are distinguished.

The skin is oily, shiny, and the hair follicles are enlarged. Sebaceous fluid flows freely from the follicles when the skin is crushed, and a small amount of white oil is secreted from the sebaceous ducts. The hair on the scalp is greasy, shiny, stuck together, and also bothers - insomnia, hair loss. When examining patients with oily seborrhea reveal signs of changes in the autonomic nervous system: sweating, increased gastric secretion, colitis, changes in blood pressure in the form of a tendency to hypotension, increased heart rate variability, increased irritability. Men sometimes experience relative functional impotence.

In seborrhoeic dermatitis, the skin is thick, brown in colour, the sebum is dark and slowly separates. The hair on the head is covered with dry, scaly scales (dandruff). Comedones in the form of large black dots appear on the face, back of the neck, chest and waist. Squeezing them releases a white or brown product consisting of thick skin oil and frozen epithelial cells.

The mixed type is characterised by a combination of symptoms of thick and liquid seborrhoea in the patient. The symptoms of oily seborrhoea are observed more often on the face and scalp, while the symptoms of dark seborrhoea are observed on the chest and back.

Treatment is carried out by dermatocosmetologists. Patients are advised to follow a work and rest schedule. Walks in the fresh air, diet (low consumption of products containing carbohydrates and animal fats), vitamins A, E, B (especially B-6) aevit, refined sulphur, 2 times a day for 3-4 weeks. Recommended topical rinse with a mixture containing boric and salicylic acid. With oily seborrhoea good results are given by the use of calendula and herbal masks, cryotherapy. In deep seborrhoea - creams containing vitamin A, E, cosmetic massage with biostimulants.

Acne is the main complication of seborrhoea. Inflammation of the sebaceous gland occurs as a result of blockage of the surface of the hair follicle by the accumulation of horny cells and wasps. In the future, pyococcal flora joins the pathological process. Comedones can be open (with a black tube) or closed (inflamed papules with purulent head, pustules, indurative, fused, pimples, passing into an abscess). It mainly affects the face, but the neck, chest, upper back and shoulders may also be affected.

The vulgar form begins with the formation of comedones and blockage of the surface of the hair follicle. Then an inflammatory infiltrate appears in the form of a nodule of bluish-pink colour. As a result of infection with pyococcus, pain and pus appear in the central part. Later, the infiltrate can increase in size, merge and erode with pus. Often the condition of the patient worsens in the winter period of time.

Sometimes there is development of a depressive state, increasing loss of calmness. It is explained to the patient that people have misconceptions about food, exercise and sex. It is also said that certain cosmetic products may aggravate the disease.

Large comedones can be removed 1-2 times a week with an extractor after hot, moist compresses. Removal of scabs covering open pus can delay healing for several weeks and cause scarring.

Treatment: The antibiotic clindamycin (lotions, dalacin) is highly effective for pustular acne. It can be used in combination with active removal agents (benzoic

acid agents: Acnecid, Acnegel, Bonoxyl, etc.). Tretinoin (a type of vitamin A: 0.025 ointment, lotion, gel) can be used, but it is explained that it is necessary to avoid exposure to ultraviolet rays. Tretinoin is recommended to be used every evening. Antibiotics: tetracycline 250 mg 4 times a day or 500 mg 2 times a day for 4 weeks, reducing the drug to the minimum effective amount. In the absence of results, stronger antibiotics are prescribed. In pregnancy, 250-500 mg of erythromycin per day is prescribed.

-ethinylestradiol-cyproterone (Diane-5) is prescribed to women only in cases of epilepsy refractory to other drugs. 1 dragee per day at the same time from day 5 to day 25 of the menstrual cycle, followed by a 7-day break and, depending on the results, can be taken again for several months.

- in severe cases of severe insomnia only under medical supervision (knowing the side effects) - isotretinoin 1.5 mg/kg per day for 20 weeks. Side effects: drying of conjunctival and genital mucosa, cracked lips, pain in large joints and limitation of movements, control of triglycerides and cholesterol in blood (symptoms of cholestasis).

INFECTIOUS ERYTHEMA

Infectious erythema differs from acute infections (measles, scarlatina, typhus, etc.) of clear aetiology in that there are few signs of general body damage and predominantly the appearance of the disease is observed through the skin. Most of these diseases are not contagious.



Nodular erythema. It is characterised by hemispherical, painful, inflamed nodules. The nodules range in size from a pea to a pigeon egg, are slightly elevated above the skin and are located in the dermis or subcutaneous tissue. During the course of the disease, the colour of the nodules changes from purplish pink, brownish red and

bluish yellow to yellow. Smoke appears predominantly in women 20-40 years old, on the anterior surface of the balls, disappears without a trace. They arise as a result of polyetiological toxic-allergic reactions from the circulatory system, developing in various acute and chronic diseases and intoxications. The disease runs acutely or chronically with periods of remission and exacerbation, mainly in spring and autumn.

Antibiotics, preferably penicillins, are prescribed for a long period of time, sometimes up to a year. Also calcium preparations, ascorutin, potassium iodide (10% solution of 1 teaspoon 2 times a day). As a local warming compress - 10% aqueous solution of ichthyol. Special attention should be paid to the identification and elimination of foci of chronic infection.

Multiple forms of exudative ehyrthema.

Infection is an allergic disease. Bacteria and viruses act as infectious agents. It is characterised by a recurrent course (agitation in spring and autumn). Increase in body temperature after the onset of the disease or several prodromal periods. tremor, rheumatic pains begin). Skin lesions are symmetrical, observed on the surface of the feet and hands, on the surface of the shoulder, on the elbows. Less frequently (sometimes to a limited extent) the face, the mucous membrane of the mouth is affected. In the centre there are pitted and bluish-pink fringed spots and swollen nodules. In most cases, a blister is formed in the centre. Vesicular elements are more common in mucous membranes, in the red papillae of the lip. When the integrity of the blisters is broken, erosions are formed, covered with bloody crusts. subjective pain and burning are observed. A severe form of exudative erythema - Stevens-Johnson syndrome with spreading rash, universal lesions of mucous membranes (conjunctiva, oral cavity, genitalia), worsening of the general condition (increased body temperature, increased chills) is characteristic.

It is important to know the difference between idiopathic and symptomatic exudative erythema. Symptomatic exudative erythema develops in patients with measles, influenza, tularemia, brucellosis, leprosy, focal infections (sore throat, after taking antibiotics, amidopyrine, burns).

Desensitising treatment is prescribed (antihistamines, calcium salts), broad-spectrum antibiotics, vitamins C and PP.

The vesicles are punctured and treated with aniline dyes. If the oral mucosa is damaged, rinse it with disinfectants (2-3% boric acid, furacillin, manganese solutions).

in severe cases - the patient is hospitalised. Glucocorticosteroid hormones (prednisolone 40-120 mg per day), asparkam reosorbilact are added to the treatment.

TRANSMISSIBLE INFECTIONS

This group of diseases can be caused by the sexual transmission of microorganisms from one person to another. In addition to the "classical" sexually transmitted diseases, this group includes a number of other diseases that are transmitted incompletely, and more often through sexual intercourse. Some of these can be transmitted from mother to child during childbirth and then sexually transmitted to others. Diagnosis of these diseases requires microscopic, culture and serological tests in special laboratories.

STD CLINIC

STIs can often appear as superficial bumps, sores, rashes and growths on the skin of the external genitalia in men and women. They may be painful or painless, itching and burning.

In recent years we have been aware of 4 "classic" venereal diseases with ulcers - among them ulcerative (syphilis), chancre or soft chancre, liver lymphogranuloma and venereal granuloma. However, STDs, or non-reproductive diseases, are sexually

transmitted can also be transmitted. Increasingly, other diseases are being added to the list of STIs, have also begun to be introduced. For example: genital chlamydia, ureaplasmosis diseases. Yeast-like fungi of the genus (*Candida*) is also transmitted from the mother, can pass to the child during birth. The present genital candidiasis through sexual intercourse is proven to be contagious to another person. In the corner of the mouthlips- Herpes simplex is transmitted most often by kissing, but also sexually

Gonorrhea

is a sexually transmitted infectious disease caused by the infectious agent gonococcus. Discovered by the German scientist Neisser in 1879. Gonococci are gram-negative diplococci. They are bean-shaped, 1.25 μm long and 0.75 μm wide. Gonococci are only harmful to the human body, they grow well on artificial nutrient media containing protein. The disease is transmitted to adults during sexual intercourse. It is transmitted to children in a non-sexual way: from infected parents and through household items. Gonococci live in the mucous membranes covered with cylindrical epithelial cells and damage them. Consequently, the normal vaginal process leads to inflammation of the following organs: urinary tract (urethritis), cervix (endocervicitis), lower colon (proctitis), vagina in girls (vaginitis), and conjunctival and corneal layers of the eye in newborns (blennorrhoea). Infection of other urogenital and extragenital organs by gonococci is a complication of gonorrhoea. Gonococci, entering the patient's body in epidemic parotitis, cause the formation of special antibodies (complement-binding, coprecipitating and other types of antibodies) in the blood serum. These antibodies belong to 6-8 types of proteins. However, the protective power of the formed immune cells is very low. They cannot protect patients from re-infected gonococci. For this reason, patients who have been treated for epidemic mumps may become



re-infected with the disease (reinfection). The phagocytosis observed in tuberculosis patients is carried out predominantly by multinucleated neutrophils. But such phagocytosis is incomplete (endocytobiosis). The course of mumps, severe or mild course of the disease depends on the immunobiological state of the patient's organism.

Urethritis

Inflammation of the urinary tract is called urethritis. Urethritis usually develops 3-5 days after infection. Sometimes symptoms may appear after 1 day and vice versa, after 15 days. At first, patients are bothered by



pain and itching of the urethra. Then mucous or mucopurulent fluid appears in the urethral orifice. The external opening of the urethra swells and the surrounding area becomes red. Pus from the urethra may harden at the mouth of the canal and make urination difficult. As the disease progresses, there is pain in the body of the penis. On palpation, we feel that the urethra has hardened like a rope and the pain increases. The inflammatory process in the urinary tract develops first in the anterior part of the urethra, then in the posterior part. For the topographical determination of this process, the method of the two cup test is used. The patient is invited to urinate alternately into the first and second cups. At the same time, the flow of urine transferred into the first cup should not be interrupted. In anterior urethritis, only the urine in the first cup is cloudy. The urine in the second cup will be clear and clean. If the goitre has also damaged the posterior urethra, the urine in both cups is turbid, threads float in it, the urine is settled (total urethritis). To avoid diagnostic error, the patient should urinate at least 200-300 ml. It should also be taken into account that the urine can be cloudy and for other reasons (for example, urolithiasis). Changes characteristic, in particular, of kidney and bladder diseases, lead to the accumulation of various salts, bacteria and purulent masses (pyuria) in

the urine. If the urine is cloudy due to phosphorus salts, pumping hydrochloric acid into it causes the urine to become clear. Urine turbidity due to urates (uric acid salts) is determined by heating the urine. Depending on the degree of development of the symptoms described above, acute, moderately acute and torpid types of urethritis are distinguished. Bacterioscopic and bacteriological methods play a decisive role in the diagnosis of gout, including the determination of urethritis associated with gout. It is necessary to prepare a smear of purulent fluid excreted from the urinary tract and stain it according to Gram staining. Depending on the results of staining (gonococci stain Gram-negative), the causative agents of thrush are distinguished from diplococci. Also determine the true nature of urethritis help to determine the location of gonococci inside the cell (endocytobionts), mating, bean-shaped shape and other signs. In men, genital urethritis leaves the following complications:

1. Paraurethritis is inflammation of the urethra;
2. Balanoposthitis - inflammation of the head of the penis and the inner surface of the glans penis;
3. Cooperitis is a lesion of the Cooper's glands;
4. Prostatitis - inflammation of the prostate gland;
5. Epididymitis is a testicular disease;
6. Vesiculitis is a lesion of the seminal vesicle;
7. Cystitis is inflammation of the bladder;
8. Orchitis is a lesion of the testis;
9. Pyelonephritis - purulent inflammation of the kidney and renal calyx and other complications. In most cases prostatitis causes impotence and orchitis causes infertility. Extragenital complications of tuberculosis develop mainly through

metastasis: tuberculous septicaemia, endocarditis, lesions of the joints, nervous system and skin. Complications in first diagnosed diabetes are rare, and in chronic diabetes complications of this type occur in almost all cases. Determination of complications of goitre has not only diagnostic value. Knowing their nature allows you to properly design a treatment plan. Complications of goiter are often caused by gonococci themselves. In addition, infectious microorganisms and other allergic processes can cause the development of goitre complications in a short period of time. Of the most frequent oral complications (45-50%), we will focus on prostatitis. A specific lesion of the prostate gland is usually formed as a result of gonococci entering the posterior urethra and entering the excretory ducts of the gland. Sometimes gonococci can enter the gland by lymphogenic and haematogenous routes. Depending on the course of the disease, a distinction is made between acute and chronic prostatitis. Acute prostatitis is rarely registered. Chronic prostatitis develops with poor treatment or incomplete treatment of the acute form of the disease. Chronic prostatitis can also be primary (without the acute form). Depending on the nature of the disease and the degree of inflammation of the gland distinguish catarrhal, follicular and parenchymatous prostatitis. In catarrhal prostatitis, the focus of inflammation is predominantly observed in the area of the output ducts of the glands. Pathological changes are practically imperceptible on palpation of the prostate gland. Only when examining the glandular fluid under the microscope, a large number of leukocytes and reduced lecithin granules are detected. With follicular prostatitis, painful overgrowths in the area of the gland can be palpated. Among the complaints of patients pay attention to the pain in the perineum, accelerated ejaculation, weak erection of the penis, decreased sense of sexual satisfaction. With parenchymatous prostatitis, the complaints listed above are intensified. Pain during urination, itching, frequent discharge of mucopurulent fluid from the urethra disturbs the mood of the patient. The increase in the symptoms of impotence does not let them sleep. In the fluid of the gland a large number of leucocytes is found with a sharp

decrease in lecithin granules. Gonococci must be detected in smears prepared from urethral fluid to prove the association of prostatitis with acute condylomas . In patients who are not helped by bacterioscopic methods, the culture method is helpful.

Gonorrhoea in women

In girls, it manifests as vulvovaginitis and urethritis. There is little or no involvement of the uterus and uterine appendages. Vulvovaginitis caused by gonococci accounts for 4% of infectious diseases seen in the female genital tract.



The tendency of girls to talk is due to the unique anatomical, physiological, biochemical and hormonal features of their bodies. In particular, the alkaline environment of the vaginal fluid, the fact that the vaginal wall does not consist of multilayered squamous epithelium, as well as the lack of development of Dederlein bacilli, considered antagonists of gonococci, cause inflammation of the vaginal mucosa. In untreated or poorly treated girls, thrush may persist until puberty. As a result of the changes observed in the body of girls who have reached puberty (puberty), there is a state of self-repair of the body. This is due to the histological changes observed in the vaginal mucosa, the physical and chemical properties of the vaginal fluid, and other immunological changes. The incubation period of mumps in girls averages 5-7 days. The disease begins with symptoms such as pain, itching and soreness observed in the genital area and anus, the patient has an increase in general temperature, frequent urination, painful sensation when urinating. Signs of inflammation are seen on the skin of the labia minora, vaginal vestibule, vaginal wall, urethra, lower rectum. In addition, signs such as redness and swelling of the labia majora and the skin between them are visible. The drying of purulent fluid from the genital discharge causes yellow-brown lumps to form in the labia region. Small erosions may appear in the corridor

of Qin . Sometimes the development of polyposis tumours in the vaginal wall and the mouth of the urethra can be seen as a result of the acute inflammatory process. All girls with vulvovaginitis have symptoms of urethritis: the external opening of the urethra is red, swollen and enlarged; when the lower wall of the urinary tract is pressed, purulent fluid is released from it. Girls urinate frequently, sometimes unable to retain urine. In girls 3-7 years of age, goitre can cause complications such as Bartholinitis and endocervicitis. In such cases, the enlargement of these glands and red dots in the area of the discharge ducts can be clearly seen. The cervix is red and swollen. From the mouth it oozes purulent fluid, and small erosions are observed around it. To make a diagnosis of thrush in girls, it is necessary to detect gonococci by the Gram method and smears stained with methylene blue. Treatment of goitre is carried out on the basis of a special methodological manual. When treating the disease on the basis of this manual, antibiotics, sulphonamides, specific and non-specific immunological preparations, as well as local preparations are used. Antibiotics include penicillin salts, levomycetin, tetracyclines, erythromycin, monomycin and kanamycin. In subsequent years, the efficacy of cephalosporins (sephorin, cefamisin, cefzol, cefuroxime, cefolexin) in the treatment of goitre has been investigated. Among sulfonamides, sulfomonomethoxine, sulfadimethoxine, sulfatone and bisseptol-480 are used. Gonovaccine, pyrogenal, prodigiosan, autoblood and vitamins are widely used in immunological treatment. Acute, moderately acute uncomplicated goitre is treated with antibiotics only. Penicillin and its long-acting derivatives are often used. Benzylpenicillin comes from 300,000 TB every 4 hours, bicillins from 1,200,000 TB every 48 hours, totalling 3 million. TB. In the treatment of new torpid and chronic uncomplicated goiter, immunotherapy is first followed by antibiotic therapy penicillin group 4-2-6 million TB per course of treatment. In the treatment of new and chronic complications, immunotherapy is first followed by antibiotics. But with such complex types of gonococci, the sensitivity of gonococci to them is determined even before the choice of antibiotics. In this

case, depending on the type of complication, this kind of local treatment (urethral lavage, massaging the prostate gland, imposing suspension on the scrotum, etc.). Sulfonamides are mainly used in patients with chronic complicated gout, when antibiotic resistance and unpleasant symptoms are observed. In secret, immunotherapy and antibiotic therapy are given alternately. In such cases, two types of antibiotics can be used simultaneously (taking into account their sensitivity to gonococci). When treating the speech of children, therapeutic measures should be carried out in inpatient (hospital) conditions. New uncomplicated goitre in girls is treated with penicillin (500,000 TB every 3 hours, for a total of 2 million TB). The amount of penicillin for new complicated and chronic diarrhoea is 4 million Before TB, erythromycin 6-8 million delivered to However, immune treatment is given before antibacterial treatment to obtain the desired result (girls over 4 years of age). The vagina and rectum are washed with a 1-2-3% solution of protargol or collargol. A 5-10% solution of glycerol is applied to the cervix. In 7 - 10 days after treatment against tuberculosis in patients determine the criterion of cure. To determine this, methods of joint provocation (artificial induction of the disease) are used. The following types of artificial induction of the disease are distinguished:

- 1) biological method - injection of gonovaxin between muscles, 0.5bn adults, 200m - 300m children. stem cells;
- 2) chemical method - 1-3% silver nitrate solution is applied topically;
- 3) alimentary method - consumption of spicy and salty food; 4) mechanical method - insertion of a plug into the urethra; 5) physical method - carrying out various heating procedures. In 24, 48, 72 hours after joint provocation methods, smears are prepared 3 times and bacterioscopic examination is carried out. Also use seeding , check the prostate fluid and perform urethroscopy. If there are no signs of disease in smears, nutrient media, gonadal fluid and urinary tract, and no gonococci are found, the examined patient is considered healthy, i.e. completely cured.

Diagnosis

The preparation of good quality smears is of great practical importance in the detection of gonococci (*Neisseria gonorrhoeae*). To obtain smears in men, the external opening of the urethra is wiped with a piece of gauze moistened with physiological solution. Then take in both hands two glass bottles and the edge of the right hand touches the place where the purulent discharge is protruding. The right side of the bottle, coloured with purulent fluid, is moved over the surface of the left side of the bottle, i.e. rubbed evenly. The prepared coating should preferably be very thin.

If tissue fluid does not discharge freely from the urethra (in torpid, chronic urethritis), the discharge is removed by squeezing the penis and moving the hand forward. Cyptma is produced from the female genital organs mainly from the urethra and cervix. For this purpose, the external openings of the urethra and cervical tube are wiped with gauze moistened with physiological solution. Then with the help of a metal spiral tube, Folkman spoon (these instruments must be sterilised) tissue fluid is removed and applied to the glass of the subject. Smears are made with circular movements in an oval shape. It is forbidden to use the Cusco mirror when addressing girls. A Volkmann tube or spoon is carefully passed through the hymenal ring and secretions are taken alternately from the bottom of the vagina and cervix. The product is applied to the bottle in a circular motion.

When preparing ointments from organs of women and girls, such as the urethra, cervix and vaginal dome, a separate agent for each organ must be used. Otherwise, a diagnostic error may occur. For example, swabbing the cervical canal with an instrument contaminated with gonococci in the urethra may result in the detection of gonococci in the cervical smear. In addition, it should be taken into account that other pathogens (trichomonads, yeast fungi, etc.) may be present in the smears examined. Gonococci are stained with all aniline dyes. An important differential-

diagnostic value of the Gram's method is that it requires staining of smears in this way. In this case, they are stained Gram-negative. Smears are examined under a 7x90 microscope. To distinguish them from other diplococci in this case helps the presence of leucocytes, gonococci inside leucocytes, coffee beans of the same size or bean-shaped pairs of cocci.

Syphilis (syphilis)

A chronic infectious disease of the skin, mucous membranes, internal organs and nerves. is a disease. The primary inflammation occurs as a superficial injury to the underlying hard skin - erosion or ulceration. The causative agent is the pale treponema. It can be seen through a microscope. It is from other bacteria to its filament. It is characterised by a similar spiral shape, length, thickness and extreme mobility.



The disease can be transmitted through the placenta when the blood of an ulcer patient is transfused to another person, or a pregnant woman with an ulcer can pass the disease to her child. In addition, professional, i.e. health care workers, can become infected through negligence.

Signs of a primary wound. The disease starts with a latency period of 3-4 weeks. The so-called chancre (from the French word chanré) is a primary wound or erosion that appears after infection at various times, ranging from 9 to 90 days. The bacteria that cause wounds cannot pass through intact skin, but can easily enter the body through microscopic scratches or wounds, including those caused by sexual intercourse. In men, a hard chancre often forms on the head of the penis or the skin around it. In women, an ulcer develops in the area of the external genitalia or in the vagina. If the wound or erosion is located in the vagina or cervix, the patient may

not even know they have a wound because they cannot see the wound, and most importantly, the primary wound is not painful or bothersome. A hard chancre can also be on the lips or tongue. In this case, the spoil is inflicted by sexual intercourse or kissing. An infant can become infected from sores on the mother's nipples. In homosexuals, such sores are located around the posterior (anal) orifice. Sometimes a hard chancre may appear as a swelling on the skin of the genitals or tonsils . Some people also have chancres on their fingers.

Hard chancres are often solitary and do not exceed 1 centimetre in size. A reddish spot appears at the front, then the base of the spot thickens, rises slightly above the surrounding skin and becomes an erosion or ulcer. A hard chancre has smooth edges, smooth shiny surface, sloping towards the bottom, no pus or other secretions inside, yellowish-red colour, hardness at the base. When you touch such a wound with your fingers, it feels like a button and at the same time does not cause any pain. If the wound is damaged by other pus-producing bacteria, it will hurt and ooze pus. Later, after 5-10 days, the nearby lymph nodes will increase in size, will not hurt on palpation, and will be mobile. They are called regional buboes. First of all, the situation that can be transmitted is analysed. The causative agent of the hard chancre can be seen under the microscope. The Wasserman reaction can be negative in the first half of the primary wound . The result of this reaction becomes positive when the leaked thiomene passes into the blood and antibodies against it are formed in the body, i.e. in the second half of the primary wound. If the wound is not detected and treated in time, the big chancre will disappear within 3-6 weeks. The disease may be temporarily latent.

Secondary syphilis. After 6-9 weeks after infection, up to 3-4 years, there is a secondary period of the disease . In this case, the wound reappears on the skin, but in the form of various painless and not itchy rashes. These lesions sometimes appear, sometimes disappear or do not appear at all, the disease is hidden, and the patient remains highly contagious. The course of the secondary wound depends on the

peculiarities of the immune response of the patient's organism to the irritant. Symptoms: First of all, body temperature rises and lymph nodes may enlarge. Some patients may experience headache, tingling in the extremities, fatigue and dry skin. About 2.5 months after infection, rashes, yellow-red spots, blotches and moles appear on the skin and mucous membranes. In the secondary wound, rosaceosis and papulosis are more common, with rare cases of pigmented syphilis, wound alopecia, and pustular wounds. Roseolae consist of numerous irregularly shaped inflamed spots with veins up to 1 cm in size, which do not flake and are located on the chest, abdomen and sides of the body. Without treatment, they disappear after 3-4 weeks. Wound papules are lenticel-shaped, copper-red or bluish-red in colour, of dense elastic consistency, often located on the sides of the body, on the oral and genital mucous membranes. You can see erosive papules on the mucous membranes, hard and soft plaque in the mouth, redness of tonsils (comparison with sore throat, diphtheria), sometimes the patient's voice becomes hoarse (wound laryngitis). Papular syphilides can also be of many types (angular, coin-shaped, lenticel-shaped, wide condylomas on the face and hands), which in turn complicates diagnosis. Rashes do not bother the patient. Pimples may form on moist areas of the body, such as between the buttocks, around the anus and around the genitals . These are called widespread condylomas and look like wart bumps or warts. Sometimes rashes on wounds or skin diseases resemble allergic rashes or rashes from skin diseases. During this period, the leaking treponema spreads throughout the body, damaging internal organs, eyes, bone tissue, and brain. Diagnosis is made on the basis of the symptoms of the disease. Serological reactions in the blood during this period will be positive. The treatment process is carried out by a dermatovenerologist - a doctor with the help of penicillin series drugs or other antibiotics. After that, the patient should be under dispensary observation. If the disease is undiagnosed or hidden and the patient is not treated, the tertiary stage of the wound develops. In this case, the rash in the secondary wound resolves in 2-3 months, and the disease may again take a latent character. After a few years - from 3 years to 10-20 years - the disease

becomes more pronounced, only now it is with erosions of the skin, mucous membranes and organs. During this period, the patient may become blind, deaf, bones, joints, vessels, internal organs, brain, which leads to disability and death. Among the internal organs, the first place is occupied by damage to the cardiovascular system (wound mesoaortitis), then the nervous system (progressive paralysis, pseudospinal cord, meningoencephalitis), the bone system (osteoperiostitis of tubular and flat bones). Often such patients do not know that they have a wound, and turn to general practitioners, cardiologists, neurologists and other specialists at symptoms of damage to internal organs and nervous system. If there is a suspicion of a wound, the doctor should undergo special serological studies (Wasserman, immunofluorescent, rush treponema-inhibiting reactions) and refer to a dermatovenerologist. Treatment and prescription is carried out by a dermatovenerologist.

The tertiary stage of the lesion (syphilis tertiaria) develops at least 3-5 years after infection, sometimes (despite lack of treatment) after many years. The rashes associated with tertiary lesions (nodules and bumps) are located not only on the skin and mucous membranes, but also damage internal organs, the nervous system, bones and joints. Symptoms of tertiary lesions may bypass the skin and mucous membranes and manifest predominantly in the internal organs and nervous system. Not all patients who have not been treated at the initial (early) wound stage will necessarily show signs of a tertiary wound (this case will be discussed in the relevant topics). The speed of transition of the wound process from one stage to another depends on the immunobiological abilities of the organism, including the state of cells, their interaction with the wound agent, as well as a number of external and internal factors. Among these factors, an important role is played by the state of health of the patient, living and working conditions, as well as other diseases observed in the patient. Above we noted that in the course of acquired and untreated wounds there is a necessary transition from one wound period to another.

However, recent almost 20-year observations (M. V. Milich, 1968) have shown that the change of periods of the wound process does not always occur according to certain laws. A number of patients may be asymptomatic after infection, and this asymptomatic period may last for many years. In recent years, the majority of patients (70-90%) presenting with delayed wounds in syphilidological wards, when recounting the history of their disease, emphasise that they did not suffer from wounds at first. They try to prove that they have not observed any rashes on the skin and mucous membranes during their whole life. This indicates that a wound can remain asymptomatic for many years. Discoveries made in the following years, news of serological science confirm this opinion. It is known that spirochetes take atypical forms if they cannot find favourable conditions after moving to a "new organism". In particular, a cyst is formed, which takes an L-shape and acquires a thrusting, draughty appearance. It turns out that spirochetes with such an atypical appearance lose activity and are unable to cause obvious (significant) lesions. Because of this, the wound begins to hide. This process can last for many years. Administration of treponemocidal drugs for various reasons, including antibiotic treatment, leads to a lengthening of the period of "unfavourable environment", that is, to a lengthening of the latent period of the wound. In such cases, infectious, early wound symptoms are not observed. Finally, as the organism weakens over the years, signs of the trauma period appear. Once the pathogens have entered the "new organism," the wound process may not occur at all. If the pale treponemes are few in number, of low virulence and immediately exposed to treponemocidal drugs, ulceration may not develop

CONGENITAL SYPHILIS

It is observed in children born to sick mothers. In this case, pale treponemes get through the placenta (through the placental circulation) into the child's body. If you carefully examine the mothers of children with congenital lesions, they will



inevitably be diagnosed with peptic ulcer disease. Congenital defects do not develop in people whose mothers were not affected. The extent of the symptoms of congenital lesions seen in children depends on when the mother contracted the disease.

Maternal injury is very dangerous for the foetus in the first 3 years of the procedure. However, children born 5-10 years after infection with the disease may also show signs of congenital lesions. In most cases, children born to pregnant mothers do not show signs of congenital lesions 10 or more years after the disease. In such children, symptoms of the disease may appear after several years (childhood, adolescence, puberty). The course of congenital lesions depends on the term at which the mother of the patient became pregnant. Symptoms of congenital lesion are observed in children born to the majority of pregnant women who have undergone the primary and secondary stages of the lesion.

In particular, all children born to pregnant women with secondary neoplasms show signs of congenital lesions. Congenital lesions may not be observed in children born to women pregnant in the third trimester of the lesion. Because a dramatic decrease in the number of spirochetes leaking out, the increased resistance of the mother's body can protect the foetus from attack by wound infection, and such children develop late congenital wounds. Pregnant women with birth defects may give birth to a sick baby. But such events are very rare.

Pregnancy in women with ulcers can have different outcomes: miscarriage, premature delivery of a sick baby, premature delivery of a sick baby, or delivery of a healthy baby. It is rare for pregnant women who have not received treatment to give birth to healthy babies. Healthy babies are born to women who receive good treatment during and before pregnancy. For this reason, identifying and treating the wound early in pregnancy can prevent birth defects. According to the 1975 Revised International Classification of Diseases, the following clinical types of congenital lesions are distinguished:

1. Early birth trauma (includes all manifestations seen before 2 weeks of infancy);
a) symptomatic early birth trauma; b) asymptomatic preterm birth trauma.
2. Late congenital injury (all forms of congenital injury seen after 2 weeks): a) pronounced late congenital injury; b) latent late congenital lesion.

SYPHILIS CONGENITA PRECOX (SYPHILIS CONGENITA PRECOX)

Symptoms of the disease appear mainly during the first two months of a child's life. Children born with clear signs of birth defects do not live long. They die in the first hours and days of their lives. The body of such babies is very small, the skin is dry, not swollen, there is no subcutaneous layer. The hands and arms of the patients are very thin, covered with folds, the faces are saffron, resembling senile. The skull is much larger than the trunk, and dilated blue veins (veins) protrude from under the skin. The skull changes its shape due to fluid accumulation in the brain cavities. Changes in the internal organs hasten the death of the sick baby. The following changes are observed in the skin and mucous membranes of healthy children: wound herpes (blisters), hardened diffuse material (infiltrate), wound infection (rhinitis), papules, roseolae, hair loss, etc. Wound blisters (remphigus syphiliticus) appear. and forms in the first days and weeks of the baby's life. The blisters are pea-sized, sometimes cherry-sized, and filled with dark red fluid or pus. The blisters are filled with clear serous fluid or pus, sometimes with an admixture of blood. The vesicles dry up and form a crust, at which point the blister shell

ruptures and inflammatory fluid comes out. The location of these blisters on the palms of the hands serves as a diagnostic sign. Large numbers of oozing spirochetes are found in the cyst fluid. Wound blisters should be distinguished from a vesicular (infectious) wound caused by staphylococci. A hard substance is felt beneath wound blisters, the blister sheath is hard and does not dissolve easily. The blisters do not merge with each other. Sometimes a rash in the form of inflamed spots and nodules is formed before the blisters appear. The infectious (vesicular) rash spreads to many parts of the body (back, shoulders, arms, face). The shell of the blister is thin, easily resorbed. There are many staphylococci in the fluid of the blister. Spots (erythema) gradually harden. Such hardened foci appear on the face, around the mouth, in the neck area. The lip on the face is especially enlarged and thickened. As a result, the child cries a lot. These cystic lesions end with a radial scar (Robinson-Furn sign). This sign helps to diagnose birth defects even after many years. During the period when Goksinger's hardening is observed, nodular (papular) rashes also appear at 4-8 weeks of the child's life. Nodules are often found on the arms and legs, buttocks, face, large folds (arms, thighs). Sometimes nodules may appear late (after 3 months). Nodules located in the area of folds, from friction wet and turn into ulcers. Often purulent cocci fall out and turn into pus (pustules). They then dry up and form a clump. Roseolae are rarely seen in early birth defects. They are bordered by pinkish-brown, pigment-like spots. Roseolae are often found on the face, body, and palms of the hands and occur in small numbers. Most affected children have hair loss. Especially when the hardened substance is in the scalp, eyebrows and eyelashes, hair loss is more severe. Hair may fall out in wisps everywhere. Wound flu (syphilitic rhinitis) appears in the first month of the sick child's life, sometimes while in the maternity ward. Rhinitis is a gross inflammation of the mucous membrane of the nasal cavity. Influenza proceeds in 3 stages: 1. Dry stage - thickening of the mucous membrane (hypertrophy); 2. Catarrhal stage - discharge of thick pus with admixture of purulent and blood; 3. Stage of ulceration - formation of erosions and

ulcers on the mucous membrane, discharge of pruritic pus with admixture of blood. This process causes sick children to breathe with their mouths. During sucking, the child often stops, takes a breath of air and continues sucking. The detection of a large number of pale treponemes in the inflammatory fluid secreted from the nasal cavity facilitates diagnosis. Prolonged stuffiness leads to erosion of the bony part of the nose, resulting in nasal prolapse (nasal-sedation). In some patients, rhinitis causes pain in the throat. In such cases, the sound is choked, the patients become hoarse, sometimes the sound does not come out at all. Another notable sign of early wounding is osteochondritis (osteochondritis syphilitica). Osteochondritis is the most frequent symptom of bone lesions. During the first months of pregnancy, the blood supply to the bone tissue located between the epiphyses and diaphyses of the long tubular bones is increased. This situation allows pale spirochetes to multiply and accumulate in this area. The formed specific inflammation promotes the transition of cartilage tissue to bone tissue, the accumulation of calcium salts. As a result, bone hardening in the metaphyseal region slows down. Sometimes it stops completely (osteomalacia). Osteochondritis is not really an inflammation, but a disorder of calcium formation, that is, the process of ossification. Osteochondritis is also seen in the ribs, scapulae, pelvis and skull. In this case, it is sufficient to perform a radiological study of the bones of the shoulder and lower leg. Osteochondritis is a radiological sign, 3 of its stages are distinguished. With Z-stage osteochondritis, granulation tissue is formed as a result of tissue erosion. This tissue is located under the bottom of the ankle, next to the diaphysis, and can rupture under various impacts. As a result, the epiphyseal part of the bone separates from the diaphyseal part. This is how a metaphyseal (epic) bone fracture occurs. This condition causes pseudoparalysis, meaning that the severe pain caused by the broken bone completely stops the movement of the arm or leg. Moving the area causes the patient to scream in pain. Musculoskeletal sensitivity and permeability are preserved in such patients. All these signs help to determine whether the paralysis is spurious. Periostitis and osteoperiostitis are often seen in

early congenital lesions; osteosclerosis and osteoporosis are rare. Enlargement of the liver and spleen at the expense of internal organs is one of the most common signs of early congenital malformations. Kidney involvement, testicular enlargement, palpation of peripheral lymph nodes may also be observed. Diagnosis of early congenital malformations is based on the following information:

1. Observing signs of trauma in parents of children with suspected birth trauma to determine if they have been treated for trauma.
2. Observation of signs associated with early birth trauma to the skin, mucous membranes, bones and internal organs.
- 3 Detection of oozing spirochetes in damaged tissues and organs.
4. Positive results of standard (WP, CR, ZVR) and specific (IMOR, TCHR) serological reactions. Despite the positive results of serological reactions in children born to mothers with wounds, the absence of clinical signs of wounds may be the basis for the diagnosis of hidden congenital wounds.

LATE CONGENITAL SYPHILIS (SYPHILIS CONGENITA TARDA).

Symptoms are often seen in children and adolescents aged 7-15 years, sometimes in children up to school age and even in older people (20-30 and 50 years). The symptoms of the disease resemble the tertiary period of an acquired wound. Bumps and lumps form on the skin and mucous membranes of patients. In the bones, gummosis periostitis, osteoperiostitis and osteomyelitis are observed. There may also be enlargement of the liver and spleen, endocarditis and aortic aneurysm, brain damage (meningitis, meningoneuritis, meningomyelitis), even spinal cord paralysis and far advanced paralysis. However, there are signs of late congenital lesions that are not present in acquired (tertiary) lesions. Reliable signs of late congenital lesions are expressed in the Getchinson triad, these signs prove that the lesion is congenital:

1. Corneal damage (parenchymatous keratitis). The cornea (cornea) of the eye becomes cloudy, tears flow, patients cannot look at light. The visual ability of the eye gradually decreases and the patient becomes blind. First one eye is affected, and after 6-10 days - the other eye. Other membranes of the eye are also affected: conjunctivitis, iritis, chorioretinitis, atrophy of the optic nerve. In patients with parenchymatous keratitis, vision is not restored.

2. Hetchinson's teeth - in which hypoplasia of the upper middle incisors. The free cutting edge of the teeth takes a semicircular shape and resembles a sickle. The body of the teeth is enlarged and thickened, the part penetrating the gingiva is thin, so it assumes a sandal or tubercled shape.

3. Traumatic deafness (lesion of the auditory cochlea, labyrinthitis). This can lead to tinnitus, dizziness, hearing loss and deafness. Deafness is caused by inflammation (labyrinthitis) and haemorrhage in the inner ear (labyrinth), as well as dystrophy of the auditory nerve. Deafness usually begins suddenly. Especially in children under 4 years of age, the developed deafness impairs speech and leads to deafness. In parenchymatous keratitis and wound labyrinthitis, specific therapeutic measures are ineffective and pale spirochetes are not detected in the affected tissues. This is a reason to assume that these pains are allergic in nature. There is now an increasing number of scientists explaining that eye and ear lesions in wounds are the result of a specific allergic reaction. The benefit of glucocorticoids in parenchymatous keratitis does not support this view. The three reliable signs of late birth trauma listed above do not occur simultaneously. Often one sign of the Hetchinson triad is observed, sometimes two. The following unstable (unconditional) signs also help in the diagnosis of late congenital injury: sabre-shaped leg, sabre-shaped wrist, Robinson-Furn trait, hump-shaped head, saddle nose, hump-shaped teeth. However, these signs do not confirm the diagnosis of late birth trauma, but give reason to guess. There are opinions that the unstable signs are the result of osteochondritis, which is seen in early wounds of the tibia.

We also recall that Robinson-Fourn scars are formed as a result of hardening of the substance. It is for these reasons that some authors include the mechoid bone and Robinson-Furna scars among the reliable signs of congenital injury. When comparing the main clinical signs characteristic of a late congenital lesion with unstable signs, determining the presence of the following dystrophic signs will facilitate the diagnosis: Austidian symptom, "Olympic" forehead, short silence, high position of the hard palate, absence of wedge-shaped swelling, Carabelli tubercles, scoliosis and other signs.

Specific serological reactions play an important role in the diagnosis of late congenital lesions. Especially in those cases where it is difficult to obtain anamnestic data (when it is not possible to examine the parents of patients), the response of TCHR and IMOR is decisive. In late congenital lesions, CSF yields positive results in 70-92% of cases and specific responses in almost all cases. Diagnosis of late birth injury is a very responsible task. Because it is almost impossible to detect oozing spirochetes in this type of wounds.

Getchinson's triad, which is a reliable sign, is not always associated with trauma in nature. Because of this, restriction of treponemal movement and positive immunostimulation reactions facilitate the diagnosis of congenital lesions. The management of congenital wounds is closely related to the management of wound disease in general. Timely diagnosis and treatment of congenital malformations is the most important way of preventing birth defects. The detection of hidden and undetected types of wounds in women who visit health centres, women's clinics and undergo a general examination is also of great preventive value. Also, regular clinical and serological examination of the population at high risk of wound infection (waiters, drivers, hotel workers) makes it possible to actively identify patients with wounds. Clinical and serological examination of children's institutions (nurseries, kindergartens and baby homes) and workers involved in the preparation, cooking and sale of food products (cooks, grocery shop clerks,

employees of confectionery companies) also leads to timely detection of patients with wounds.

The importance of women's clinics in the prevention of congenital malformations is undeniable. According to an order of the Ministry of Health, all pregnant women entering a maternity hospital must be examined for wounds at least twice (in the first and second halves of pregnancy), including taking blood for the Wasserman reaction.

The blood of patients treated for chronic inflammatory diseases of the genital organs and women who have seen a doctor for an induced termination of pregnancy is also tested for wounds. In addition, all women who have been treated for a wound and are under clinical and serological surveillance for a wound should be reported to the relevant antenatal clinics. This activity will help them to have appropriate examinations and take preventive measures in case of pregnancy. Traumatized women are given the opportunity to terminate their pregnancy.

However, this procedure is performed after the infectious symptoms of the wound observed in the pregnant woman have resolved. If pregnancy is detected in a woman who has suffered a wound, the woman's medical document should be sent to the maternity hospital of her place of residence. If maternity hospitals do not conduct wound investigations, it is necessary to thoroughly conduct clinical and serological investigations of pregnant women in these maternity hospitals in a timely manner (before delivery). Positive Wasserman reactions and other classical serological reactions in pregnant women examined for wounds are not sufficient to conclude that the woman has a wound. In such cases, the possibility of a false-positive Wasserman reaction should be considered.

In addition, it should be remembered that RV can give a false-positive response even within 10-15 days after delivery of the pregnant woman. Therefore, repeated serological tests should be performed 2-3 weeks after delivery in such women.

Only a positive serological response after this time indicates specificity, and the level of specificity of CSF should be determined by the treponeme restriction reaction.

According to the guidelines, a hidden wound is diagnosed in pregnant women on the basis of positive RIT and RIF results and a positive CSF response. In cases of low CSF positivity, positive RIT and RIF results are the basis for the diagnosis of a latent wound in the woman. All children born to sick mothers should undergo a thorough clinical and serological examination. The health of the newborn is evidenced by negative serological reactions in children without signs of lesions of the skin and mucous membranes and internal organs, as well as the absence of changes in radiological examination. Radiological examinations should be performed no later than 3 months of age. Prophylactic treatment of healthy newborns can prevent the risk of late signs of birth defects. All of the above preventive measures prevent the development of congenital malformations.

Diagnosis of syphilis

Wound-forming spirochetes (*Treponema pallidum*) only a certain part of them stains when staining , and even when staining stains the emon . That is all because of them natural , moist medicine prepared and darkened to see in the field will be visible . Wound triggers live , live (native) preparation preparation preparation spirochaete movement observation to enable ladies . This purpose made magnification for Abbot condenser microscope is special dark to see the area which provides condenser (cardioid bro paraboloid) with will be replaced .

The study of infiltrating treponemes in a dark field of view is based on Tyndall's phenomenon (anomalous phenomenon): if light is introduced into a dark room through a narrow slit, small particles not visible in natural light are excited by the naked eye. seems Microscope darkened to see the field too the lens immediately did not fall , broken fire light with melted . This case is natural in the fire did not

see treponemes too microscope to see in the field apparently the reason is Reading spirochaete light is very less level of breaks . That's all because of silver colourful out of rolls admonition obvious in the eye discarded .

Wet and live preparations are prepared as follows: a drop of tissue fluid is taken from the surface of the element to be examined (erosion, wound, wet nodule) and dripped into the glass of the subject . Tissue liquid (serum) . get for tested element surface physiological solution with the help of wipe is cleaned . If wounds on dead , dead wipe and waste if , tweezers with the help of take discarded and physiological solution with is wiped . Usually reading the spirochaete deeper , binding the wipe between , lymph and blood veins around will be collected .

Therefore tissue fluid is obtained by several methods (extrusion , combing , cauterisation) . Went - wash this method with spirochete if not found , checked element physiological solution with one how many hour during it soaks . Element bottle dripped one drop wipe liquid (serum) one drop sodium chloride isotonic solution with mixed and with a cap or will be covered . Then a drop of immersion oil or distilled water is dropped on the surface of the condenser, by touching the same drop the drug is fixed. Pale spirochetes are examined at a size of 10x40. In this case, the microscope mirror is melted with OI-10 solvent. Wound-causing spirochetes differ from saprophytic spirochetes by specific movements (pendulous, wave-like, oscillating, around the nucleus) in the field of view of the microscope. In addition, their thin and evenly spaced coils glow in the dark and appear spiral. Other species of spirochetes (*S. buccalis*, *S. dentinum*) are characterised by coarse folds and varied types of movement. In addition, they sometimes stop, sometimes move abruptly, change shape during their movements. If pale treponemes cannot be detected in the investigated elements (this is observed during the healing period of rashes), lymph nodes are punctured, tissue fluid of the gland is taken and examined under a microscope.

Syphilis treatment

The treatment of patients with wounds will be according to the guidelines approved in 2021. It is its guideline drug above universities skin - genitals disease departments and scientific research in institutions heal methods simplification in order to next years collected experience based on the work developed and recommendation made Care next methods current made :

1. In patients with ulcers, specific treatment is used to kill the oozing spirochetes that cause the disease. Drugs used for this purpose are called specific drugs.
2. Non-specific treatment. It is used to increase the resistance of the organism of traumatised patients and to accelerate the negative response of serological reactions. Such preparations are called non-specific drugs.
3. Preventive (prophylactic) treatment is given to persons who have sexual or domestic relations with patients with wounds (in this case antibiotics are used).
4. Prophylactic (prophylactic) treatment. Used in children born to ulcer patients and pregnant women who have had an ulcer (with penicillin).
5. Trial treatment. Diagnosis observed in the late stages of the wound is made under conditions of uncertainty (bismuth preparations are often used, sometimes antibiotics). In the treatment of peptic ulcer the following specific drugs are allowed: penicillin preparations, erythromycin, tetracycline, olethrin, bismuth and iodine preparations. Penicillin preparations - as a result of many years of clinical observations and scientific research, the healing effect of the penicillin group in wound infection has been confirmed. Penicillin preparations can be used alone or in combination with bismuth preparations against wounds. If the amount of penicillin in each ml of blood exceeds 0.03 IU, this amount is considered capable of treating the wound. Benzylpenicillin is well tolerated by patients compared with other extended duration drugs and rarely causes complications. However, it should

be determined if the patient has a history of any adverse events associated with penicillin. One of the antihistamines (dimedrol, diazolin, suprastin) should be given 30 minutes before the first penicillin injection, just in case. In addition, antihistamines should always be used before the administration of long-acting penicillins.

The following preparations of penicillin series are used in the treatment of wounds:

1. Water-soluble sodium and potassium salt of beisylpenicillin-benzylpenicillin acid. Aqueous solution is administered intramuscularly every 3 hours without overnight breaks (the amount of drug depends on the type of wound). To maintain therapeutic level of penicillin in the blood, the drug should be administered every 3 hours. Otherwise, the amount of penicillin in the blood will decrease, the ability of penicillin to destroy treponemes will decrease and, as a consequence, the treatment will be unsuccessful.

2 Bicillin-3 is a mixture of sodium and potassium salts of benzylpenicillin and salts of novocaine and dibenzylethylenediamine. It is injected into the muscle in two injections once every 4 days.

3. Bicillin-1 (dibenzylethylenediamine salt of benzylpenicillin) and bicillin-5 (80% dibenzylethylenediamine salt of benzylpenicillin) and 20% novocaine salt (mixture). These drugs are injected into the muscle once every 5 days in a twofold method. The needle itself should be pricked first so that the injected drug does not enter the blood vessels. After making sure that no blood comes out of the needle, it is necessary to put a syringe on it. The medicine is then injected slowly and carefully.

4 Erythromycin is an antibiotic that kills treponemes. It is used when there are various complications from penicillin-type drugs. The wound-healing ability of erythromycin is lower than that of penicillin. Because of this, chelgis itself is not used in the treatment of the wound, that is, after the course of treatment with

erythromycin, bismuth salts are administered. Erythromycin is prescribed 0.5 g every 6 hours (4 times a day) after meals.

5. Tetracycline and olemethrin. This preparation is used in patients with hypersensitivity to penicillin and erythromycin. In this case, bismuth preparations are used simultaneously with tetracycline and olethrin. These antibiotics are prescribed 0.5 g 4 times a day. If there are obstacles to treatment with bismuth preparations, treatment is carried out only with antibiotics. In the treatment of wounds, non-specific methods of treatment (pyrogenal, vitamins, substances that increase biological strength) give positive results. Complications observed during antibiotic treatment are as follows: Reaction of increased body temperature (Herxheimer reaction) in treated patients. This complication is observed in many cases (frustration, headache, overt manifestation of disease symptoms, etc.). Such unpleasant phenomena usually last for 24 hours and then disappear. This does not prevent the continuation of treatment measures. During penicillin treatment, especially with long-acting penicillin preparations, various allergy-related complications may occur. In this case, skin rashes appear in the form of urticaria or allergic dermatitis (toxiderma). In such cases, penicillin treatment should be discontinued and immediate use of antihistamines and calcium preparations. Intravenous administration of physiological solution or sodium thiosulfate also gives good results. The most severe and serious complication observed under the influence of antibiotics is the state of defenceless organism (anaphylactic shock). This condition is characterised by a sharp drop in blood pressure, the patient loses consciousness, shakes, the skin bleeds, and the lips turn blue. In such cases, drugs that constrict blood vessels and increase blood pressure (adrenaline, noradrenaline, ephedrine, caffeine) and anti-allergic agents such as prednisolone solution and dimedrol should be administered intravenously. Erythromycin often causes allergic rashes, the patient may experience nausea and diarrhoea. Contraindications to the use of penicillin group and other antibiotics used in the treatment of wounds : -

allergic diseases (bronchial asthma, urticaria), diseases of the glands of internal secretion, acute diseases of the gastrointestinal tract, neglected tuberculosis, blood diseases, cardiovascular diseases, severe systemic diseases. ; - tetracycline and olethrin are not prescribed for pregnant women and children under 5 years of age. In addition, it is necessary to take into account the possibility that these drugs may interfere with the body of a particular patient. Bismuth preparations.

According to the instructions, the following bismuth preparations are used in the treatment of wounds:

1. Biiochinolum is a mixture of bismuth, iodine and quinine dissolved in peach oil. It contains 25 per cent. of bismuth, 56 per cent. of iodine, and 19 per cent. of quinine. It is injected into the muscle, in the upper outer quarter of the buttock, using a long needle at two points. 1 ml of bioquinol contains 0.02 g of pure bismuth. Before injecting bioquinol and other bismuth preparations between muscles, they are heated in hot water and shaken well . 1 ml a day, 2 ml every other day and 3 ml 2 times a week. The volume of the treatment course is 40-50 ml.

2. Bismoverol (Bismoverolum). A mixture of bismuth salt of monovismuthic acid in peach oil. In 1 ml of the mixture contains 0.05 g of pure bismuth. 1.5 ml is administered once a week, for one course - 10-20 ml. 3. Pentabismol (Pentabismolum). Water-soluble compound containing 47.9% pure bismuth. 1 ml of solution contains 0.01 g of pure bismuth. Intramuscularly administered 2 ml every day, treatment course 40-50 ml. Diseases of the oral mucosa, kidney and liver diseases, tuberculosis, diabetes mellitus are conditions that prevent treatment with bismuth preparations. Treatment with bismuth preparations may cause the following complications:

1. Accumulation of bismuth salts in milk, especially at its edges, in which bluish-grey rims are formed. (so-called bismuth rims). The affection of the gums is called gingivitis.
2. Stomatitis is a lesion of the oral cavity. Although rare, it can bother the patient for a long time.
3. Kidney damage (nephropathy) - with the appearance of proteins in the urine (albuminuria), sometimes cylinders are seen (cylindruria). Evidence that nephropathy is associated with the wound is the appearance of bismuth cells (epithelial cells with granular cytoplasm) in the urine. Among iodine preparations, sodium iodine, potassium iodine, and calcium iodine (sayodine) are commonly used. These preparations are mainly used in tertiary injuries, internal organ injuries, sensory injuries and late birth injuries. It is also used in early types of wounds to prevent fever reaction (Herxheimer reaction). For this purpose, iodine preparations are administered before the administration of specific drugs (especially before the administration of penicillin preparations). In patients receiving bismuth preparations, iodine preparations are also administered for the purpose of rapid elimination of these bismuth salts from the body (so-called elimination). In this case iodine preparations are administered between courses of treatment, i.e. in breaks. Iodine also contributes to the rapid negation of the results of serological reactions. Iodine preparations accelerate the resorption of nodules and nodules, as well as large volumes of other inflammatory substances, reduce night pain in the bones. 4-5% solutions of potassium iodide and sodium iodide are taken 1 tablespoon 2 times a day with milk after meals. Calcium iodide is taken 1-2 tablets after 3 meals for 1-1.5 months. For each course give 60-80 g of pure iodine. Diseases that prevent the use of iodine preparations:

1. Cases of hypersensitivity and allergy to iodine preparations.
2. Disseminated pulmonary tuberculosis.

3. Kidney disease (nephritis and nephrosis).
4. Diseases of the cardiovascular system with irreversible changes.
5. Diseases of the haematopoietic organs. Iodine preparations may cause the following unpleasant conditions: - conjunctivitis (inflammation of the conjunctival membrane of the eye), rhinitis (inflammation of the mucous membrane of the nasal cavity), bronchitis (pulmonary respiration or inflammation of the larynx), diseases of the gastrointestinal tract. tract, iodine rashes (iodine rashes), tumours (iodododerma). If the above symptoms of iodism appear, iodine treatment should be temporarily discontinued. Traumatized patients are treated by the following methods.

In cases of primary seronegative, primary seropositive, secondary new lesions and stimulation therapy, 400,000 TB of penicillin solution is administered every 3 hours for 14 days. A total of 44.8 million TB. TB. Patients with secondary relapses and early latent lesions are treated with 400,000 TB penicillin 8 times daily for 28 days. Total 89.6 million RR. TB. For late latent wounds (acquired and congenital), initially administered bioquinol (from 2 ml every other day until a volume of 12-14 ml was reached). Then treated with penicillin (200,000 TB every 3 hours for a total of 40 million TB). At the end of treatment, the amount of bioquinol was increased to 40-50 ml. After 1.5-2 months, the penicillin-bismuth treatment course is repeated. Two more courses of treatment with bismuth preparations should be carried out to consider the treatment of such patients as completed. Each time the type of bismuth preparation should be changed (sometimes bismoverol, sometimes pentobismol) and a break of 1.5-2 months should be made between the courses of treatment. Treatment of patients with tertiary lesions is the same as for late latent lesions. In this case, the initially administered amount of bioquinol should be increased to 20 ml.

Children with early congenital lesions (severe and latent) are treated continuously with penicillin alone for 30 days. The single and daily dosage of the drug is given in Table 2. Table 2. Treatment of children with preterm labour

Age of child	Daily dosage per kg of body weight
75 000 TB/kg	50 000-100 000 TB
100 000-150 000 TB	100 000-200 000 TB

For example, treatment of a 4-month-old child weighing 6 kg with penicillin solution should be administered at 600 000 TB per day (100 000 TB every 4 hours) for 30 days (total 18 million TB). Prophylactic (prophylactic) treatment with penicillin solution is administered for 2 weeks. In this case, the daily amount of the drug is 100,000 TB/kg. For example, a one-month-old baby weighing 5kg will receive 500,000 TB/day, for a total of 7 million. Anti-TB penicillin is administered. Preventive (prophylactic) treatment is more often given to children under 3 months of age, with the amount of penicillin treatment varying according to the age of the child: - 500,000 TB/kg for children under 1 month; - 400,000 TB/kg for 1-5 weeks; - for 6-10 days - 300,000 TB/kg; - 11-15 days - 200,000 TB/kg; - 100,000 TB/kg for adolescents over 15 years of age. Non-specific therapies used in the treatment of injured persons often give good results in its late stages (late latent trauma, tertiary trauma, damage to internal organs and nervous system). Non-specific drugs are expedient to prescribe in secondary relapses and early latent lesions. In this case, the following nonspecific drugs are more often used:

1. Pyrogenic substances (pyrogenal, pyrogenal);
2. biogenic stimulants (aloe, FBS, vitreous, splenin);
3. Vitamins (thiamine, pyridoxine, vitamin C, vitamin B12).
4. Non-specific immune preparations (decaris, sodium nucleic acid, methyluracil);
5. Reinfusion of blood irradiated with ultraviolet rays (reinfusion);

6. Adaptogenic drugs (pantocrine, eleutherococcus, etc.). In seroresistant wound, in cases of serological relapse, when profound changes in cerebrospinal fluid are observed, the widespread use of nonspecific treatment, especially pyrogenic, gives the expected results. At present, wound disease is successfully treated. The most severe types of injury (optic atrophy, spinal cord injury, advanced paralysis) are rarely observed. Congenital defects are also reduced. The beginning of treatment in the early stages of the wound can be a guarantee of complete recovery of the disease. The disappearance of disease symptoms, negative serological reactions in patients treated for ulcer does not mean that the patient's ulcer will disappear. Wound symptoms may reappear after a certain period of time, and serological reactions may be positive. Therefore, the criterion for wound healing is determined by long-term follow-up of treated patients. Patients on dispensary registration are observed from a year to 5 years: - patients with primary seronegative lesion - 1 year; - primary seropositive, secondary neoplasm - 3 years. - secondary recurrent, latent and tertiary wounds and other late types of wounds - 5 years. Patients treated for early and late congenital lesions, as well as children receiving preventive (prophylactic) treatment will be excluded after 5 years of successful clinical and serological follow-up. At the same time, patients with wounds will undergo monthly clinical and serological follow-up until all classical serological reactions are negative. Thereafter, clinical and serological follow-up is performed quarterly for one year, and every six months in the second and third years of follow-up. In subsequent years of follow-up, patients should undergo clinical and serological examination once a year. All periods and stages of clinical and serological follow-up are carried out in the dispensary of the district or region of the patient's residence. The fact is that treatment could be carried out in dispensaries located in other cities. High-quality and timely treatment with the help of modern methods of treatment leads to full recovery of the victims. Patients who have undergone treatment can be considered free from wound infection on the basis of:

- (1) Due to quality treatment initiated and carried out in all stages of the wound, especially in the primary and secondary stages, these patients are free of wound symptoms throughout the follow-up period;
- 2) When new wound symptoms only appear as a result of re-infection;
- (3) Absence of both clinical and serological signs of wounding in children born to pregnant women after specific treatment, with quality treatment resulting in healthy babies born in the first half of pregnancy;
- 4) the fact that no specific signs of damage are found in the internal organs of people who have received good medical care for wounds but died as a result of other accidents. In some patients, however, classical serological reactions may be positive despite treatment. A seroresistant lesion is a condition in which CSF results remain exclusively positive for more than one year after continuous treatment. Seroresistance also refers to cases of positive CSF response in chronically treated patients who have started the last course of treatment. Additional courses of treatment are administered when cases of seroresistance are identified in wound patients. In such cases, treatment is often repeated in patients with secondary relapse.

A serous wound can be treated with 3 courses of treatment including a combination of antibiotics and bismuth preparations. Regardless of the chosen treatment methods for serous ulcer, it is best to combine this specific treatment with non-specific therapies. Cases of positive CSF response despite therapeutic measures carried out at late stages of trauma (in all types of internal organ and nervous system injuries) are not understood as seroresistance. Therefore, additional courses of treatment are not prescribed. In these late types of wounds, the disappearance of clinical symptoms of the disease is the main criterion of recovery.

In patients treated for wounds, the criteria of treatment are: a) quality of treatment measures (correctness of the applied method, sufficient amount of drugs, order of

replacement of drugs, period between courses of treatment, etc.); b) absence of wound signs on the skin and mucous membranes; c) current state of specific changes observed in internal organs and systems; g) results of radiological examination; d) results of laboratory (clinical, serological, liquorological) studies.

For this reason, patients with acquired and congenital injuries should be thoroughly examined before discharge. Especially important are the results of clinical examinations by paediatricians and general practitioners (depending on the patient's condition), neurologists, ophthalmologists, otolaryngologists, gynaecologists (boys and girls) and radiologists. Blood and cerebrospinal fluid should also be drawn and all serological reactions (CSF, RIT, RIF) should be performed.

Radiological follow-up is carried out. During the period of clinical and serological observation, no new wound symptoms were observed, no specific changes developed in all organs and systems, patients with negative results of serological reactions (except for late stages of wounding) are hospitalised. recognized as healthy and excluded from the register. Persons infected with infectious types of wounds are allowed to work in children's institutions and catering enterprises after the disappearance of all clinical signs of the disease as a result of quality treatment.

AIDS

Groups prone to AIDS. Acquired immunodeficiency syndrome is more common in the following populations:

1. Homosexuals - they make up about 75% of AIDS patients (the reasons for this are explained in detail above).
2. Drug addicts - their number varies from country to country (11-17%), most of them are homosexuals.

3. haemophilia patients. This disease mainly affects men. Such patients lack factors VIII-IX involved in blood clotting. Blood from 2000-5000 donors is needed to prepare a concentrate (sum of necessary factors) from fresh and natural blood. This increases the risk of transmission of ITV. Such patients account for 1-4%.

4. Patients and other categories of persons receiving blood transfusion for various indications. In recent years, the number of AIDS cases among people who receive blood and blood products has been increasing. They account for 1.4-20.2 per cent of AIDS patients.

5. Heterosexuals who frequently change sexual partners. The disease is increasing, especially among men and prostitutes visiting "massage parlours" and religious houses. Most patients are women (29-50%). While homosexuality has led to the spread of AIDS among men, heterosexual contacts and large-scale blood transfusions are causing an increase in the incidence among women.

6. Children born to the populations listed above, especially to AIDS patients and persons infected with ITV. The disease is often transmitted to the baby through the placenta. The foetus can also be affected by retroviruses in the vagina and cervix when passing through the birth canal (during labour). It has been mentioned above that babies nursed by sick mothers have been infected with AIDS. Lesions of the skin and mucous membranes in AIDS. Skin lesions in ITV have not been thoroughly studied. Warner L.S. and Fisher W.K. (1988.), Y.V.A. Ashmarin (1988) describes skin changes as follows:

1. Skin lesions with tumours. Various tumours occur in patients with ITV disease, especially in the latter stages of the disease (Kaposi's sarcoma, lymphomas, carcinomas, Berkey's tumour, etc.). These tumours vary in number and their types determine the severity of the disease. Kaposi's sarcoma occupies a special place among them. Kaposi's sarcoma is known to occur in the elderly and with a weakened immune system. However, in patients with ITV disease a specific course of this

disease has been revealed: a) it is observed in people under 30-35 years of age; b) it is observed in all parts of the body, more often affecting the hands, genitals and internal organs; c) the nodes are large in number, they turn into a hard, rapidly developing wound. Tumours may be found in the oral cavity, abdomen, g) are severe, easy treatment worsens the patient's condition; d) metastasises very quickly, often metastasising to lymph nodes and internal organs; e) occurs more often in children, even in infants, and is rapidly fatal.

2 Infectious skin diseases: a) viral skin diseases: colds, shingles, warts, tumours on mucous membranes, viral diseases of the ear; b) purulent skin diseases: folliculitis, ringworm, streptoderma, chronic pyoderma, fistulas, acne, etc.; c) fungal skin diseases: candidiasis, asnergilosis, cryptococcosis, toxoplasmosis, etc.; d) fungal skin diseases: candidiasis, asnergilosis, cryptococcosis, toxoplasmosis, etc.; e) fungal skin diseases: asnergilosis, cryptococcosis, toxoplasmosis, etc.

3. non-specific skin diseases: a) gout caused by vaccination; b) itchy skin; c) atopic dermatitis; g) my donkey; d) pruritus. In the early stages of the disease, rashes appear on different parts of the skin. These rashes are accompanied by symptoms of the disease, that is, there is weakness, headache, nausea, stiffness of the bones, increased body temperature. Sometimes the general condition of the patient is worsened by tremors, and he is paralysed . The above symptoms resemble such diseases as measles, diarrhoea, rubella, rash. In the 2-3rd week of the disease, rashes (roseolae) increase in size and turn into erythema (inflamed spots). At the same time, their size is a penny or more, and the skin on these areas is itchy and hot. These spots are often located on the skin of the face, then on the body . During the course of the disease, dermatitis, an acute inflammation of the skin, may develop into auricular . Clinic: ITV disease does not have specific distinctive symptoms. The disease often progresses gradually. In this case, periods of exacerbation and remission of the disease alternate, the patient's condition worsens. According to the proposal of the World Health Organisation, it is accepted to distinguish 5 stages of the disease. Stage

1. Initial stage - at this stage, the symptoms of infectious mononucleosis appear. On average, it lasts 3-14 days, after which all signs disappear. Light pink spots are predominantly observed on the skin. They are round and oval in shape and are about the size of millet. Stage 2. Asymptomatic stage - there are no signs of the disease. This stage is determined only by laboratory method. This stage can last from 5 months to 5-6 years. Stage 3. Stage of diffuse lymphadenopathy - in which several lymph nodes are enlarged. If at least two groups of lymph nodes are enlarged, this symptom is considered AIDS-related. In this case, the enlarged lymph nodes should be located in the upper waist area. Stage 4. AIDS-related symptom collection.

Fatigue, sweating, tremor, cough, muscle and joint pain, weight loss, diarrhoea, various infectious diseases, tumours and a combination of changes observed in the internal organs determine the deterioration of the patient's condition. Various types are found on the skin and mucous membranes: spots, nodules, nodules, bumps, etc. In this type of dermatosis (eczema, eczema) candida, herpes simplex, shingles and other similar dermatoses are formed. Step 5: The stage of acquired immunodeficiency - in which all immunological indicators are sharply reduced. Symptoms that appeared before this period worsen and exhaust the patient. There are 4 types of AIDS at this stage:

- a) pulmonary type; b) neurological type;
- c) gastrointestinal type;
- d) febrile type;

The development of various symptoms observed in AIDS, as well as the "deepening" of several types of changes simultaneously leads to the failure of important organs. A sharp decline in the immunological abilities of the organism, including a reduction in the number of T-lymphocytes to 1000-100, makes it unable to fight against the various pathological processes that have developed. This situation leads to the death of patients. In other words, the AIDS stage is the last stage of HIV disease (ITV),

which decides the fate of the patient. The above-mentioned changes in the skin and mucous membranes intensify, giving the patient's skin a unique colour. Kaposi's sarcoma and other benign (dangerous) tumours are particularly prone to increase the number of metastases. Laboratory methods help to determine the exact nature of the disease and distinguish it from skin and infectious diseases. The method of counting and comparing lymphocyte types by immunological analyses is of great practical importance. In this case, the number of helper lymphocytes decreases, but the total number of lymphocytes may not decrease. A decrease in the total number of lymphocytes (lymphocytopenia) is observed in the late stages of the disease. In this case, the number of lymphocytes in 1 ml of blood may decrease to 500 (in healthy people 1200-1700). It is known that in normal individuals the ratio of suppressors to helpers is 1.5:1.8; in HIV infection this number falls below 1. In healthy heterosexuals the Tx/Ts is -1.75 and in healthy homosexuals the Tx/Ts is -1.2 (Sthel et al., 1982). When HIV infects patients with various chronic skin diseases (pus, ringworm, pruritus, urticaria, etc.), their old skin diseases are aggravated. In addition, newly formed rashes complicate diagnosis. However, a careful history, detection and use of AIDS-related signs for diagnostic purposes, and immunobiological and virological laboratory tests can help to determine the exact nature of the disease. The ELISA method, which is widely used in mass screening, is called enzyme-linked immunosorbent assay. This method is very sensitive and detects the presence of even a single antibody molecule in 1 ml of blood. However, the enzyme immunoassay is positive in 82 per cent of AIDS patients, positive in 16 per cent and undetectable (negative) in 2 per cent. The immunoblotting method is preferred over the enzyme immunoassay method. The immunoblotting method is only applied to ELISA-positive individuals because it is expensive to use in mass testing. Antibodies against retroviruses appear in the blood 6-8 weeks after infection. Also the formation of antibodies against HIV can take up to 3-6 months. Therefore, if the ELISA method gives negative results in the examined person, it is erroneous to conclude that the disease has not been transmitted, that is, in this case, antibodies

may not have formed in sufficient quantity. For this purpose it is necessary to use the ELISA method 2 times. Currently, all active AIDS laboratories widely use the ELISA method to detect HIV infection in the population. Pregnant women with trauma, blood donors, HIV patients, patients with tuberculosis, sexually transmitted diseases, and people belonging to special social classes should be carefully screened for HIV. According to special instructions of the Ministry of Health, the above-mentioned persons should also be tested for hepatitis B virus (NVSAg).

HAZARD GROUPS

Risk groups consist of individuals who are the source of the aircraft that spread the infection. Those who are infected with HIV/AIDS and transmit the disease to others because of their moral principles are called the "core groups" of the disease. Prostitutes, drug addicts and some mentally retarded men have a special place among them. In addition, recipients infected with infected blood or blood products from donors infected with the virus that causes HIV pose an epidemiological risk.

Teacher

suggests discussing the results of individual work with the work, preparing a report on analysing and solving the situation and drawing it up in the form of a poster for presentation.

Students

jointly analyse individual cases, identify the most important aspects of the situation, the main problems and ways of their solution, formalise the results of the search for a mutually acceptable solution, and make adjustments.

Teacher: announces the beginning of the presentation of the group work.

Group speakers: present a solution to the situation, answer questions and clarify their suggestions.

The speaker's presentation will last no more than 10-15 minutes. He/she should not be interrupted, only questions will be asked after his/her speech.

Learners: evaluate, respond to solutions proposed by groups, choose the best option.

The general discussion should last no more than 20-25 minutes. Broad participation of all panellists should be encouraged.

Discussion Organising Teacher:

Asking questions, giving opinions, recalling theoretical material.

Instruction for independent work on analysing and solving practical situations:

No	Stages of work	Recommendations and advice
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1.	Familiarity with the work	First, check the work.
2.	Familiarise yourself with the situation. Please read the information carefully again. Highlight the paragraphs that are important to you. List the factors mentioned in the case history. Try to describe the situation. Identify what is important and what is unimportant.	Familiarise yourself with the situation. Please read the information carefully again. Highlight the paragraphs that are important to you. List the factors mentioned in the case history. Try to describe the situation. Identify what is important and what is unimportant.
3.	Identify, formulate and justify the main problem and subproblems. Objective: To determine the cause of the rash, perform laboratory tests and develop a treatment plan.	Identify, formulate and justify the main problem and subproblems. Objective: To determine the cause of the rash, perform laboratory tests and develop a treatment plan.
4.	Diagnosis and analysis of the situation.	As you analyse the situation, answer the following questions: 1. What diseases can cause such rashes? 2. What additional investigations should be performed to make a definitive diagnosis? 3. State the factors that cause this disease? 4. What is your treatment plan? 5. What clinical forms of vesicular vesicles do you know? 6. What clinical criteria can be used to diagnose this dermatosis?

		7. How to determine Nikolsky's symptom ? 8. What laboratory criteria can be used to identify this disease?
5.	Selection and justification of problem-solving methods and tools.	List all possible ways and means of solving the problem in this situation.
6.	Development of proposed interventions to address the problem situation. Development of a diagnosis and treatment plan.	Development of proposed interventions to address the problem situation. Development of a diagnosis and treatment plan.

Using the brainstorming method

To work with this technique, it is necessary to establish an atmosphere of trust and overcome psychological tension as a barrier to open discussion. The method combines the possibility to expand the stereotype of thinking, to abstract from existing limitations, to develop dynamism of thinking activity, to activate learning activity. The method teaches to argue, defend one's point of view, find an acceptable solution, establish a dialogue and convince others of the correctness of one's position.

The methodology provides:

- welcome the emergence of an idea, believing that the more unusual the idea, the better;
- to accept the largest number of offers ;

- The harmony of ideas and their development;
- No comments or criticisms that interfere with the formation of an opinion ;
- brief statements without detailed evidence;

Students are given an assignment. No criticism or statements that interfere with the formation of ideas are made during the response process. Comments and new ideas are welcome. This method allows to find the most optimal solution in any situation and teaches to competently defend one's point of view.

A 35-year-old patient was admitted to the hospital with complaints of ulcers in the oral cavity, difficulty swallowing, and blisters on the skin of the trunk and arms.

BACKGROUND: I fell ill against a background of complete well-being. Blisters began to appear in my mouth, which quickly burst, leaving erosions. I went to a dentist, who prescribed gargling with furacilin and manganese solution, but the treatment had no effect. In 2.5 months blisters appeared on the skin of the torso and upper extremities, which opened up and left painful erosions. 10 years ago I suffered from Botkin's disease.

Local condition: Examination of the oral cavity reveals wide erosions of bright red colour on the background of unchanged mucous membrane of cheeks, palate and lower surface of the tongue. Blisters 0.5 to 2.0 cm in diameter appear on the skin of the trunk and upper extremities. Some blisters are dense, others have a loose cap, some are transparent and others are cloudy. Weeping, polycyclic erosions remain in place of the blisters that have opened. Some of them are covered with a brown crust. When pressing on the blister, the fluid clears the adjacent epidermis and the blister moves. When the flaps of the bladder sheath are retracted, the epidermis separates beyond the borders of the bladder.

QUESTIONS:

1. Your presumed diagnosis;
2. What additional investigations should be performed to make a definitive diagnosis and determine a complete etiological and pathogenetic therapy?
3. What diseases should be differentiated from dermatoses in this patient?
4. What is the dentist's error in treating this condition?
5. A 45-year-old man went to the doctor with a complaint of blisters, blisters and red spots on the skin of the body and hands, accompanied by itching and burning on the mucous membrane of the oral cavity.

BACKGROUND: I became ill two weeks ago. The onset of the disease was due to severe nervous and physical overexertion. At first itching appeared, then grouped blisters appeared on the skin of the trunk, and then a rash appeared in the oral cavity. Among the affected diseases rarely noted acute respiratory infections, influenza and chronic pneumonia.

Local status: The rash is widespread. On the skin of the extensor surfaces of the extremities, trunk and neck there are tense, transparent, spotty-papular and urticarial elements of pea size, abrasions, erosions, grouped vesicles. In the oral cavity, pea-sized vesicles with transparent contents are grouped on the mucous membrane. The mucous membrane around the blisters is oedematous and hyperaemic. In place of the opened blisters erosions with a tendency to epithelialisation occur. Nikolsky's symptom is negative. It is difficult to eat.

Treatment methods for this dermatosis;

QUESTIONS:

1. Your presumed diagnosis;
2. What additional investigations should be performed to make a definitive diagnosis?
3. What diseases should be distinguished from dermatoses in this patient?
- 4 Determine the treatment plan and prognosis;
5. Recommendations to the patient after clinical recovery.

A 25-year-old patient came to the dentist with complaints of acute pain in the oral cavity, increased salivation when eating and talking. Acute onset of the disease after hypothermia, high body temperature (39.5 degrees Celsius), general weakness, headache.

Past medical history: chronic tonsillitis, allergy to some drugs. On external examination: the skin is pale. On the back of the hands there is a blue-pink rash with hemorrhagic crust in the centre. The red border of the lips is swollen, lymph nodes are enlarged, painful and mobile.

QUESTIONS:

- Make a primary diagnosis.
- Make a research plan to confirm this diagnosis.
- Identify the factors that cause this disease.
- Carry out differential diagnosis of this pathology.
- General and local treatment and prognosis plan.

Tests

1. Primary morphological elements in acantholytic vesicular vesicles:
 - (a) Bubbles
 - b) pustules
 - c) bubbles
 - d) papules
 - d) erythema
2. Secondary morphological elements in acantholytic vesicular disease:
 - (a) Observation
 - b) erosion
 - c) lichenification
 - d) scars
 - d) wounds
3. In acantholytic vesicles.
 - (a) (+) Kebner's sign
 - b) (+) Pospelov's symptom
 - c) (+) Balser test
 - d) (+) Jadassohn test
 - e) (+) Nikolsky's symptom
4. In smears - traces of acantholytic vesicles, detect:
 - (a) LE cells

- b) Hansen rods
- c) Tzanck's cells
- d) Borowski's corpuscles
- (e) Mycobacterium koch

5. Treatment of acantholytic vesicular vesicles

- (a) Antimalarial drugs
- (b) Diaminodiphenylsulfone
- c) corticosteroids
- d) antituberculosis drugs
- e) sulphonamides

6. Blisters are not characterised by acantholytic vesicles:

- (a) The size of a pea to a hen's egg
- b) opens quickly
- c) creates long-term, incurable erosions
- d) lethargic
- e) is located as in herpes

7. In the diagnosis of acantholytic vesicular vesicles, the following are crucial:

- (a) Detection of acantholytic cells
- b) (+) Benier-Meschersky symptom
- c) eosinophilia in vesicles

d) leucopenia

e) epidermal location of the bladder

8. The main feature that distinguishes pemphigoid from acantholytic vesicles.

(a) Absence of acantholysis

b) (+) Balzer's test

c) dangerous course of pemphigoid

d) (+) as a result of antibiotic treatment

e) intradermal location of the bladder

9. Medical treatment for acantholytic vesicles requires a prescription.

(a) Corticosteroids

b) vitamins

c) antimalarial drugs

d) gold preparations

e) antimycotics

10. Which clinical sign is not characteristic of vesicular vesicles?

(a) Rash polymorphism

b) (+) Nikolsky's symptom

c) symmetry of rashes

d) seasonality of relapses

e) begins with lesions in the oral cavity and pharynx

11. Hypothesis on the origin of vesicular vesicles:

- (a) Autoimmune processes in the body
- b) endocrine system damage
- c) has a clear association with gastrointestinal diseases
- d) there is a parallel with cardiovascular pathology
- e) metabolic disorders

12. vesicular rashes on the oral mucosa are characteristic.

The following statement is not appropriate for vesicles :

- (a) Leads to the formation of extensive erosions
- b) accompanied by pain
- c) causes increased salivation
- d) along with specific breath odour
- d) will be resolved quickly

13. The group of pemphigoid, only superficially similar to vesicular diseases, is united:

- (a) Good course
- b) epidermal location of vesicles
- c) absence of acantholysis
- d) (-) Nikolsky's symptom.
- e) high eosinophilia in the blood

14. Lever's bullous pemphigoid:

- (a) Characterised by the appearance of tense bubbles

- b) usually occurs in people over 50 years of age
- c) erosions arising on the oral mucosa rapidly epithelialise
- d) the aetiology is unclear
- e) all of the above are true

15. Rubbing pemphigoid is not characterised by the following features:

- (a) Blisters on the conjunctiva, oral mucosa and skin
- b) where vesicles appear and adhesions form
scar
- c) usually begins with trauma to the eye
- d) immobility of the eyeball and blindness is formed
- (e) Identification is the decisive factor in diagnosis

acantholytic cells

16. Additional tests are performed to diagnose true vesicular vesicular disease:

- 1) bacterioscopic
- 2) cytological
- 3) histological
- 4) shine light on wooden beams
- 5) 2) and 4) are true

17. Diagnostic cells of true vesicular vesicular disease:

- 1) Langas
- 2) Tsanka

3) atypical

4) huge multi-core

5) 1) and 4) are correct.

18. A specialist who treats patients with true vesicular vesicular disease:

1) oncologist

2) dentist

3) dermatologist

4) venereologist

5) endocrinologist

19. Treatment results in remission of true vesicular vesicles:

1) antibiotics

2) anabolic steroids

3) tranquillisers

4) antifungal drugs

5) corticosteroids

20. Primary lesion element in vesicular vesicles:

1) bubble

2) bubble

3) blister

4) node

5) tuberculosis

Practical part.

The technology for obtaining fingerprint smears is as follows. The doctor examines the mucous membrane of the oral cavity and identifies the eroded surface formed after opening the bladder to collect the material. If the bladder has not yet opened, the bladder lid should be gently lifted with forceps to expose the eroded surface. If the erosion is bleeding, it should be dried with a dry swab. Do not use hydrogen peroxide for this purpose, as the foam causes the separation of acantholytic vesicular cells. The material is removed from the bottom of the erosion with a thin layer of elastic eraser and transferred to two slides, pre-treated with alcohol and dried with a napkin. The place of pressing is marked with a tape recorder or a ball pen. The glasses are folded, the sealing strokes are on the inner surface, and at the edges they are separated from each other by rubber or wooden spacers. The slides are then secured (with a rubber band or string) and sent to the cytological laboratory of a dermatological clinic, as acantholytic vesicles are known to be a dermatological disease.

Acantholytic cells are smaller than normal cells and have a very large nucleus of a dense violet or violet-blue colour, occupying almost the whole cell. It contains two or more light nuclei. The cytoplasm of the cells is sharply basophilic, light blue around the nucleus and blue or dark purple around the periphery ("edge of concentration"). The cell often has more than one nucleus. Polymorphism of cells and nuclei is highly marked. Acantholytic cells may be solitary or multiple.

Nikolsky's sign: 1. When pulling out a piece of bladder membrane with tweezers, a detachment of the upper layers of the epidermis in the form of a gradually narrowing band appears on the outwardly healthy skin. 2. Finger friction (shear pressure)

appears to cause healthy skin to easily peel away (slough off) the upper layers of the epidermis both between blisters and at a distance.

Supervisory Questions:

- Definition of vesicular dermatoses.
- Classification of vesicular dermatoses.
- Etiology, pathogenesis of cystic dermatoses.
- Criteria, principles and methods of diagnosis of vesicular dermatoses.
- Principles of treatment of cystic dermatoses.
- Which is crucial in the diagnosis of acantholytic vesicular vesicles.
- the correct definition of Nikolski's symptom?
- Name the main morphological elements of acantholytic vesicular vesicles.
- Which drug treatment leads to remission of true vesicular vesicles?
- Characterise the acantholytic cells.

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