Chapter-2

Abdullaev D.M.
Salamova L.A.
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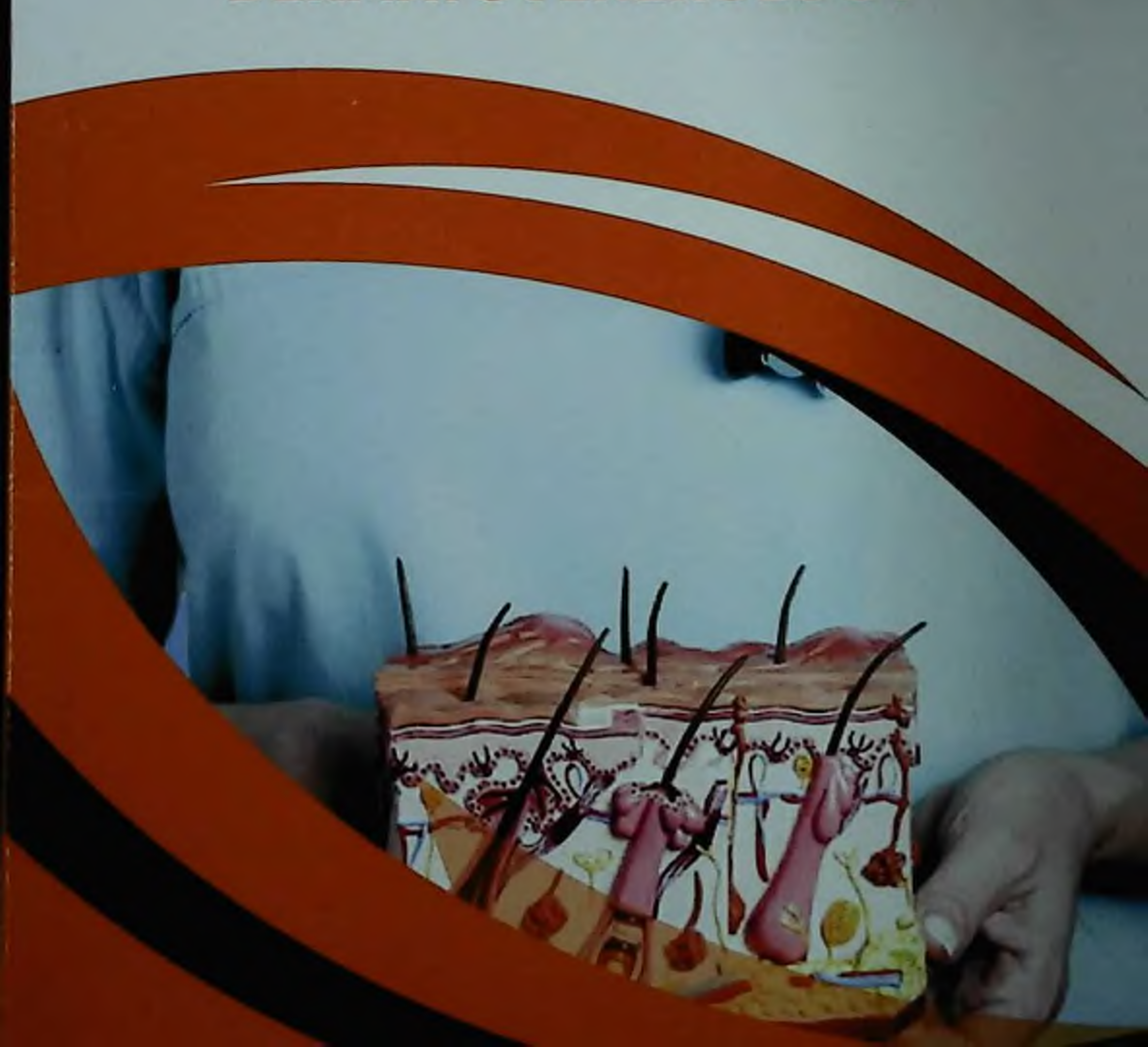
DERMATOVENEROLOGY



MINISTRY OF HEALTH OF THE REPUBLIC UZBEKISTAN
SAMARKAND STATE MEDICAL UNIVERSITY

Abdullaev D.M., Salamova L.A., Tillakobilov I.B., Oripov R.A.

DERMATOVENEROLOGY

Chapter-2

Area of expertise - Public welfare and health care - 500000
Area of study-510000

Educational methodological manual

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Dermatovenerology Part 2 [Text]: Educational methodological manual/ D.M. Abdullaev, L.A. Salamova, I.B. Tillakobilov, R.A. Oripov. – Samarqand : Samarqand, 2023. – 100 p.

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Despite the revolutionary changes that have taken place over the past decades, dermatology still remains an urgent problem. In active consideration, possible causes of the development of dermatoses are considered and pathogenetically sound approaches to the description of such patients are explored. A study based on studies showed the presence of persistent positive dynamics, both clinical and functional, in almost 25.2% of patients with dermatoses. One of the reasons for the resistance of the disease to the method of treatment may be the presence of concomitant therapy, which aggravates the course of the disease, the serious effectiveness of therapy and the worsening of the prognosis of the disease.

***Educational methodological manual** is intended for use by students of universities, masters, as well as for general practitioners.*

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LIST OF ABBREVIATIONS AND SYMBOLS

♠ - trade name of the medicinal product
℘ — medicinal product is not registered
⊗ — canceled medicinal product
AG - antigen
AGLS - antihistamine drugs
AD - atopic dermatitis
ACTH - adenocorticotropic hormone
ANF - antinuclear factor
ASD - Dorogov's antiseptic stimulator
AT - antibody
NPP - antiendotoxin component
BCG - Bacillus Calmette-Guerin
HIV - human immunodeficiency virus
WHO - World Health Organization
HSV - herpes simplex virus HPV - human papillomavirus
GC - glucocorticoids
GKP - glucocorticoid drugs
GLP - glycoprotein
DM - dermatomyositis
DNA - deoxyribonucleic acid
GIT - gastrointestinal tract
IB - immunoblotting
IR - immune complex
IL - interleukin
PI - protease inhibitor
PPI - drug intake index
ELISA - enzyme immunoassay
IFN - interferon
ICG - immunochromatographic reaction
ICL - method of immunochemiluminescence

FOREWORD

The development in recent years of fundamental research in the field of immunology, biophysics and pharmacology has made it possible to make a breakthrough in elucidating individual links of pathogenesis, to improve the diagnosis and treatment of a number of dermatoses and sexually transmitted infections (STIs). The mechanisms of development of psoriatic arthritis and severe forms of psoriasis are clarified, methods of diagnostics and cytokine therapy are being improved. The possibilities of photodynamic therapy with the use of various photosensitizers are being expanded, non-steroidal external preparations are being used in the staged treatment of allergic dermatoses, methods of specific immunogenetic diagnosis of infectious diseases of the skin and genitourinary organs are being introduced. The skin performs many functions, has a large area, closely interacts with the internal organs and systems of the whole organism due to neurohumoral connections, and therefore is a projecting screen for various clinical stigmas, which are sometimes symptoms of very serious diseases. This underlines the importance and significance of dermatovenereology as a medical discipline. The authors analyzed new data in the field of dermatology, hereditary skin diseases and STIs and shared their experience.

The authors hope that "Dermatovenereology", based on the latest achievements of medical science, will become a reference book for dermatovenereologists and will contribute to improving the professional level of doctors and quality patient care.

Introduction

The skin performs many functions, has a large area, closely interacts with the internal organs and systems of the whole organism due to neurohumoral connections, and therefore is a projecting screen for various clinical stigmas, which are sometimes symptoms of very serious diseases. This underlines the importance and significance of dermatovenereology as a medical discipline. The authors analyzed new data in the field of dermatology, hereditary skin diseases and STIs and shared their experience. The brief edition of the national guide is a unique work and, in addition to the traditional sections on the specialty, includes a number of original ones: "Legal regulation of the organization of the provision of dermatovenereological care in modern conditions, ways to improve its quality and accessibility to the population", "Dermatological aspects of Lyme disease", "Tropical miases", "Medico-legal aspects of the activity of a dermatovenereologist", "Intestinal endotoxin and inflammation", "Peptide bioregulation", etc. Some chapters have been shortened due to the loss of relevance at the present time, while others, on the contrary, have been expanded.

SUBJECT CLASSES NO. 1: "VIRAL DISEASES SKIN. HERPES. WARTS. POINTED WARTS. CONTAGIOUS CLAM. HERPETIFORM DERMATITIS DÜHRING. PEMPHIGUS."

1. Motivation of the topic : Viral dermatoses - diseases of viral etiology manifested bubble rashes painful clinical manifestations, having recurrent character, which are frequent cause temporal disability at adults. Manifestation on skin these diseases It has similarity With many other pathological conditions and a practicing physician of any specialty must confidently diagnose viral diseases skin: herpes, warts, pointed warts, contagious clam, herpetiformis dermatitis Dühring, pemphigus from others diseases, A Also be able to on one's own pick up rational therapy, to carry out anti-epidemic and recreational measures in case of contagious dermatoses.

2. goal: To study the etiology, pathogenesis, features of the clinical course, differential diagnostics, principles treatment And prevention sick With viral And vesicular skin diseases. To study the method of managing outpatients, the rules for filling outpatient cards patients V polyclinic, be able to apply practical skills, received on clinical classes.

3. Tasks classes:

Student must know:

- Definition, etiology and pathogenesis viral and cystic dermatoses.
- Clinical manifestations viral And cystic dermatoses.
- Methods viral diagnostics And cystic dermatoses.
- differential diagnostics viral And cystic dermatoses.
- Methods therapy viral And cystic dermatoses.
- Prevention methods viral and cystic dermatoses.

Student must be able to:

- Right collect anamnesis And put diagnosis diseases at sick With viral Andcystic dermatoses.

- Conduct methods diagnostics at sick with viral And vesicular dermatoses.
- Conduct final differential diagnosis at sick With viral And cystic dermatoses.
- Compose plan treatment sick With viral and vesicular dermatoses.
- write out recipes major outdoor medicinal forms

Facilities necessary For holding classes:

- tables And visual allowances:
- Models on the topic: "Viral skin diseases. Herpes. Warts. pointed warts. Contagious clam. herpetiform dermatitis Dühring. Pemphigus."
- Atlas "Dermal And venereal disease" under ed. V.V.Vladimirova.- M. 1986, 2000.
- Presentation on theme: "Viral Skin Diseases. Herpes. Warts. pointed warts. Contagious clam. herpetiform dermatitis Dühring. Pemphigus."
- Clinical tasks on the topic: "Viral skin diseases. Herpes. Warts. Pointed warts. Molluscum contagiosum. Duhring's dermatitis herpetiformis.Pemphigus."
- Sick With viral and vesicular dermatoses
- Kit tools For holding classes

Basic knowledge:

- Chapter By histomorphology viral and cystic dermatoses

Clinical and morphological diagnostics And principles treatment skin diseases. Management For doctors. - M.: JSC "Publishing house "Medicine", 2006.- 512 With.

- Chapter By diagnostics morphological elements viral And cystic dermatoses

Dermal And venereal illness. Management For doctors, V 2nd volumes. Under editorial Yu.K. Skripkin. Moscow, Medicine. - 2004.

- Chapter By classification of viral And cystic dermatoses

Dermal And venereal illness. Under edited by O.L. Ivanov. M.: Shiko, 2006 - 480s.

- Chapter principles therapy viral And cystic dermatoses

Clinical recommendations. Dermatovenereology. Under editorial A.A. Kubanova. - M.:GEOTAR-Media, 2006. - 320 With.

4. Tasks For self-training:

Fill table By main provisions Topics, using educational allowance under edited by Yu.K. Skripkin. Moscow, Medicine. – 2004 p. or edited by O.L. Ivanov. M.: Shiko, 2006 - With. 197-208.

Main provisions Topics	Their characteristic
The pathogenesis of the development of viral and cysticdermatoses.	Filled instudent
The main complaints of patients with viral skin diseases, herpes, warts, genital warts, contagious mollusceg, Dühring's dermatitis herpetiformis, pemphigus	
Classification of viral and bladderdermatoses.	
Methods for diagnosing viral and cystic dermatoses.	
Medical methods treatment viral Andcystic dermatoses.	
Prognosis of patients with viral and cystic dermatoses.	

Control questions:

1. Why simple bubble lichen should differentiate With solid chancre.
2. Why factors risk at herpes are hypothermia And SARS.
3. Why simple bubble lichen recurs, A herpes zoster No.
4. Methods treatment contagious clam. Methods treatment warts.
5. pointed warts. Contagious clam. Simple bubble lichen.
6. Shingles lichen. Varioliform eczema Kaposi. nodules milkmaid.
7. Treatment of viral skin diseases. Prevention of viral skin diseases.

8. Definition. Etiopathogenesis. Diagnosis. Principles of treatment of herpetiform

dermatitis Dühring.

9. Definition. Etiopathogenesis. Diagnostics. Principles therapy pemphigus.

5. Content practical classes:

8.00 - 8.05 Examination present.

8.05 - 8.30 Control initial level knowledge students.

8.30 - 8.50 Outpatient reception sick V polyclinic. Parsing sick with a teacher.

8.50 - 9.00 Break.

9.00 - 9.50 Outpatient reception sick V polyclinic. Parsing sick with a teacher.

9.50 - 10.05 Break.

10.05 – 10.55 ambulatory reception of patients in the polyclinic. Analysis of patients with the teacher. Solution of situational clinical problems. slide show, table drawings, photos, multimedia accompaniment.

10.55 - 11.05 Break.

11.05 - 11.15 Control final level knowledge, answers on questions.

11.15– 11.20 Instruction O content And methodology training next classes.

6. Block information By topic classes:

CLASSIFICATION VIRAL DERMATOSES

GROUPS SKIN DEFEATS	NOSOLOGICAL FORMS
herpes	Simple Shingles
Warts	Simple flat plantarfiliform Genital wartsContagious clam
Paravaccination	nodules milkers

SYMPTOM NIKOLSKY P.V. AND ASBO-HANSEN

Application: For diagnostics acantholytic pemphigus And differential diagnostics bullous dermatoses.

1. When pulling with tweezers behind a piece of the bubble cover is detached upper layers epidermis V kind of gradually tapering ribbons on apparently healthy skin.

2. Friction finger (sliding pressure) By apparently healthy skin, How between bubbles, So And V distant Also enough easily causes rejection (shift) upper layers epidermis.

Note. This symptom is also found in other skin diseases in which there is acantholysis (chronic benign family pemphigus and etc.), but it is called only in lesion (regional symptom Nikolsky By N.D. Sheklakov, 1967).

DIFFERENTIAL DIAGNOSTICS Vesicles AND DERMATITIS DURYING

CHARACTERISTIC, SYMPTOMS	PEMPHIGUS	DERMATOSIS DURYING
Defeat mucous shells	constantly and early	Rarely
Other rashes	Missing monomorphism elements	More often polymorphism rashes
Flow	progressive	jerks
Delay chlorides	Necessarily	Rarely
Histology bubbles	Location of the bubbles epidermis, acantholysis	Location bubbles subepidermal, acantholysis absent
Cytology cells	Acantholytic cells Tzanka	Acantholytic cells rarely. Eosinsphilia
Symptom Nikolsky	Positive	Negative
Try with iodide potassium	negative	Positive
Treatment sulfones	Unsuccessful	successful
Forecast	unfavorable	Relatively favorable

Option this symptom is described at true pemphigus G. Asbo-Hansen phenomenon increase area bubble at pressure on his central Part.

RESEARCH ON CELLS TTSANKA

Application: For diagnosis of vulgaris pemphigus And differential diagnostics bullous dermatoses.

At monomorphic rashes bubbles on skin And erosion on mucous shell cavities mouth unspecified origin applied method strokes-imprints For possible detection of acantholytic cells (Pavlova-Tzank) occurring in vulgar pemphigus. The cytological feature of true pemphigus should be considered acantholytic cells (cells Tzanka), used V quality diagnostic test. Acantholytic cells characteristic For pemphigus, But may determined And at others diseases (herpes, chickenpox , bullous variety of Darier's disease ,chronic benign family pemphigus And etc.).

Technique detection: a piece sterile student's rubber bands (But Can Also tight attach a fat-free glass slide to the erosion surface) press firmly to the bottom fresh erosion and transferred to a glass slide. Usually they make several prints for 3-5 glasses. Then they are air-dried, fixed and stained according to Romanovsky-Giemsa. (like regular blood smears). Acantholytic cells are smaller than normal cells, have a very large core of intense violet or violet-blue color, occupying almost the entire cell. It has two or more light nucleoli. The cytoplasm of the cells basophilic around nuclei she light blue, A By periphery blue or dark purple ("rim concentration"). Often V cage available some nuclei. Sharp pronounced polymorphism cells And nuclei. Acantholytic cells may be single or multiple. Sometimes there are so-called "monster cells", which differ gigantic size, abundance cores, And bizarre forms. IN early diseases acantholytic cells are not found in every preparation or are not detected at all, in the height of the illness their a lot of And appear "monstrous" cells.

TRY YADASSON

Application: for diagnostics dermatitis herpetiformis Dühring and differential diagnostics bullous dermatoses.

A sample with potassium iodide (Yadasson's test) in two modifications: on the skin and inside. Per 1 cm^2 apparently healthy skin,

better than the forearm, apply an ointment with 50% under the compress for 24 hours potassium iodide. The test is considered positive if erythema occurs at the site of application, vesicles or papules. With a negative test after 48 hours, it is repeated: now the ointment applied on pigmented plot skin on place former rashes.

With a negative result, 2-3 tbsp is prescribed orally. spoons of 3-5% potassium iodide solution. Try counts positive at appearance signs exacerbations diseases.

DIFFERENTIAL DIAGNOSTICS VIRUS HERPES SIMPLE (HSV)

,,,	Genital ulcers	Note
Syphilis	In the primary period, it can drive education multiple venous primary affects -solid chancre, in secondaryperiod - erosive papules	Positive serologicalsyphilis testing, detection T. pallidum under microscopy in the dark field
Soft chancre	IN primary stages formed erosions and ulcers, accompanied soreness	Are formed rounded, A Not poly-cyclic erosive and ulcerativeelements, absent their sgrulpi- evenness. Reaction inguinal lim- phatic nodes brightly expressed. Atmicroscopy of discharge of ulcersis found pathogen softchancre - Haemophilus ducreyi
inguinal granuloma	Begins With education nodule, pustules, which fast out-ulcerate forming primary affect — ulcer. By periphery often arise child ulcers satellites	Pronounced tissue breakdown is characteristic, the edges ulcers edematous, hyperemic, somewhat raised. Atmicrobiological research discover pathogen — bodies Donovan (Calyim-matobacteriwn granulomatis)
Scabies	Maybe leak With erosive defeats genital bodies, emerging due to race-scratching and maceration of the skin with serous separable	Availability itchy rashes V interdigital intervals on wrist, in the cubital fossae and in other typical For scabies places.Detection scabies itch at microscopy

Fixed erythema	Arises V answer on reception once- personal medicines - sul- phanilamide preparations, sleeping pills funds And others Maybe be accompanied educationerosive elements How on genital organs, as well as in the oral cavities And on others plots skin	characteristic symptom bullish eyes": erosion is formed V central partsspots, the color intensity of which decreases from center To periphery. A carefully taken history helpsinstall correct diagnosis
erythroplasiaKeira	Characterized education pinkish red velvetyplaques, which Sometimes ulcer-is With appearance serous detachable	Arises after 50 years. Installdiagnosis help clinical paintingAnd histological study
Disease Behcet	Accompanied appearance af- painful painful rashes on genital bodies	rashes there are Also V oral cavities - aphthous stomatitis. Characteristic defeat eye. Diagnosisset on the basis clinical signs
Disease Crown	Terminal ileitis Maybe leak With education ulcers, located How on genital bodies, So And V perianal areas	Characterized by abdominal pain, scarringdue to previously transferred appendectomy, asthenicphysique of patients
Contact dermatitis, injury	Appear due to appli-cations on genital bodies once- personal antiseptics, ointments And others funds. Meet al- allergic reactions on latex And lubricant condoms. Can accompanied by erosionon the sexual member	Install diagnosis helps thoroughly assembled anamnesis

Bubble dermatoses	Can manifest form- title cystic, A then erosive and ulcerative elements, Vvolume including And on genital bodies	There are also rashes on other areas of the skin, in the oral cavity. At differential diagnosisuse cytological study,direct immunofluorescence census.
Streptococcus-	pustular diseases,which may	IN difference from herpetic

howl impetigo, shancriform-naya pyoderma	leak With about- development erosive and ulcerative elements	lesions V detachable erosion And ulcers discover streptococci And staphylococci
Balanop osteitis	Maybe be accompanied image-vanity painful erosion on head And domestic leaflet extreme flesh	Often arises at accompanying urethritis due to maceration urethral separable. Often reveal decline tolerance glucose. The diagnosis is established by exceptions others diseases
Plasma cell-balanitis _ Zuna	leaking With education eri-thematic erosive bezbo-lazy, clearly delineated plaques with a shiny surface on the skin heads sexual member	Histological study site affected skin revealsplasmacytic infiltrate

7. Tasks For final control classes:

Control final level knowledge:

1. Specify morphological element, characteristic For simple herpes:

A. Blister
B. bubble
C. Flikten
D. tubercle
E. Papule

2. Specify a drug, usually applied during treatment herpes simplex:

A. Prednisolone ointment
B. Erythromycin ointment
C. Synthomycin emulsion
D. Salicylic ointmentE. Ointment Acyclovir

3. On reception addressed sick with complaints on appearance rashes accompanied itching. On examination: in the area of the corner of

the mouth on the right against an erythematous edematous background grouped small vesicles filled with clear serous contents, and small erosion. For what diseases characteristic specified higher clinical painting:

A. Primary syphilis

B. Streptococcal impetigo

C. vulgar pemphigus D Simple herpes

E. Shingles herpes

1 The combination of which of the following elements of the rash is typical for herpes simplex: A. pustules, ulcers, purulent crusts

B. Nodules, scales, hyperpigmentation WITH. Papules blisters, excoriations

D. bumps, ulcers, hemorrhagic crusts

E. bubbles, erosion, serous crusts

5. Specify the subjective sensation most characteristic of herpes zoster: A. Itching

IN. Burning

C. Pain

D. Feeling contractions skin

E. Feeling tingling V skin

6. Specify disease With which necessary differentiate simple herpes:

A. Shingles herpes

B. Primary syphilis

C. Streptococcal impetigo D Soft chancre

Yo. All listed right

7. A patient came to you with complaints of painful erosions on the penis. From history revealed the frequent appearance of such rashes during the year. On examination: head of the penis grouped vesicles and erosion of polycyclic outlines, with clear boundaries, soft on palpation. What disease is described for? clinical painting:

A. vulgar pemphigus

B. Shancriform pyoderma

C. Primary syphilis

D. Scabies

E. Recurrent herpes

Standards answers : 1.b; 2.E; 3.D;4.E; 5.C; 6.E; 7.E

8. List recommended literature:

Main:

- Dermal And venereal illness. Under editorial Yu.K. Skripkin. Moscow, Triad - X - 2000 -657s.
- Dermal And venereal illness. Under edited by O.L. Ivanova. M.: Shiko, 2006 - 480s.

Additional:

- Dermal And venereal illness. Management For doctors, V 2nd volumes. Under editorial Yu.K. Skripkin. Moscow, Medicine. - 2004.
- Clinical and morphological diagnostics And principles treatment skin diseases. ManagementFor doctors. - M.: JSC "Publishing house "Medicine", 2006.- 512 With.
- Clinical recommendations. Dermatovenereology. Under editorial A.A. Kubanova. - M.:GEOTAR-Media, 2006. - 320 With.
- Atlas "Dermal And venereal disease" under ed. V.V. Vladimirova.- M..1986.

SUBJECT CLASSES NO. 2: "FUNGAL DISEASES SKIN. MICROSPORIA. TRICHOPHYTOSIS. FAVUS."

1. Motivation Topics: IN practice doctor any specialties meet Patients With manifestations on skin, which necessary differentiate With contagious diseases, before Total fungal nature. Necessary navigate in everyone most often meeting, clinical varieties mycoses.

2. Target: Explore peculiarities clinical flow, etiology And pathogenesis, differential diagnostics And therapy microsporia, trichophytosis, favus.

3. Tasks classes:

Student must know:

- Definition microsporia, trichophytosis, favus
- etiology And pathogenesis microsporia, trichophytosis, favus
- differential diagnostics microsporia, trichophytosis, favus
- Methods diagnostics microsporia, trichophytosis, favus
- Methods therapy microsporia, trichophytosis, favus
- epidemiological Events V hearth.
- Methods prevention microsporia, trichophytosis, favus

Student must be able to:

- Right collect anamnesis And put diagnosis diseases (stage, character flow,heaviness And etc.)
- Conduct diagnostic methods microsporia, trichophytosis, favus
- Conduct final differential diagnosis
- Compose tactical scheme patient management
- write out recipes For treatment on main medicinal facilities By datadiseases
- Conduct anti-epidemic And wellness Events

Facilities necessary For holding classes:

- tables And visual allowances:
- dummies By topic:
- Atlas "Dermal And venereal disease" under ed. V.V.Vladimirova.- M. 1986 2000.

- slides by topic: "Microsporia. Trichophytosis. Favus"
- Clinical tasks By topic: "Microsporia. Trichophytosis. Favus"
- Sick microsporia trichophytosis favus
- Kit tools For holding classes

Basic knowledge:

- Chapter By histomorphology microsporia, trichophytosis, favus

Clinical and morphological diagnostics And principles treatment skin diseases. Management For doctors. - M.: JSC "Publishing house "Medicine", 2006.- 512 With.

- Section on the diagnosis of morphological elements of microsporia, trichophytosis, favus Skin and venereal diseases. Guide for doctors, in 2 volumes. Edited by Yu.K. Skripkin. Moscow, Medicine. - 2004.
- Chapter By classification microsporia, trichophytosis, favus

Dermal And venereal illness. Under edited by O.L. Ivanov. M.: Shiko, 2006 - 480s.

- Chapter By principles therapy microsporia, trichophytosis, favus

Main provisions Topics	Their characteristic
The pathogenesis of the development of microsporia, trichophytosis, favus	Filled instudent
The main complaints of patients with microsporia, trichophytosis, favuse	
Classification microsporia, trichophytosis, favus	
Methods for diagnosing microsporia, trichophytosis, favus	
Medical methods of treatment of microsporia, trichophytosis, favus	
The prognosis of patients with microsporia, trichophytosis, favus	

Clinical recommendations. Dermatovenereology. Under editorial A.A. Kubanova. - M.:GEOTAR-Media, 2006. - 320 With.

4. Tasks For self-training:

Fill table By main provisions Topics, using educational allowance under edited by Yu.K. Skripkin. Moscow, Medicine. – 2004 p. or edited by O.L. Ivanov. M.: Shiko, 2006 - With. 197-208.Control questions:

1. Classification fungal diseases.
2. Classification trichophytosis.
3. Chronic trichophytosis adults. Etiology. Pathogenesis. Clinical painting.
4. Etiology and epidemiology of the infiltrative-suppurative form trichophytosis.
5. Clinical signs of infiltrative-suppurative form of trichophytosis hairy parts of the head. Clinical signs of the superficial form of trichophytosis of smooth skin. Clinical signs chronic trichophytosis smooth skin And hairy parts heads.
6. Methods diagnostics trichomycosis.
7. Epidemiology trichomycosis (microspores, trichophytosis, favus).
8. Prevention trichomycosis.
9. Etiology, epidemiology and clinical varieties of microsporia. Etiology and clinical signs microsporia hairy parts heads. Clinical varieties microsporia smooth skin And hairy parts heads.
10. Clinical varieties of the favus of the scalp. Clinical signs squamous And impetiginous, scutular forms favus.
11. Treatment (general And external) superficial forms microsporia And trichophytosis hairy parts heads.
12 Mechanism actions griseofulvina on mushrooms at domestic application drug.
13. List Events, which necessary conduct at availability sick trichomycosis among schoolchildren And unorganized contingent of children.
14. quarantine Events V children's institution under trichomycoses. Kindsdisinfection V epidemiological hearth.

5. Content practical classes:

8.00 - 8.05 Examination present.

DIFFERENTIAL DIAGNOSTICS MICROSPORA

microsporia	Diseases heads And skin fungal And non-fungal etiology
<u>On the head:</u> 1-2 major hearth And some small, neat borders, high broken off hair (4-5 mm), layering 1too-white scales. In large foci develop acute inflammatory phenomena:infiltration, hyperemia, division pus, layering crust yellow colors increase occipital, cervical And behind the ear lymphatic nodes, secondary allergic rashes on the skin torso And limbs foci small, multiple, wrong outlines, with hyperemia, small plate peeling, prone to fusion, are located V regional zones With capture adjacent areas of smooth skin, borders fuzzy <u>On skin</u>: foci small (1-2 cm) on open and behind-covered plots, multiple, county-lykh or oval outlines, With clear borders, towering roller By periphery covered with bubbles thin crusts, With hyperemia	**superficial trichophytosis** <u>On the head:</u> foci small or large, With fuzzy borders, short-cut hair (2-3 mm), without inflammatory phenomena,with insignificant small-scale tinted peeling <u>On skin:</u> foci are located on any site skin, But bowl on open - face, neck, chest, forearms. They With clear verge- tsami, rounded or oval outlines, With towering valkompo edge, on which visible bubbles, drying up V crusts, center hearth pink colors, foci By size more 2 cm, may merge. Foci By size more large, how at microsporia, may merge **Pityriasis rosea Zhibera** Foci are localized on skin torso, less often limbs. rashes V form spots pink colors, rounded or oval forms, inclined To peripheral growth. Through some days V center coloring turns brown, appears pityriasis peeling **seborrholds** Foci are located on seborrheic month-tach: V areas sternum, between shoulder blades V nasocuccal folds, on the head. This plaques With clear borders, yellowish pink , covered with bold scales

8.05 - 8.30 Control initial level knowledge students. test control.

8.30 - 8.50 Independent curation of patients under control teacher.

8.50 - 9.00 Break.

9.00 - 9.50 Clinical analysis of patients with a teacher.

9.50 - 10.05 Break.

10.05 – 10.55 Clinical analysis of patients with a teacher. Solution of situational clinical tasks. Show slides, pictures, tables, photos, multimediaaccompaniment. Show slide film: "Fungal diseases skin."

10.55 - 11.05 Break.

11.05 - 11.15 Control final level knowledge. Answers on questions.

11.15– 11.20 Instruction O content And methodology training next classes.

6. Block information By topic classes:

CLASSIFICATION FAVUSA (achorion Schonleini)

1. Scalp: A. scutular;

b. impetiginous; V. squamous.

2. Smooth skin;

3. nails.

CLASSIFICATION trichophytosis

I. superficial (tr. endothrix: tr. violaceum, tr. crateriforme)

1. Children's age:

a) the scalpb) Smooth skin;

V) nails.

2. Chronic trichophytosis:

A) hairy parts heads (black dot, erythematous squamous, atrophying).b) Smooth skin;

V) nails.

II. deep (tr. ectothrix: tr. faviforme, tr.gypseum) A) hairy parts heads;

b) Beards and mustaches; V) Smooth skin.

7. Trichophytids. Tasks For final control classes:

Control final level knowledge:

1. source infections microsporia more often Total there are:

a) horses, cowsb) cats, dogs V) mice rats

2. Clinical signs of smooth skin microsporia include: A) erythematous-squamous rashes

b) rounded or oval foci V) raised, edematous the edges foci G) All listed

3. superficial form trichophytosis called:

A) Trichophyton violaceum; Trichophyton tonsurans (crateriforme)

b) Trichophyton mentagraphytes (var. gipseum); Trichophyton verrucosum (var. faviforme) V) Trichophyton mentagrophytes (var. interdigitale); Trichophyton purpureum (rubrum)

4. For typical clinical paintings favus h/h heads characteristic: A) breaking off hair

5.b) education scooter

III.

DIFFERENTIAL DIAGNOSTICS trichophytosis

Trichophytosis	Disease heads And skin fungal And non-fungal etiology
superficial trichophytosis On the head : foci small or large, With fuzzy borders, With short broken off hair (2-3 mm), without inflammatory phenomena, With insignificant small-scale tinted peeling On skin : foci are located on any site skin, but more often on open ones - the face, neck, chest, forearms, with clear boundaries, rounded or oval forms, With elevate staggering	**microsporia** On the head: 1-2 major hearth And some small, With clear borders, highly brokenhair (4-5 mm), stratification of grayish- whites scales On skin: foci are small (1-2 cm), multiple, on open and closed areas, rounded and oval forms, With clear borders,towering roller By periphery, covered bubbles And thincrusts **squamous form favus** On head (skin): foci with layering of whitish-gray scales, sometimes with a yellowish tint, the hair is not broken off

roller By edge, on which bubbles are visible, drying up in crusts, the center of the lesion is pink, the foci are over 2 cm, may merge	**seborrheic eczema (seborrhea)** Foci are located on seborrheic month-max: in the sternum, between the shoulder blades, innaso-buccal folds, on head. This plaques With clear borders, yellowishpink colors, covered fatty scales **Pink lichen Gibera** The foci are located on body skin, less often limbs. Rashes in the form of spots pink colors, rounded or oval forms prone to peripheral growth. Through some days V center coloring becomes brown colors, appears pityriasis peeling
Chronic trichophytosis <u>On a smooth skin:</u> Foci reddish bluish colors, withoutclear boundaries, with peeling and nodules on the surface, in the buttocks, thighs, knee joints, forearms **Infiltrative suppurative tricho-phytia** on the head or skin tumor-like vocation, covered purulent crusts, With hyperemia, at pressure from hair-nyh follicles stands out pus, may be allergic rashes on skin, violated general state, V process are involved lymphatic nodes, afterpermissions foci remains cicatricial atrophy skin	**Rubromycosis** <u>On a smooth skin:</u> foci with clear boundaries, intermittent roller By periphery, hyperemia, small infiltration **Staphylococcal sycosis** Foci more often V areas top lips chin, V form infiltrate, status presenting from osteofollicular pustules covered purulent crusty **Folliculitis** knot size from peas before cherries permeated hair, Sometimes With pustularon surface, painful, Maybesuppurate And open up, after race- succumbing remains pinpoint scar**Chronic abscess pyoderma** Knots located V deep layers skin, crimson purple colors, which slowly soften, open up With
	education one or several holes, from which stands out pus; after permissions remains scar With re-sliver And bridges **Chronic generalized(granulomatous) candidiasis** On head or skin plaques size 1 cmand more, covered with dense crusts or papillomatous growths, With infiltrated continuous rollerBy periphery

V) symptom honey honeycomb"

6. Pathogen favus is:

A) microsporum Audioni

b) Trichophyton tonsurans (crateriforme) V) Trichophyton Schonleinii

References: 1.b.; 2.y.; 3.a.; 4.b.; 5.c.

situational tasks:

1. At child, visiting kindergarten, diagnosed superficial trichophytosis V hairy parts heads. All other children kindergarten healthy.

Who is the source of infection?

Who needs examine?

2. At child on hairy parts heads a lot of small foci With debris hair And peeling. Under luminescent lamp glow debris hair Not observed.

ABOUT what disease Can think?

How the diagnosis is confirmed diseases?

3. A 6-year-old child has ring-shaped lesions on the skin of the neck with a diameter of 1 to 3 penny coins, oiled diamond greenery. Boy had contact With sick microsporia. At microscopic research scale fungus Not discovered.

What additional tests are needed to confirm the diagnosis? diseases?

Solution references tasks:

1. source infections appeared sick trichophytosis. Examine all children, the whole staff children's garden, all members families sick child.

2. Trichophytosis. Diagnosis confirmed laboratory way.

3. Inspection under luminescent lamp, cultural method research

8. List recommended literature:

Main:

- Educational allowance Dermal And venereal illness. Under editorial Yu.K. Skripkin. Moscow,Triad-X - 2000 - 657 With.

- Educational allowance Dermal And venereal illness. Under editorial O.L. Ivanova. M.: Shiko,2006 - 480s.

Additional:

- Skin and venereal diseases. Guide for doctors, in 2 volumes. Edited by Yu.K.Skripkin. Moscow, Medicine. - 2004.

- Clinical and morphological diagnostics And principles treatment skin diseases. ManagementFor doctors. - M.: JSC "Publishing house "Medicine", 2006.- 512 With.

- Clinical recommendations. Dermatovenereology. Under editorial A.A. Kubanova. - M.:

GEOTAR-Media, 2006. – 320 With.

SUBJECT CLASS NUMBER 3: "TUBERCULOSIS SKIN. LEPROSY. LEISHMANIASIS"

1. Motivation for the topic: Skin tuberculosis, leprosy and leishmaniasis are socially significant chronic skin infections. Clinical manifestations can be contagious to others. The manifestation of these diseases on the skin is similar to many other pathological conditions. states And practicing doctor any specialties must confidently diagnose tuberculosis skin, leprosy And leishmaniasis from others diseases, A Also be able to on one's own

select rational therapy, conduct anti-epidemic and wellness Events.

2. Purpose: To study the etiology, pathogenesis, features of the clinical course, differential diagnostics, principles treatment and prevention a patient with tuberculosis skin, leprosy And leishmaniasis. Explore methodology reference outpatient sick, rules filling outpatient cards patients V polyclinic, be able to apply practical skills, received on clinical classes.

3. Tasks classes:

Student must know :

- Definition tuberculosis skin, leprosy And leishmaniasis.
- etiology, pathogenesis, classification tuberculosis, leprosy skin And leishmaniasis.
- Clinical manifestations tuberculosis skin, leprosy And leishmaniasis.
- Basics diagnostics tuberculosis skin, leprosy And leishmaniasis.
- Principles treatment And prevention skin tuberculosis, leprosy And leishmaniasis.

Student must be able to :

- Collect anamnesis at sick With tuberculosis skin, leprosy And leishmaniasis.
- Put disease diagnosis at sick With tuberculosis skin, leprosy and leishmaniasis.

- Make a final differential diagnosis in a patient with skin tuberculosis, leprosy And leishmaniasis.
- Compose plan treatment sick With skin tuberculosis, leprosy and leishmaniasis..
- write out recipes major medicinal forms

Facilities necessary For holding classes:

- tables And visual allowances:
- dummies By topic:
- Atlas "Dermal And venereal disease" under ed. V.V.Vladimirova.- M. 1986 2000.
- slides by topic: "Lupus. Leprosy. Leishmaniasis" - Clinical tasks By topic:

"Lupus. Leprosy. Leishmaniasis" - Sick pyoderma, scabies And pediculosis

- Kit tools For holding classes

Basic knowledge:

- Chapter By histomorphology tuberculosis, skin leprosy And leishmaniasis

Clinical and morphological diagnostics And principles treatment skin diseases. Management For doctors. - M.: JSC "Publishing house "Medicine", 2006.- 512 With.

- Chapter By diagnostics morphological tuberculosis elements, skin leprosy And leishmaniasis

Skin and venereal diseases. Guide for doctors, in 2 volumes. Edited by Yu.K. Skripkin. Moscow, Medicine. - 2004.

- Chapter By tuberculosis classification, leprosy skin And leishmaniasis

Dermal And venereal illness. Under edited by O.L. Ivanov. M.: Shiko, 2006 - 480s.

- Chapter By principles therapy tuberculosis, leprosy skin And leishmaniasis

Clinical recommendations. Dermatovenereology. Under editorial A.A. Kubanova. - M.:GEOTAR-Media, 2006. - 320 With.

4. Tasks For self-training:

Fill table By main provisions Topics, using educational allowance under edited by Yu.K. Skripkin. Moscow, Medicine. – 2004 p. or edited by O.L. Ivanov. M.: Shiko, 2006 - With. 197-208. Control questions :

1. Etiology, pathogenesis and classification of skin tuberculosis. Clinical formsskin tuberculosis.
2. Diagnostics tuberculosis skin.

Main provisions Topics	Their characteristic
The pathogenesis of tuberculosis, skin leprosy andleishmaniasis.	Filled in student
Main complaints patients at tuberculosis,leprosy skin And leishmaniasis.	
Classification tuberculosis, leprosy skin And leishmaniasis.	
Methods for diagnosing tuberculosis, skin leprosy and leishmaniasis.	
Drug treatments for tuberculosis,leprosy skin And leishmaniasis.	
Prognosis of patients with tuberculosis, skin leprosy and leishmaniasis.	

3. Treatment and prevention tuberculosis skin.
4. Etiology, pathogenesis And classification leishmaniasis. Clinical forms leishmaniasis. Ways transmission infections.
5. Diagnostics leishmaniasis.
6. Treatment And prevention leishmaniasis.
7. Etiology, pathogenesis And classification leprosy. Clinical forms leprosy.

5. Content practical classes:

8.00 - 8.05 Examination present.

8.05 - 8.30 Control initial level knowledge students.

8.30 – 8.50 Ambulatory admission of patients in the clinic . Analysis of patients withteacher.

8.50 - 9.00 Break.

9.00 – 9.50 Ambulatory reception of patients in the polyclinic. Analysis of patients withteacher.

9.50 - 10.05 Break.

10.05 – 10.55 ambulatory reception of patients in the polyclinic. Analysis of patients with teacher. Solution of situational clinical problems. Slideshow, drawings tables, photographs, multimedia accompaniment.

10.55 - 11.05 Break.

11.05 - 11.15 Control final level knowledge, answers on questions.

11.15– 11.20 Instruction O content And methodology training next classes.

6. <u>Block information By topic classes:</u>

CLASSIFICATION TB SKIN

Localized forms	Deseminated forms
Lupus vulgaris	Collicative tuberculosis of the skin (scrofuloderma)
Warty tuberculosis skin	Papulonecrotic tuberculosis
ulcerative tuberculosis skin And mucous	compacted erythema Bazin (indurated tuberculosis skin)
tuberculous chancre	Lichenoid tuberculosis (lichen scrofulous)
	Miliary disseminated lupus
	Spicy disseminated miliary tuberculosis of the skin

DIFFERENTIAL DIAGNOSTICS TB LUPUUS AND BUGORKOV SYPHILIS

Diagnostic signs	tuberculosis lupus	Papulose syphilis
Start diseases	More often V childhood	At any time life
Flow (without treatment)	Many years	Months
Tubercle color	Red with yellowish shade	Copper or ham red
Consistency	Soft	Tight-elastic
Symptom probe	Positive	Absent

Symptom "apple jelly"	Positive	Absent
Character scar	Superficial, smooth, thin,lace pattern	Mosaic (due to various depths, quantities And age tubercles)
Appearance on scars new tubercles	Usually	Not It happens
Histopathology	Granuloma: giant in the center cells, around them - epithelial, in the peripherallymphoid, Sometimes - plasmatic cells	Endo-meso-perivasculitis, infiltrate from plasmatic cells
tuberculin test	Positive	negative
Serological reactions on syphilis	Negative	Positive

DIAGNOSTICS TB SKIN

1. Playback symptom "apple jelly" And symptom Pospelov. Application:For diagnostics lupoid skin tuberculosis.

2. Symptom “apple jelly".

DIFFERENTIAL DIAGNOSTICS LEPRIDOV

LEPRIDS	DISEASES, C WHICH SHOULD DIFFERENTIATE
Spotted	Erysipelas, syphilitic roseola,lupus erythematosus, pink lichen Zhibera, toxic coderma, syphilitic leukoderma, vitiligo
nodular	Annular papular syphilis, red flat lichen, psoriasis
Tubercular And nodal	tuberculous syphilides, tuberculous lupus,cutaneous leishmaniasis, indurated erythema Bazin, erythema nodosum
Leprosy infiltrates	scleroderma And sclerodactyly, syphilitic skies gummy infiltrates, elephantiasis
Leprous pemphigus	All varieties of pemphigus, burn pimples zyri, dermatosis herpetiformis Duhring, pu- spicy form red flat depriving, bubble-naya form of toxicoderma, hysterical pemphigus, bullous epidermolysis

7. At pressure subject glass on surface tuberculosis tubercle going on change colors tubercle. At this under pressure subject glass dilated vessels of the tubercle subside, and a bloodless yellowish brown coloring infiltrate like colors apple jelly.

8. Symptom Pospelova or "probe". Allows reveal pathognomonic diagnostic sign at tuberculosis lupus. At lung pressure bellied probe on the surface of the tubercle, it easily sinks into the depth of the tissue (s.m. Pospelov). For comparison, when pressing on healthy skin nearby, the resulting fossa is restored faster than on the hillock

9. Tasks for final control classes:

Control final level knowledge:

Instructions: For each question or incomplete statement, one or some answers are faithful. Choose:

A	IN	WITH	D	E
If right only 1,2,3	If right only 1 And 3	If right only 2 And 4	if trueonly 4	If everything is correct

1. For tuberculosis lupus true the following provisions:
1. Phenomenon apple jelly characteristic of lipomas
2. Lipomas — manifestations tuberculosis lupus
3. Symptom probe Pospelova positive
4. Atrophy Not characteristic For tuberculosis lupus
2. hearth warty tuberculosis skin characterized nextzones:
1. Zone tubercles With warty growths
2. Zone infiltrate without warty layers
3. Inflammatory border
4. bezel peeling
3. Tuberculosis skin collicative characterized nextsigns:
1. Nodes in hypodermis tight soldered in proper tissues
2. Fistulas With bloody separable
3. "Ragged" scarring
4. atrophic smooth areas
4. Borreliosis 1st stages characterized by:
1. Erythema nodosum

2. erythema multiform exudative
3. erythema centrifugal Bietta
4. erythema chronic migratory
5. Borreliosis treat:

1. Corticosteroids
2. vitamins
3. Antihistamines drugs
4. Antibiotics

Standards answers : 1.b; 2.A; 3.A; 4.D; 5.D

8. List recommended literature:

Main:

- Educational allowance Dermal And venereal illness. Under editorial Yu.K. Skripkin. Moscow,Triad - X - 2000 - 657s.
- Educational allowance Dermal And venereal illness. Under editorial O.L. Ivanova. M.: Shiko,2006 - 480s.

Additional:

- Skin and venereal diseases. Guide for doctors, in 2 volumes. Edited by Yu.K.Skripkin. Moscow, Medicine. - 2004.
- Clinical and morphological diagnostics And principles treatment skin diseases. ManagementFor doctors. - M.: JSC "Publishing house "Medicine", 2006.- 512 With.
- Clinical recommendations. Dermatovenereology. Under editorial A.A. Kubanova. - M.: GEOTAR-Media, 2006. – 320 With.
- Atlas "Dermal And venereal disease" under ed. V.V. Vladimirova.- M..1986.

SUBJECT CLASS NUMBER 4: "RED LUPUS AND SCLERODERMA"

1. Motivation: Red lupus And scleroderma - alone from most common dermatoses of multifactorial genesis. Damage to internal organs and body systems leads not only to chronicity, but often to disability. The manifestation on the skin of these diseases has similarities with many other pathological conditions and the practitioner a doctor of any specialty must confidently differentiate psoriasis and red flat lichen from other diseases, as well as be able to independently select therapy, prevention For cuts relapses And extension remissions these diseases.

2. Target: Explore peculiarities clinical flow, etiology And pathogenesis, differential diagnostics And therapy red lupus And scleroderma. Explore methodology reference outpatient sick, rules filling outpatient cards With application practical skills acquired on clinical classes.

3. Tasks classes:

Student must know:

- Definition red lupus And scleroderma
- etiology And pathogenesis of red lupus And scleroderma
- differential diagnostics red lupus and scleroderma
- Methods diagnostics red lupus And scleroderma
- Methods therapy red lupus And scleroderma
- Methods prevention of red lupus and scleroderma

Student must be able to:

- Right collect anamnesis And put diagnosis diseases (stage, character flow,heaviness And etc.)
- Fill outpatient map dermatological sick.
- Conduct final differential diagnosis
- Compose tactical scheme patient management
- Write out, issue prescriptions for essential drugs used in therapy these diseases.

Facilities necessary For holding classes:

- tables And visual allowances:
- dummies By topic:
- Atlas "Dermal And venereal disease" under ed. V.V.Vladimirova.- M. 1986 2000.
- slides by topic: "Red lupus And scleroderma"
- Clinical tasks for topic: "Red lupus And scleroderma"
- Sick red lupus and scleroderma
- Kit tools For holding classes

Basic knowledge:

- Chapter By histomorphology red lupus And scleroderma

Clinical and morphological diagnostics and principles treatment skin diseases. Management For doctors. - M.: JSC "Publishing house "Medicine", 2006.- 512 With.

- Chapter By diagnostics morphological elements red lupus And scleroderma Skin and venereal diseases. Guide for doctors, in 2 volumes. Edited by Yu.K. Skripkin. Moscow, Medicine. - 2004.
- Chapter By classification red lupus And scleroderma

Dermal And venereal illness. Under edited by O.L. Ivanov. M.: Shiko, 2006 - 480s.

- Chapter By principles therapy red lupus and scleroderma

Main provisions Topics	Their characteristic
The pathogenesis of lupus erythematosus and scleroderma.	Filled instudent
The main complaints of patients with redlupus And scleroderma.	
Classification lupus erythematosus and scleroderma.	
Methods for diagnosing lupus erythematosus and scleroderma.	
Non-drug treatments for redlupus And scleroderma.	
Medical treatments for redlupus And scleroderma.	
The prognosis of patients with lupus erythematosus and scleroderma.	

Clinical recommendations. Dermatovenereology. Under editorial A.A. Kubanova. - M.:GEOTAR-Media, 2006. - 320 With.

4. Tasks For self-training:

Fill table By main provisions Topics, using educational allowance under edited by Yu.K. Skripkin. Moscow, Medicine. – 2004 p. or edited by O.L. Ivanov. M.: Shiko, 2006 - With. 197-208.Control questions:

1. Etiology, pathogenesis And classification red lupus
2. Clinical forms red lupus.
3. Diagnostics red lupus.
4. Treatment And prevention red lupus.
5. Etiology, pathogenesis And classification scleroderma.
6. Clinical forms scleroderma.
7. Diagnostics scleroderma.
8. Treatment And prevention scleroderma.

5. **Content practical classes:**

8.00 - 8.05 Examination present.

8.05 - 8.30 Control initial level knowledge students.

8.30 - 8.50 Outpatient reception sick V polyclinic. Parsing sick with a teacher.

8.50 - 9.00 Break.

9.00 - 9.50 Outpatient reception sick V polyclinic. Parsing sick with a teacher.

9.50 - 10.05 Break.

10.05 – 10.55 ambulatory reception of patients in the polyclinic. Analysis of patients with the teacher. Solution of situational clinical problems. slide show, table drawings, photos, multimedia accompaniment.

10.55 - 11.05 Break.

11.05 - 11.15 Control final level knowledge, answers on questions.

11.15– 11.20 Instruction O content And methodology training next classes.

6. **Block information By topic classes:**

RED LUPUS

Red lupus - disease from groups diffuse diseases connective fabrics (collagenoses). Distinguish two main forms diseases: discoid (skin) And system. At discoid form defeat limited predominantly or exclusively foci on skin, V That time How at systemic form V pathological process are involved many organs and tissues in various combinations, and on the skin and mucous membranes there are highly polymorphic changes. Cutaneous form usually appears as discoid red lupus, less often meet centrifugal erythema Bietta And deep red lupus Kaposi-Irganga.

Etiology And pathogenesis

etiology discoid red lupus it is forbidden recognize finally installed. The most likely viral origin of the disease: with electron microscopy in affected skin show tubuloreticular virus-like inclusions. IN pathogenesis, chronic focal (usually streptococcal) infection plays a certain role, hypothermia, insolation, drug intolerance, autoallergy. Assume viral genesis of the disease (including the involvement of retroviruses) in combination with familial genetic predisposition. Systemic lupus erythematosus is an autoimmune disease with the development of a hyperimmune response in relation to the components of one's own cells (nuclear and cytoplasmic), especially native DNA. Antinuclear antibodies circulating in the blood can form immune complexes that are deposited in the vessels of various organs and tissues and causing a local or systemic inflammatory response. Histopathological changes are usually expressed by systemic disorganization of connective tissue and generalized defeat vessels (lupus vasculitis).

Floor. Predominantly women of young and middle age are ill, men are 10 times less often.

Clinical painting. For skin defeat characteristic three cardinal symptom: erythema, hyperkeratosis and atrophy. The first

(erythematous) stage of the process is characterized by the appearance of a small pink, slightly edematous, clearly delimited spot, gradually increasing V sizes. In second (hyperkeratotic-infiltrative) stages on surfaces spots appear small, dense grayish white scales, removed With big labor And pain (symptom Benier-Meshchersky), myself hearth is turning V raft- new discoid plaque. At transition V third (atrophic) stage V center hearth formed smooth tender alabaster white cicatricial atrophy, gradually spreading on all square hearth, V zone which may be telangiectasia And regional pigmentation. typical localization on open plots skin: face (especially on nose and cheeks, where the focus may resemble a butterfly in shape), auricles, neck, open Part chest. Often are amazed hairy Part heads And red border lips. Maybe lesions of the oral mucosa, where the foci look bluish-red or whitish, clearly limited dense plaques With sunken, Sometimes eroded center.

Centrifugal erythema of Biette is a superficial variant of the red skin form. lupus. Of the three cardinal symptoms characteristic of the discoid form, clearly expressed only hyperemia, V That time How dense scales And cicatricial atrophy almost or are completely absent. Lesions are usually located in the midface and are often outlines resemble a butterfly. Multiple, scattered over various areas of the skin lesions of the discoid type or Biett's centrifugal erythema are often referred to as chronic disseminated lupus erythematosus. With *deep lupus erythematosus of Kaposi-Irgang,* along with previously described skin changes in the subcutaneous tissue, there is one or more sharply delimited dense, mobile nodular seals - lupus-panniculitis. When action unfavorable factors discoid red lupus Sometimes Maybe cross over V system.

SLE Disease more often starts after childbirth, abortion, excessive insolation with the recipient migratory arthritis, fever, malaise, skin rashes, rapid weight loss. IN subsequent develop progressive pathological changes V various bodies: polyarthritis With arthralgia, myositis with myalgia, polyserositis (dry or effusion pleurisy, pericarditis, peritonitis), lupus carditis syndrome

Raynaud, lupus jade, pneumonia, asthenovegetative syndrome, polyneuritis, cerebrovasculitis with mental violations, lymphadenopathy, hemolytic anemia, leukopenia, thrombocytopenia, etc. Skin lesions in the systemic form are more diverse and common than in discoid. Sometimes (in 10-15% of patients) they are absent, but this condition is temporary, transitory. With systemic lupus erythematosus, the following are noted: manifestations of skin syndrome: diffuse alopecia, foci of discoid type, erythema on face like a butterfly, disseminated edematous erythematous spots along type exudative erythema (Rowell's syndrome), "capillary" fingers, general dry skin (xeroderma), papulonecrotic rashes widespread mesh And branched

livedo, purpura, erosions on the mucous membranes, cheilitis, chills of the fingers, bullous rashes, telangiectasias, pigmentation, increased keratinization of the skin of the palms and soles (keratoderma), various changes in the nails (onychodystrophy). special diagnostic matter inflammatory changes in the middle zone of the face - the so-called lupus butterfly.

Diagnosis of systemic lupus erythematosus is based on the clinical picture (especially valuable erythema butterfly, the presence of foci of discoid type, Raynaud's syndrome, alopecia, ulceration mucous membranes of the mouth. photosensitivity, arthritis without joint deformity, polyserositis, psychosis or seizures), as well as on laboratory data (LE cells, high credits antinuclear antibodies And antibodies To native DNA, pancytopenia).

Treatment

Skin treatment forms must be complex. The main method of general therapy is the long-term use of quinoline derivatives (delagil according to 1-2 tablets V day or plaquenil By 2-3 tablets per day for several months). efficiency and portability quinoline drugs rises at simultaneous appointment vitamins (At $_6$ And At $_{12}$ intramuscularly, pantothenate calcium inside). locally apply fluorine-containing corticosteroid ointments (flucinar, lorinden A, fluorocort, sinaflan,

betnovat, celestoderm, elokom, diprosalik) - lubricate the foci 2-3 times V day (for night better under occlusal bandage). At small area foci apply intradermal (By type lemon crusts) injections 10% solution hingamina or 5% ra- alignment delagila 1-2 times V week (not more 2 ml per procedure). In particular stubborn cases, cryodestruction is performed. The use of general corticosteroid therapy for discoid lupus erythematosus is inappropriate. Treatment of SLE is complex: adequate anti-inflammatory and immunosuppressive therapy (corticosteroids, cyclophosphamide, quinoline drugs) symptomatic facilities.

The prognosis for systemic lupus erythematosus remains generally poor, although adequate modern treatment significantly increases the life expectancy of patients. Sick must for life be under dispensary observation rheumatologist.

Differential diagnosis. IN primary stages discoid red lupus necessary differentiate from red acne, seborrheic dermatitis, psoriasis.

Prevention. Sanitation of the identified chronic focal infection is recommended. Sick must constantly observe prophylactic mode: avoid stay on Sun, the wind frost; before way out on street lubricate open plots body photoprotective creams ("Ray", "Shield").

Synonyms lupus erythematodes; erythematosis

ICD. L93.0 Discoid red lupus ICD. M32 Systemic red lupus

Scleroderma is a skin lesion characterized by diffuse or limited seal followed by development fibrosis and atrophy affected plots.

Dominant age. 30-60 years; more often get sick women

Classification. Distinguish limited and systemic scleroderma. With limited scleroderma usually affected only leather, V That time How at systemic V process, besides skin, are involved other organs.

Etiology And pathogenesis Etiology unknown. Available assumptions about infectious origin diseases, So How it sometimes occurs after acute or chronic infections. IN pathogenesis scleroderma have meaning neuroendocrine And vascular violations. IN last thing time scleroderma considered How autoimmune disease. Clinical

picture Limited scleroderma has several clinical forms. For *plaque scleroderma* characteristically education small numbers rounded foci By- fights, which V his development pass 3 stages: spots, plaques And atrophy. Begins disease With appearance one or several lilac-pink round or oval spots magnitude With palm And more. Gradually center spots turns pale And starts thicken, the lesion soon turns into a very dense characteristic plaque yellowish white colors With smooth brilliant surface, reminiscent ivory bone. By periphery plaques some time preserved lilac whisk, behind check whom their growth takes place. Hair on plaques fall out, cutaneous the picture is smoothed out, then - And sebum secretion stops; skin on the affected site it is forbidden collect V crease. IN in this state, foci of limited scleroderma can remain for a long time (months, years), A then gradually exposed cicatricial atrophy: center their softens, sinks, and soon the entire plaque turns into a site of atrophy. The skin is more commonly affected torso and limbs, rarely — mucous shells.

A variety of limited scleroderma is *a linear scleroderma*, lesions _ at which have view stripes And are located usually longitudinally on final news And By sagittal lines on forehead (remind scar from strike sabers). *scleroderma drop-shaped* (white spot disease, white lichen Tsumbusha) appears pearlescent white rounded spots size 0.1-1.0 cm, located predominantly V top parts torso. rashes exist for a long time, ending atrophy.

Diffuse scleroderma usually begins with a prodrome in the form of a general malaise, subfebrile temperature, chilliness, arthralgia, numbness of the extremities, tingling in the skin, mild itching. Skin becomes yellowish gray coloring, it is impossible to collect crease, at pressure finger pits on the skin Not is formed. So time seal skin intensifies, she becomes woody, immobile. Surface skin seems smooth brilliant And thanks to waxy yellow shade reminds ivory bone.

Face mask-like, amimic, oral gap narrows (microstomia). On individual plots skin appear telangiectasia And uneven pigmentation, What attaches to her mottled look. Sometimes diffuse scleroderma

starts and subsequently remains the most pronounced on hands: on the background seizures acroasphyxia (syndrome Raynaud) develops dense edema, A then sclerosis, thinning And stiffness, crookedness fingers hands often With education trophic sores (sclerodactyly). At systemic scleroderma damage to muscles, joints, digestive tract, lungs (pneumosclerosis), kidneys (nephrosclerosis), cardiovascular system (pericarditis, myocarditis, arteriosclerosis), bones (osteoporosis, osteolysis) nervous systems. Maybe combination With calcification (Tibierger- Weissenbach syndrome).

Treatment. IN stages indurations effectively application drugs hyaluronidase actions (lidase - By 0.1 G V 0.5% solution novocaine subcutaneously in one day). Vitamins A And E (inside V form oil solutions By 5-10 drops 3 times V day), aevit (according to 1 capsule 2 times V day). At sclerodactyly - nicotine acid (according to 0.1 G 3 times in day); topically - applications 30- 50% dimexide solution. IN Lately V therapy scleroderma are used immunosuppressants. At severe systemic scleroderma With diffuse defeat skin appoint corticosteroids, Sometimes V combined With cytostatics (d-penicillamine, kuprenil), A with limited forms shown delagil And his analogues (By 1-2 pills V day). At detection of endocrinopathy (insufficiency of the thyroid, sex and other glands) is prescribed corrective therapy. Thermal procedures (baths, paraffin applications), massage, ultrasound, diathermy. Patients are referred to sulfuric and mud resorts.

Flow And forecast. Sick scleroderma must be under permanent supervision of a dermatologist and rheumatologist, avoid physical and nervous strain, colds diseases.

ICD M34 Systemic sclerosis

7. Tasks For final control classes:

Control final level knowledge:

Instruction: For everyone question or unfinished statements one or some answers are faithful. Choose:

A	IN	WITH	D	E
If right only 1,2,3	If right only 1 And 3	If right only 2 And 4	if true only 4	If everything is correct

1. Specify the main factors that are important in pathogenesis discoid red lupus:

1. Foci of chronic infections
2. Medicinal intolerance
3. Autoimmune violations
4. Insolation

2. Specify the characteristic symptoms of skin lesions in discoid red lupus:

1. Erythema
2. Follicular hyperkeratosis
3. cicatricial atrophy
4. Lichenification

3. Specify clinical stages erythematosis:

1. atrophic
2. Hyperkeratosis-infiltrative
3. Erythematous
4. Necrotic-ulcerative

4. Specify main clinical varieties skin forms red lupus:

1. plaque
2. Discoid
3. stripe
4. Chronic disseminated

5. Specify characteristic localization discoid red lupus:

1. Nose
2. Cheeks
3. Red border lips
4. hairy Part heads

6. name clinical forms integumentary (dermal) scleroderma:

1. Disease whites spots

2. plaque
3. stripe
4. Discoid

7. Specify most characteristic localization strip-like scleroderma:

1. Nose, cheeks
2. Forehead
3. Neckline
4. limbs

8. name clinical stages plaque scleroderma:

1. Erythema
2. hyperpigmentation
3. Atrophy
4. Seal

9. Specify clinical manifestations, characterizing initial stage plaque scleroderma:

1. Hypopigmented spots With insignificant pityriasis peeling
2. Plaques of red colors With inflammatory roller By periphery
3. Papules hot pink colors, With scales
4. Lilac pink spots rounded or oval outlines

10. name characteristic clinical signs plaque scleroderma:

1. yellowish white color, shiny surface
2. Dropping out hair And smoothing skin drawing
3. woody density
4. Decrease sweat- And sebum secretion V hearth

Reference answers: 1-D; 2-A; 3-A; 4-C; 5-E; 6-A; 7-C; 8-E; 9-D; 10-E.

8. List recommended literature:

Main:

- Educational allowance Dermal And venereal illness. Under editorial Yu.K. Skripkin. Moscow, Triad - X - 2000 - 657s.
- Educational allowance Dermal And venereal illness. Under editorial O.L. Ivanova. M.: Shiko, 2006 - 480s.

Additional:

- Skin and venereal diseases. Guide for doctors, in 2 volumes. Edited by Yu.K. Skripkin. Moscow, Medicine. - 2004.
- Clinical and morphological diagnostics And principles treatment skin diseases. Management For doctors. - M.: JSC "Publishing house "Medicine", 2006.- 512 With.
- Clinical recommendations. Dermatovenereology. Under editorial A.A. Kubanova. - M.:

GEOTAR-Media, 2006. – 320 With.

SUBJECT CLASS NUMBER 5: "ACQUIRED SYPHILIS. GENERAL PATHOLOGY. PRIMARY AND SECONDARY PERIODS SYPHILIS."

1. Motivation Topics: Syphilis - one from most common And contagious diseases, transmitted sexual way. Defeat domestic bodies And systems organism at syphilis often leads To disability. Except Togo, This disease transmitted offspring. Manifestation rashes on skin a syphilis It has similarity With many other pathological conditions and a practicing physician of any specialty must confidently their differentiate And conduct preventive actions.

2. Target: Explore etiology, pathogenesis, peculiarities clinical currents primary And secondary period syphilis, methods diagnostics, conduct differential diagnosis.

3. Tasks classes:

Student must know:

- Definition syphilis
- etiology And pathogenesis syphilis
- Clinical manifestations primary And secondary period syphilis
- Methods diagnostics syphilis
- differential diagnostics primary And secondary period syphilis
- Methods prevention syphilis

Student must be able to:

- Right collect anamnesis and put diagnosis diseases
- Conduct laboratory diagnostics syphilis
- Conduct differential diagnosis
- Compose tactical scheme patient management

Facilities necessary For holding classes:

- tables And visual allowances:
- dummies By topic:
- Atlas "Dermal And venereal disease" under ed. V.V.Vladimirova.- M. 1986 2000.
- Slides By topic: "Syphilis primary And secondary"

- Clinical tasks for topic: "Syphilis primary and secondary
- Sick syphilis
- Kit tools For holding classes

Basic knowledge:

- Chapter By histomorphology syphilis
- Chapter By histomorphology syphilis

Clinical and morphological diagnostics And principles treatment skin diseases. Management For doctors. - M.: JSC "Publishing house "Medicine", 2006.- 512 With.

- Chapter By diagnostics morphological elements syphilis

Skin and venereal diseases. Guide for doctors, in 2 volumes. Edited by Yu.K. Skripkin. Moscow, Medicine. - 2004.

- Chapter By classification of psoriasis syphilis

Dermal And venereal illness. Under edited by O.L. Ivanov. M.: Shiko, 2006 - 480s.

- Principles Section therapy syphilis

Clinical recommendations. Dermatovenereology. Under editorial A.A. Kubanova. - M.:GEOTAR-Media, 2006. - 320 With.

4. Tasks For self-training:

Main provisions Topics	Their characteristic
Pathogenesis development primary And secondaryperiod syphilis	
The main complaints of patients during primary andsecondary period syphilis	
Classification of primary and secondary periodsyphilis	Filled instudent
Methods for diagnosing primary and secondaryperiod syphilis	
Medical methods treatment primary And secondary period syphilis	
Criteria for cure of patients with primary andsecondary period syphilis	

Fill table By main provisions Topics, using educational allowance under edited by Yu.K. Skripkin. Moscow, Medicine. – 2004 p. or edited by O.L. Ivanov. M.: Shiko, 2006 - With. 197-208.Control questions:

1. Etiology syphilis. Conditions And ways of infection Classification.
2. Clinic primary period syphilis.
3. Typical solid chancre. Atypical solid chancre.
4. Methods diagnostics.
5. Clinic secondary period syphilis.
6. laboratory diagnostics syphilis

5. Content practical classes:

8.00 - 8.05 Examination present.

8.05 - 8.30 Control initial level knowledge students. test control.

8.30 - 8.50 Independent curation of patients under control teacher.

8.50 - 9.00 Break.

9.00 - 9.50 Clinical analysis sick With teacher.

9.50 - 10.05 Break.

10.05 – 10.55 Clinical analysis of patients with a teacher. Solution of situational clinical tasks. Show slides, pictures, tables, photos multimediaaccompaniment.

10.55 - 11.05 Break.

11.05 - 11.15 Control final level knowledge. Answers on questions.

11.15– 11.20 Instruction O content And methodology training next classes.

6. Block information By topic classes:

CLINICAL VARIETIES PRIMARY syphilomas (SOLID CHANCRE)

Typical solid chancre.

1. Erosive hard chancre;
2. Ulcerative hard chancre;Atypical solids chancre.
1. inductive edema;
2. Chancre panaritium;

3. Chancre-amygdalite. Complicated solid chancre.
1. Inflammatory chancre;
2. Gangrenous chancre;
3. Phagedenic chancre;

LABORATORY DIAGNOSTICS SYPHILIS

Microscopic research.

In primary syphilis, treponema pallidum is examined for discharge of chancre or punctate of regional lymph nodes; with secondary syphilis - material from various defeats skin And mucous shells.

The material for the study is obtained from the patient before treatment directly in laboratories. To obtain material, the surface of the ulcer is wiped with cotton wool moistened with sterile isotonic saline sodium chloride, then the bottom of the ulcer is slightly irritated glass rod or platinum loop, previously calcined on fire and chilled. For greater secretion of tissue fluid with fingers in a rubber glove squeeze dense base ulcers.

DIFFERENTIAL DIAGNOSTICS SOLID SHANCROW

FORMS SHANCROW	DISEASES, WITH WHICH DIFFERENTIATED
TYPICAL	
erosive	Simple herpes, balanoposthitis (vulgar, candidiasis, from exposure to chemicals, etc.), traumatic erosion, bullous toxicoderma
ulcerative	Soft chancre, syphilitic gumma, scabies ecthyma, chancriform pyoderma, cancerous ulcer, tuberculosis ulcer
ATYPICAL	
inductive edema	At men - induration, elephantiasis penis, at women - bartholinitis, abscess bartholin glands
Chancre panaritium	Felon banal (staphylococcal infection)
Chancre-amygdalite	Lacunar angina, diphtheria, angina Vincent

syphilides SKIN SECONDARY PERIOD

SPOTTED	PAPULOSIS	PUSTULAR	DEFEAT HAIR
syphiliticroseola	Million (follicular)	Acne	Small focal baldness
small-spotted	Coin-like	Impetigo-similar	mixed baldness
Elevating	Hypertrophic	Ecthymous	Defeat eyebrows and
(urticoid)	ie (wide warts)		eyelashes (symptom Pinkus)
grainy	Erosive (wet)	Rupiodic	
Drain	Psoriasisforms		
Annular	Annular		
Pigmentarysyphilis (leucoderma)	Horny papules palms And soles		

The studied tissue fluid is introduced with a stick or loop into a drop of isotonic solution sodium chloride on a slide, mix, cover with a slide andexamined in an optical microscope with a dark-field condenser, objective 40, eyepiece 7X, 10X, or 15X. There should be a drop between the condenser lens and the slide distilled water.

GENERAL CHARACTERISTIC CURRENTS SYPHILIS IN VARIOUS PERIODS

CHARACTERISTIKA	PERIOD		
	Primary	Secondary	Tertiary
Localization manifestations	Only on place introduction of treponema	Everywhere (leather And mucous)	Everywhere
Morphologically e elements	Chancre (erosive, ulcerative	Roseola, papules, pustules, vesicles	tubercles, gummas

	And etc.)		
Exodus rashes	disappears without a trace or leaves scar	Mainly without a trace	Always scarring
Increaselymph nodes	Regional adenitis	Polyadenitis with secondary fresh, residual effects orabsence of polyadenitisat secondary recurrent	Absent
contagiousness	contagious	contagious	Practically Not contagious
Acute inflammatory reaction	Absent	That same	That same
subjective Feel	Missing	Missing	Missing
Defeat nervous systems	Occasionally, benign	Often wear benign character	Often wear malignant character (organic defeat)
Defeatdomestic bodies	Possible functional violations	Often wear functional character	Often wear heavy character
Serological reactions	First 2-3 weeks negative, thenpositive	Positive V 97 %	Positive in 70-75%

Punctate from lymphatic node receive V aseptic conditions at help syringe With thick needle, containing some drops isotonic solution chloride sodium.

Fixing the needle with your fingers in the lymph node, it is slightly swung to destroy environmental fabrics, introduce available V syringe isotonic solution chloride sodium, A then suck off material For research.

DIFFERENTIAL DIAGNOSIS OF SECONDARY FRESHAND RECURRENT SYPHILIS PERIODS

ПРИЗНАКИ	Fresh	Recurrent
1. Rash: A) magnitude	small	Large
b) quantity	Abundant	meager
V) color	Bright	Faded
d) prevalence	scattered	On individual plots
e) symmetry	symmetrical	Asymmetrical
2. Polyadenitis	Expressed	Absent or expressed weakly
3. Leftovers primary sclerosis	Available	No
4. Prodromal phenomena	There are	Not observed

7. Tasks for final control classes:

Control final level knowledge:

1. Primary Period syphilis continues:

1 2-3 weeks

2 4-5 weeks

3 6-7 weeks

4 8-10 weeks

5 11-12 weeks

2. The varieties of papular syphilis of the palms and soles include alllisted, except:

1 follicular

2 lenticular

3 hemorrhagic

4 horny

5 wide

3. TO complications solid chancre relate All listed, except:

1 phimosis

2 paraphimosis

3 gangrenization

4 regional scleradenitis

5 erosive balanoposthitis

4. rash elements at secondary recurrent syphilis possess everyone listed properties, except:

DIFFERENTIAL DIAGNOSTICS syphilides SECONDARY PERIOD

VARIETIES syphilides	WITH WHAT DISEASE DIFFERENTIATED
Roseola: regular, edematous, scaly, confluent, punctate, circular	Pink lichen Gibera, hives, colorful (pityriasis) versicolor, toxicoderma, livedo (marble leather)
Roseola: spotted, lacy, marble	vitiligo, secondary de- And hyperpigmentation
Papules: miliary, lenticular, coin-like, weeping erosive), vegetative (wide warts), psoriasiform	Lichen planus, psoriasis, genital warts, parapsoriasis, vegetative pemphigus
Papulo-vesicular rash	Chicken pox, herpes zoster lichen, herpetiformis dermatosis Dühring
impetigo, acne-like, smallpox, ecthymoid, rupee	Impetigo strepto- and staphylogenic, ecthymavulgar, vulgar, iodine And bromine acne
Focal, diffuse, mixed	nesting baldness, fungal defeat scalp (trichophytosis, microsporia), red lupus
spotted, papular, pustular	Various forms of angina (vulgar, Vincent), aphthous stomatitis, red flat lichen.

1 paucity
2 dimming
3 major size
4 absence propensity to grouping
5. For syphilitic erythematous sore throats characteristic :
1 sharp borders erythema V pharynx
2 pronounced puffiness tonsils
3 sharp soreness
4 high temperature body
6. Secondary period syphilis comes from moment infections later:
1 2-3 months

2 4-5 months
3 6-7 months
4 8-9 months
7. TO varieties pustular syphilides relate All listed, except:
1 acneiform
2 smallpox
3 impetiginous
4 rupioid
5 corimbiform
References: 1.3.; 2.1.; 3.4.; 4.4.; 5.1.; 6.1.; 7.5.
situational tasks:

1. A 25-year-old man went to the doctor with complaints of erosion on the inner leaf foreskin about 25 days after sexual intercourse with a little-known woman. At examination V basis erosion identified painless dense infiltrate, erosion covered with whitish raid V center.

Which your supposed diagnosis?

What laboratory tests can confirm the alleged diagnosis? What need to specify For prevention diseases at others persons.

2. In the women's consultations woman an ulcer was found in areas bottom adhesions genital lips, sore rounded contours, painless.

Adjacent areas of the labia are swollen. Patient during rest 40 days ago had sexual intercourse with a man With which supports acquaintance.

Which conjectural diagnosis Can put?

What else can be found during examination and palpation of the ulcer?How can confirm diagnosis?

Which anti-epidemic Events need to execute, to warn spreading infections?

3. Sick AND. addressed To otolaryngologist With complaints on hoarseness vote. IN flow 2nd weeks was treated at him With nonspecific diagnosis laryngitis. Improvements from there was no treatment. At the same time, the patient turned to a dermatovenereologist. At inspection: on palms And soles not plentiful

small, magnitude With lentils papules reddish yellow colors, dense consistency, Not confluent Friend With friend. At talking with the patient, he was diagnosed with severe aphonia. From the epidemiological history it is known that sick single, promiscuous, oh some genital partners Maybe give necessary intelligence.

1. Put deployed clinical diagnosis.
2. Which other clinical symptoms can be at alleged diagnosis?
3. Which methods additional surveys should conduct sick?
4. WITH what diseases should be differentiated manifestations syphilis at sick?
5. Which documentation must be framed on given sick?
6. What is cause diagnostic mistakes, admitted ENT- doctor?

Reference answers:

Task 1

Syphilis primary; research on pale treponema; examination of contacts. Task 2

Syphilis primary; compaction at the base; research on pale treponema and RV; examination of contact persons.

Task 3

Syphilis is secondary; roseola, papules on the trunk; research on pale treponema and RV; psoriasis, lichen planus; outpatient card for a patient with a venereal disease, emergency notice; incomplete survey patient.

8. List recommended literature:

Main:

- Educational allowance Dermal And venereal illness. Under editorial Yu.K. Skripkin. Moscow, Triad - X - 2000 - 657s.
- Educational allowance Dermal And venereal illness. Under edited by O.L. Ivanov. M.: Shiko, 2006 - 480s.

dditional:

- Skin and venereal diseases. Guide for doctors, in 2 volumes. Edited by Yu.K. Skripkin. Moscow, Medicine. - 2004.

- Clinical and morphological diagnostics And principles treatment skin diseases. Management For doctors. - M.: JSC "Publishing house "Medicine", 2006.- 512 With.

- Clinical recommendations. Dermatovenereology. Under editorial A.A. Kubanova. - M.:

GEOTAR-Media, 2006. – 320 With.

- Atlas "Dermal And venereal disease" under ed. V.V.Vladimirova.- M..1986.

THEME OF THE LESSON NUMBER 6: "SYPHILIS TERTIARY, CONGENITAL, LATENT ACQUIRED. PECULIARITIESCLINICS ACQUIRED SYPHILIS AT CHILDREN. TREATMENT AND PREVENTION CONGENITAL SYPHILIS."

1. Motivation Topics: Studying syphilis, being infectious venereal disease, necessary V connections With prevalence this infection, serious danger For health human, negative action on offspring. At untimely recognition, the spread of the disease occurs, and the chronic course infections leads To defeat all bodies And systems organism. That's why knowledge manifestations syphilis important For doctors all specialties.

2. Target: Explore etiology, pathogenesis, peculiarities clinical currents tertiary And congenital syphilis, methods diagnostics, conduct differential diagnosis.

Student must know:

- Definition syphilis
- etiology And pathogenesis of tertiary And congenital syphilis
- Clinical manifestations tertiary And congenital syphilis
- Methods diagnostics tertiary And congenital syphilis
- differential diagnostics tertiary And congenital syphilis
- Methods prevention tertiary And congenital syphilis

Student must be able to:

- Right collect anamnesis And put diagnosis diseases
- Conduct laboratory diagnostics tertiary And congenital syphilis
- Conduct differential diagnosis
- Compose tactical scheme patient management

Facilities necessary For holding classes:

- tables And visual allowances:
- dummies By topic: "Syphilis tertiary, congenital"
- Atlas "Dermal And venereal disease" under ed. V.V.Vladimirova.- M. 1986 2000.
- Related slides: "Syphilis tertiary, congenital"

- Clinical tasks on this topic: "Syphilis tertiary, congenital"
- Sick syphilis
- Kit tools For holding classes

Basic knowledge:

- Chapter By histomorphology syphilis

Clinical and morphological diagnostics And principles treatment skin diseases. Management For doctors. - M.: JSC "Publishing house "Medicine", 2006.- 512 With.

- Chapter By diagnostics morphological elements syphilis

Skin and venereal diseases. Guide for doctors, in 2 volumes. Edited by Yu.K.Skripkin. Moscow, Medicine. - 2004.

- Chapter By classification of psoriasis syphilis

Dermal And venereal illness. Under edited by O.L. Ivanov. M.: Shiko, 2006 - 480s.

- Principles Section therapy syphilis

Clinical recommendations. Dermatovenereology. Under editorial A.A. Kubanova. - M.:GEOTAR-Media, 2006. - 320 With.

3. Tasks For self-training:

Fill table By main provisions Topics, using educational allowance under edited by Yu.K. Skripkin. Moscow, Medicine. – 2004 p. or edited by O.L. Ivanov. M.: Shiko, 2006 - With. 197-208.

Main provisions Topics	Their characteristic
Pathogenesis development tertiary And congenital syphilis	Filled instudent
Main complaints patients at tertiary And congenital syphilis	
Classification tertiary And congenital syphilis	
Diagnostic methods tertiary And congenital syphilis	
Medical methods treatment tertiary And congenital syphilis	
Forecast of patients With tertiary And congenital syphilis	

Control questions:

1. Conditions and timing occurrence tertiary syphilis.
2. Classification tertiary syphilis.
3. Clinic tertiary period syphilis. Tubercular syphilis. gummy syphilis.
4. Methods diagnostics. Prevention tertiary syphilis.
5. Conditions and terms of occurrence of congenital syphilis. Classification of congenital syphilis.
6. Clinic congenital period syphilis. Syphilis fetus. Early congenital syphilis.
7. Late congenital syphilis. Diagnostic methods. Prevention of congenital syphilis.
8. laboratory diagnostics syphilis

5. Content practical classes:

8.00 - 8.05 Examination present.

8.05 - 8.30 Control initial level knowledge students. test control.

8.30 - 8.50 Independent curation of patients under control teacher.

8.50 - 9.00 Break.

9.00 - 9.50 Clinical analysis sick With teacher.

9.50 - 10.05 Break.

10.05 – 10.55 Clinical analysis of patients with a teacher. Solution of situational clinical tasks. Show slides, pictures, tables, photos, multimedia accompaniment.

10.55 - 11.05 Break.

11.05 - 11.15 Control final level knowledge. Answers on questions.

11.15– 11.20 Instruction O content And methodology training next classes.

6. Block information By topic classes:

Tertiary syphilis

Tertiary period syphilis develops at small numbers sick, which Not were treated or undertreated for early forms of the disease. Syphilis

tertiary in the "classic" course of a syphilitic infection, it develops after a secondary period, later 3-4 of the year after infections.

The tertiary period of syphilis is divided into tertiary active syphilis and syphilis tertiary hidden (latent). Defeats V this period appear tubercles And gums. Tertiary syphilides appear in a small amount (tubercles - dozens, gummas are often single), proceed with the destruction of tissues, always leave behind scars. Without treatment heal Very slowly, low contagious, Fine lend themselves antisyphilitic treatment.

Tubercular syphilis. Tubercular syphilide is more often located in a small area skin, How rule asymmetrically. tubercle It has value With cherry bone, hemispherical or flat shape, copper red color, clear borders, dense consistency. Regression of tuberculous syphilides can occur either in the so-called dry way, and then in their place remains a slightly hyperpigmented cicatricial atrophy. Or tubercular syphilides necrotizing With education ulcers rounded forms With clear borders, even, sheer, dense edges. Ulcers have different depths, their bottom uneven, covered necrotic by the masses dirty-purulent or greenish gray colors. After healing of ulcers, slightly retracted, focally located, grouped scarring, surrounded pigmented border. Because of different depths ulcerative defects formed "mosaic" scarring.

Hummous syphilis. Gummy syphilis is a node located in subcutaneous adipose tissue, the size of a walnut, of a densely elastic consistency with sharp borders, limited mobile. Leather above him at first Not changed V further acquires brownish red or Dark red color. Subsequently softening and disintegration of gumma are noted with the formation of a deep ulcer, the bottom of which is covered leftovers decaying infiltrate ("gummy kernel"). Ulcer It has roundedoutlines, deep bottom and very characteristic roll-like thick, densely elastic bluish-red edges rising above the level of the skin. Gradually the ulcer scars, leaving a retracted in the center, star-shaped scar with a zone of hyperpigmentation along the periphery. gummas usually solitary, but several gummas of different localization may appear. Distinguish the

following forms gummy syphilis: isolated gummas, gummy infiltrates, fibrotic gummas (periarticular nodularity).

gummy infiltrates arise on one's own or V result mergers several gumm. This foci With sharp limited edges And staging development, inherent solitary gumme.

Fibrous gummas or periarticular nodularity formed V result fibrous rebirth syphilitic gumm.

VARIETIES TERTIARY syphilides

Tubercular syphilides	gummy syphilides
scattered	isolated gummas
grouped	gummy infiltrates
IN form spilled infiltrate	fibrotic gummas (periarticular nodularity)
Dwarf	

Congenital syphilis

Congenital syphilis — This infectious disease, infection which occurs in utero from a sick mother, and the manifestation of the disease can occur as fetus, and in children from infancy to adulthood. Infection occurs through the placenta mother with syphilis. A sick mother can infect the fetus, starting from 10 weeks pregnancy, but usually intrauterine infection occurs at 4-5 months of pregnancy. placenta at syphilitic infections increased hypertrophied. Its mass is 1/4 - 1/3 (V norm 1/5-1/6) masses fetus.

IN dependencies from clinical signs, features currents And timing manifestations congenital syphilis subdivided on syphilis fetus, early congenital syphilis (from birth of a child under 4 years of age), late congenital syphilis (in children over 4 years of age), hidden congenital syphilis.

According to ICD-10, early congenital syphilis is diagnosed in children before 2 years old late — at children 2 years And older.

Syphilis fetus. IN connections With defeat placenta violated nutrition fetus, metabolism becomes more difficult, intrauterine death and fetal rejection may occur. miscarriages more often happen between

6 And 7 (less often 4-5) lunar months intrauterine development. Penetration pale treponem V fetus going on By type treponemal septicemia And Maybe be accompanied heavy defeats domestic organs. Among visceral bodies more often suffer liver, spleen, lungs, endocrine gland, central nervous system.

Early congenital syphilis. Early congenital syphilis may first present as breastfeeding (before 12 months), So And V early children's (from of the year before 4 years) age.

Congenital syphilis of infancy. Congenital syphilis of infancy manifests itself more often With moment birth V first 2 month, or V age 2-4 months. At this are celebrated diverse defeat skin, mucous shells, domestic bodies, bone and nervous systems. Clinical symptoms: *diffuse papular infiltration Gochsinger* ; with *iphilitic pemphigus* ; papular *rash; patchy rash; specific bone lesion systems.*

Syphilis early children's age (from 1 of the year up to 4 years).

This period congenital syphilis is different weakly pronounced clinical signs. More often Total meets large papular rash, located on genital bodies, buttocks, limbs, less often on face. Rarely meets pustular syphilis, predominantly in malnourished children with weakened immune systems. In some patients on skin may form single gummy nodes. Bone system V this age it is affected in the form of limited periostitis and osteoperiostitis with osteosclerosis phenomena predominantly long tubular bones, detectable usually only radiographically.

In many children aged 1 to 4 years, congenital syphilis occurs latently, without any or clinical symptoms And diagnosed only on basis positive serological reactions blood.

Late congenital syphilis

Late congenital syphilis is diagnosed in children aged 4-15 years and older. Downstream, late congenital syphilis resembles tertiary syphilis, since in patients there are gummas or gummous infiltrations of the skin and mucous membranes, bones and joints, internal organs, nervous system. In late congenital syphilis may be affected vessels head

And dorsal brain. signs late congenital syphilis share V depending on the degree of specificity on reliable or unconditional; relative or probable (observed more often at late congenital syphilis But meet And at other diseases), and dystrophy (may be the result of both congenital syphilis and others diseases).

TO unconditional or credible, refer *triad Getchinson:* parenchymal keratitis,syphilitic labyrinthitis, teeth Getchinson.

Probable signs have less diagnostic value and require additional confirmation, evaluated V aggregates With others manifestations. TO him relate: saber shins, syphilitic chorioretinitis, persecutors, scarring Robinson-Fournier, buttock-shaped skull, nose deformities (saddle-shaped, lornet-shaped, "goat" nose) and some dystrophy teeth.

Among dystrophy at late congenital syphilis greatest meaning have the following: symptom ausitidia - thickening sternal end clavicle (more often is affected right collarbone); high ("lancet" or "Gothic") solid sky; infantile little finger (symptom dubois - Hissar); axiphoidia Keira - absence xiphoid offshoot sternum; observed dental dystrophy: tubercle Carabelli And diastema Gachet. Wide spaced upper incisors (diastema Gaucher) meets And at healthy, But Also wears dystrophic character.

CLASSIFICATION INGENITAL SYPHILIS

<table>
<tr><th colspan="2">Early congenital</th><th>Late congenital</th></tr>
<tr><td>At children first of the year life</td><td>At children early age (1-5 years)</td><td rowspan="2">Triad Getchinson:
1. Change teeth;
2. Parenchymalkeratitis
3. Defeat labyrinth (deafness)</td></tr>
<tr><td>1. Diffuse infiltrate</td><td>1. Papular syphilides skin And mucous</td></tr>
<tr><td>2. syphilitic pemphigus</td><td>2. Increase lymphatic nodes</td><td></td></tr>
<tr><td>3. Syphilitic rhinitis</td><td>3. Defeat bone systems (periostitis)</td><td>4. Saber shins, saber forearms</td></tr>
<tr><td>4. Osteochondritis (pseudoparalysis Parro)</td><td>4. Defeat internalbodies (liver, spleen)</td><td>5. Syphilitic chronic persecutors</td></tr>
<tr><td rowspan="2">5. Defeat domestic organs (liver,spleen)</td><td rowspan="2"></td><td>6. saddle nose</td></tr>
<tr><td>7. Radial scarring around the mouth</td></tr>
</table>

There are also dystrophies of the bones of the skull - protruding frontal and parietal tubercles, but without dividing strip; Tarnovsky's hypertrichosis (overgrowth of forehead hair almost to eyebrows).

DIFFERENTIAL DIAGNOSIS OF EPIDEMIC ANDsyphilitic vesicle NEWBORN

sign	epidemic pemphigus	syphilitic pemphigus newborns
Time appearance bubbles	5-7 days With moment birth	Is born With bubbles or appear V 1 week
Tire	flabby, wrinkled	dense
Content	Purulent	serous, hemorrhagic
Inflammatory phenomena surrounding fabrics	pronounced	Not expressed
Typical localization	Everywhere (except palms And soles)	palms, soles, flexion surfaces limbs, face
visceropathy	+	-
Serological reactions blood	Negative	Positive
contagiousness	High	At close contact
Survey mothers	Seroreaction " - » Healthy	Seroreaction " + »

Prevention congenital syphilis

For prevention sun recommended 2x serological survey pregnant women: in the first half of pregnancy (when registered) and in the second half (on 6-7 month, But Not later design maternity leave holidays). At unfavorable epidemiological environment decision bodies health care Maybe be introduced triple serological examination for syphilis, which is carried out directly before childbirth. At positive results DAC held survey With help

RIF, RIBT and other specific reactions. If these tests are negative pregnant must be on clinical and serological control With monthly examination before childbirth And V flow 3 months after them.

At identifying at pregnant women early stages syphilis treatment held By relevant schemes treatment. At establishing at pregnant late or unspecified syphilis treatment held By methodology No. 2.

Preventive treatment pregnant.

Prophylactic treatment is indicated for women treated before pregnancy which by the beginning of pregnancy there was no complete negativity of the CSR, as well as all women started treatment in time pregnancy, regardless from her term.

Prophylactic treatment is usually carried out from the 20th week of pregnancy, but late begun specific treatment - directly after behind him.

Preventive treatment children.

At the birth of a child without manifestations of syphilis from an untreated mother, with late onset specific treatment of the mother (from the 32nd week of pregnancy), in the absence of negative CSR (MR) by the time of delivery or seroresistance in the mother is carried out prophylactic child treatment.

Preventive treatment of a child born to an untreated mother with syphilis - is carried out according to any from methods, destined For treatment congenital syphilis.

Preventive treatment of a child due to insufficient treatment of the mother, lack of she has negative CSR (MR) by the time of delivery or seroresistant is carried out according to relevant methodology.

CHARACTER OF CLINICAL AND SEROLOGICAL REACTIONS IN SYPHILIS. MODERN LABORATORY DIAGNOSTICS SYPHILIS

Antibody formation at syphilis. Dynamics education antibodies V body patients with syphilis has been most fully studied in recent years. It was found that already on the second week after infections

produced treponema-specific antibodies class IgM, the largest number of which falls on the 6-9th week of the disease. It is noteworthy that specific IgM ceases to be produced when the antigen disappears from the body, except In addition, large IgM molecules do not pass through the placenta from mother to fetus, and therefore availability these antibodies at child judge about his infection pale treponema.

Treponemospecific IgG appear V end 4 weeks after infections All V higher concentration, at 6 weeks they begin to prevail over IgM. This species immunoglobulins V greatest quantity determined through 1-2 of the year after infections. Is big interest dynamics these antibodies after treatment syphilis. If specific IgM V process therapy And after her graduation produced All less And V flow 6 - 12 months stop be determined That level IgG Maybe hold on on enough high level many years, What due, By opinion row authors, their synthesis clones

memory cells.

Serological reactions at syphilis. Serodiagnostics applied For confirmation clinical diagnosis syphilis, productions diagnosis hidden syphilis, control behind efficiency treatment, How one from criteria cured sick syphilis For prevention syphilis (survey certain groups population). Serological reactions allow reveal immune shifts V body sick V answer for implementation V organism pale treponema.

1. Reaction binding complement (RSK) - reaction Wasserman.

RSK put With two antigens: cardiolipin (actually reaction Wasserman) And treponemal antigen, made from non-pathogenic cultural treponem.

Essence RSC: For binding antigen (AG) With antibodies (AT) - reagins, serum blood, needed complement. This compound - AG + AT + complement - Not determined

visual examination of the patient's serum. To determine whether the formation of this complex (linked whether complement), applied

hemolytic system (GS). HS - This erythrocytes sheep + hemolytic serum. But hemolysis Maybe happen only at availability complement.

If in the first phase of the reaction (AH + serum + complement) a binding reaction occurred complement with reagins and cardiolipin antigen, then on the HS added to the first phase complement Not enough, hemolysis Not will come All erythrocytes ram settle down on bottom test tubes And test subject serum will remain colorless And transparent.

If V test subject serum reagins Not was, That happen binding complement HS - will come hemolysis And serum will be colored V red color.

Grade results (quantitative staging):

Strongly positive 4+ (no hemolysis) Positive 3+

Weakly positive 2+

Doubtful 1+

Negative - (complete hemolysis occurred). Evaluation of results (quantitative method)

If at ordinary staging serum blood sick getting divorced physiological solution by 5 times, then with a quantitative setting of 10, 40, 80, 160 and 320 times. The more reagins is contained in the blood serum, the more you can dilute the serum so that it continued give positive result.

<u>Clinical interpretation RSC results</u>

IN primary period syphilis (WITH) titer reagins gradually is growing And becomes highest soon after mass hematogenous dissemination pale treponem, those. to secondary fresh syphilis. During this period, the reagin titer is 1:160, 1:320 and even higher. Then the titer of reagins begins to decrease and in secondary recurrent C usually does not exceed 1:80. With an early latent titer of reagins, it is also low - 1:40 - 1:80. With late, tertiary, WITH titer reagins Also It happens low.

Under the influence of successful therapy, the titer of reagins decreases and CSR becomes negative. If during therapy the titer of reagins decreased by 4 times or more, then This regarded as positive result therapy. Persistent preservation positive DAC (serous resistance) connected With genetically deterministic high level humoral immune response, which persists even after the destruction of pale treponema in body. false positive results - titer 1:5 - 1:20 or at quality staging - 2+ or 3+.

Precipitation microreaction with cardiolipin antigen (MP, RPR, VDRL, USR, ART And etc.). RPR- With plasma blood; VDRL - With inactivated serum blood; USR-s active blood serum; ART - automated reagin test. Degree of positivity microreactions precipitation evaluate Also How reaction Wasserman: "4+" (sharp positive), "3+" (positive) "+" or "1+" (weakly positive), + -» (doubtful) "-" (negative).

Reaction immobilization pale treponem (RIBT, RIT, TPI - Treponema pallidum immunobilization).

Reveals Availability V serum blood sick syphilis species-specific antitreponemal antibodies. It becomes positive after a few months infection and, therefore, unsuitable for the diagnosis of primary and secondary fresh C. To establish a reaction, it is necessary to have a constantly standard suspension of live pathogens. treponem. Weekly rabbits, contained V vivarium, instill tissue strain pale treponem. suspension treponem serves antigen, A V serum blood sick the presence of antitreponemal antibodies that stop the movement of pathogens is determined - immobilizins. After incubation mixtures test subject serum blood With complement And suspension pale treponem under microscope counted percent pathogens stopped movement.

Reaction results:

+ immobilization of more than 51% of pale treponemas weakly positive 31-50% of pale treponemas dubious 21-30%

negative 20% And less.

It is forbidden research on RIBT blood sick, receiving antibiotics, because the recent suppress development BT. After introductions benzylpenicillin blood Can to investigate not earlier than after 5 days, with the introduction of penicillin durants (bicillins), sumamed and others slowly emerging from organism drugs - Not before 2 weeks.

Indications To appointment productions RIBT:

1. Suspicion on late visceral And nervous forms WITH, A DAC - negative.
2. For confirmation diagnosis hidden (latent) WITH at positive KSR.
3. At availability assumptions O false positive reaction Wasserman.
4. When available discrepancy between positive DAC And negative REEF (by immunofluorescence reaction) or vice versa (negative DAC And positive REEF).

Advantages and disadvantages of the reaction: lasts a long time (years). Relatively fast RIBT negatively only at primary And secondary fresh WITH. Persistent negativity RIBT

- weighty proof cure WITH.

Reaction immunofluorescence (REEF, FTA- test-Fluorescent treponemal antibody test). Sensitive - becomes positive in the primary stage even earlier than the CSR, in 100% can be positive in secondary and late untreated C. RIF refers to group treponemal reactions that detect antibodies not only against pale treponema, but also others types treponem. Reaction RIF-abs, at which With help absorption group antitreponemal antibodies RIF becomes species-specific, i.e. antibodies are determined only To BT. REEF founded on indirect method luminescent serodiagnosis. For research are used labeled fluorochrome serum blood rabbits, immunized against globulins person. For productions REEF suspension alive virulent pale treponem applied on subject glass And fixed To him acetone. Then the tested

blood serum (or cerebrospinal fluid) is poured onto this glass. liquid). If it contains anti-treponemal antibodies, then they are firmly attached to BT, fixed To subject glass. A drug washed out water, excess antibodies washes off remain only antitreponemal antibodies on themselves BT. Further on This subject glass applied labeled fluorochrome serum against gamma globulins person. These antibodies are attached by immune bonds to anti-treponemal antibodies, enveloping BT. After repeated flushing water, removing excess labeled fluorochrome antibodies,

the preparation is viewed under a fluorescent microscope, where brightly glowing yellow- greenish BT on dark background.

If there are no antitreponemal antibodies in the test serum, then poured onto the subject glass labeled fluorochrome serum will washed away water, a BT Not will shine V luminescent microscope.

The reaction is evaluated according to the degree of brightness of the BT glow: 4+, 3+, 2+. Since the caption antitreponemal antibodies great, That researched serum is diluted physiological solution 10 times (RIF-10) or 200 times (RIF-200). RIF-10 is very sensitive, but gives false positive results, RIF-200 is less sensitive, but the number of non-specific results Not exceeds 0.3%.

RIF-abs By sensitivity And specificity close To RIBT, For her productions Not required fresh antigen And reaction put With killed treponemes.

To detect treponema-specific IgM antibodies, the IgM-RIF-Abs., which founded on use in second phase conjugate anti-IgM, instead of anti-human fluorescent globulin. This reaction is of particular value. to determine the activity of the process, to detect recurrence of the disease and reinfection against the background positive reactions after treatment, diagnosis of early congenital syphilis, as well as For recognition false positive results others serological reactions.

Reaction passive hemagglutination (RPGA; TPHA - Treponema pallidum haeagglutination test). TPHA refers to treponemal tests for syphilis. It is aimed at detection of specific antitreponemal antibodies in serum and plasma. Principle reactions is V volume, What at connection erythrocytes, bearing antigens pale treponema, with specific antibodies in the blood serum of a patient with syphilis occurs hemagglutination phenomenon. The results of the reaction are evaluated from 1+ - negative, to 4+ - positive.

ELISA analysis (IFA, ELISA- enzymelinked immunosorbent assay). IN In recent years, a diagnostic test has been used to detect specific antibodies - ELISA on surfaces solid phase carrier. Principle method ELISA is V binding of the antigen-antibody complex with a conjugate labeled with an enzyme detected with help substrate mixtures.

Specificity test ELISA is 94.7% at specificity RIF-abs 98.1%. Sensitivity test at sick, giving positive RIF-abs, at primary And secondary syphilis is 100%, at latent syphilis 84.6- 96.4%.

Peculiarities serological reactions at syphilis at newborns.

1. At children have congenital immune deficiency systems - first 10 days after birth blood For serological study take Not recommended.

2. At newborns may circulate transplacental penetrated AT mothers - cause false positive reactions on syphilis at newborn. Are being destroyed maternal antibodies To 3-4 month life child.

3. In cases where, after 3-6 months of life, RIBT and RIF remain positive, this means that in the child's body there are foci of immune irritation, where pale treponema, the child is sick with early congenital C, and his body itself produces AT.

4. Immunoglobulins, produced V primary phase syphilitic infections - Ig

M. Only later do they begin to produce Ig G. If the mother had only the beginning syphilitic infections, then her AT, owned

to class Ig M will also fall V the body of a newborn. You can distinguish them next way: Ig M With coefficient sedimentation 198, discovered at newborn With using the RIF-abs reaction, they are actively produced in the body of the fetus and newborn, Then How Ig M With coefficient sedimentation 7 may pass transplacental from sick mother. In addition, antibodies come from a sick or previously ill C mother, owned To class Ig G.

7. Tasks for final control classes:

Control final level knowledge:

1. Tertiary syphilis Maybe appear:

A. tubercles
B. Mosaic scars
C. gummi
D. stellate scars
E. All listed right

2. syphilitic tubercle is:

A. infectious granuloma
B. papular benign neoplasm
C. edema papillary layer dermis
D. Specific vasculitis
E. none of listed

3. syphilitic gumma is:

A. Non-inflammatory node
B. edema papillary layer dermis
C. infectious granuloma
D. papular benign neoplasm
E. All listed right

4. Exodus grouped tubercular syphilis is:

A. Hypopigmentation
B. Smooth scar
C. Mosaic scar
D. Keloid scar

E. hyperpigmentation

5. infection fetus pale treponemes happens:

A. On 1m month pregnancy

B. On 2nd month pregnancy

C. On 3m month pregnancy

D. On 5th month pregnancy

E. On 9th month pregnancy

6. At congenital syphilis observed:

A. Specific panvasculitis placenta

B. Mandatory defeat liver fetus

C. Penetration treponem V organism fetus through umbilical vein

D. Penetration of treponema into the fetal body through the lymphatic vessels umbilical cord

E. All listed right

7. Signs of early congenital syphilis at chest children are:

A. Pemphigus

B. Rhinitis

C. Infiltration Gochsinger

D. Osteochondritis

E. All listed right

8. diffuse infiltration Gochsinger formed from:

A. Roseol

B. papules

C. Pustule

D. Bugorkov

E. Gumm

Reference answers : 1-E; 2-A 3 –C; 4 –C; 5-D; 6- E; 7- E; 8- b.

8. List recommended literature:

Main:

- Educational allowance Dermal And venereal illness. Under editorial Yu.K. Skripkin. Moscow, Triad - X - 2000 - 657s.

- Educational allowance Dermal And venereal illness. Under editorial O.L. Ivanova. M.: Shiko, 2006 - 480s.

Additional:

- Skin and venereal diseases. Guide for doctors, in 2 volumes. Edited by Yu.K. Skripkin. Moscow, Medicine. - 2004.

- Clinical and morphological diagnostics And principles treatment skin diseases. Management For doctors. - M.: JSC "Publishing house "Medicine", 2006.- 512 With.

- Clinical recommendations. Dermatovenereology. Under editorial A.A. Kubanova. - M.:GEOTAR-Media, 2006. - 320 With.

SUBJECT CLASS NUMBER 7: "GONORRHEA TEENAGERS (BOYS). VULVOVAGINITIS GIRLS.TREATMENT AND PREVENTION GONORRHEA AT CHILDREN."

1. Motivation Topics: Gonorrhea, non-gonococcal urethritis - most common inflammatory diseases urethra. Clinical manifestations gonorrhea And non-gonococcal urethritis are frequent cause impotence And infertility at men And women. The manifestation of these diseases on the skin is similar to many other pathological conditions. states And practicing doctor any specialties must confidently diagnose

gonorrhea adolescents (boys), vulvovaginitis girls from other venereal diseases, A also be able on one's own pick up rational therapy.

2. Purpose: To study the etiology, pathogenesis, features of the clinical course, differential diagnostics, principles treatment And prevention gonorrhea teenagers (boys) And vulvovaginitis girls.

3. Tasks classes:

Student must know :

- Definition gonorrhea And non-gonococcal urethritis.
- etiology, pathogenesis, classification gonorrhea And non-gonococcal urethritis.
- Clinical manifestations of gonorrhea And non-gonococcal urethritis teenagers (boys) And vulvovaginitis girls.
- Basics diagnostics gonorrhea And non-gonococcal urethritis teenagers (boys) And vulvovaginitis girls.
- Principles treatment And prevention gonorrhea And non-gonococcal urethritis teenagers (boys) And vulvovaginitis girls.

Student must be able to :

- Collect anamnesis at sick With gonorrhea And non-gonococcal urethritis.
- Put diagnosis diseases With taking into account stage, flow, gravity at sick With gonorrhea And non-gonococcal urethritis teenagers (boys) And vulvovaginitis girls.

- Make a final differential diagnosis of a patient with gonorrhea andnon-gonococcal urethritis teenagers (boys) And vulvovaginitis girls.
- Compose plan treatment sick With gonorrhea And non-gonococcal adolescent urethritis (boys) And vulvovaginitis girls.
- write out recipes major medicinal forms

Facilities necessary For holding classes:

- tables And visual allowances:
- dummies By topic:
- Atlas "Dermal And venereal disease" under ed. V.V.Vladimirova.- M. 1986 2000.
- Slides on this topic: "Gonorrhea, non-gonococcal urethritis"
- Clinical tasks By topic: "Gonorrhea, non-gonococcal urethritis"
- Sick gonorrhea, non-gonorheal urethritis
- Kit tools For holding classes

Basic knowledge:

- Chapter By histomorphology gonorrhea And non-gonococcal urethritis

Clinical and morphological diagnostics And principles treatment skin diseases. Management For doctors. - M.: JSC "Publishing house "Medicine", 2006.- 512 With.

- Chapter By classification gonorrhea And non-gonococcal urethritis

Dermal And venereal illness. Under edited by O.L. Ivanov. M.: Shiko, 2006 - 480s.

- Chapter By principles therapy gonorrhea And non-gonococcal urethritis

Clinical recommendations. Dermatovenereology. Under editorial A.A. Kubanova. - M.:GEOTAR-Media, 2006. - 320 With.

4. Tasks For self-training:

Fill table By main provisions Topics, using educational allowance under edited by Yu.K. Skripkin. Moscow, Medicine. – 2004 p. or edited by O.L. Ivanov. M.: Shiko, 2006 - With. 197-208. Control questions :

1. Etiology gonorrhea. Ways infections. Classification gonorrhea.

2. Clinic And diagnostics gonorrhea at men, gonorrhea teenagers (boys). Complications gonorrhea at men, gonorrhea teenagers (boys)

3. Clinic And diagnostics gonorrhea at women. Complications gonorrhea at women.

4. Peculiarities currents gonorrhea at girls. Treatment And prevention gonorrhea.

Main provisions Topics	Their characteristic
The pathogenesis of the development of gonorrhea and non-gonococcaladolescent urethritis (boys) And vulvovaginitis girls.	Filled instudent
The main complaints of patients with gonorrhea and non-gonococcal urethritis of adolescents (boys) andvulvovaginitis girls.	
Classification of gonorrhea and non-gonorrheaadolescent urethritis (boys) And vulvovaginitis girls.	
Methods for diagnosing gonorrhea and non-gonococcal adolescent urethritis (boys) And vulvovaginitis girls.	
Medical treatments for gonorrhea and non-gonococcal urethritis of adolescents (boys)And vulvovaginitis girls.	
Prognosis of patients with gonorrhea and non-gonorrheal urethritis of adolescents (boys) and vulvovaginitis girls.	

5. Clinic And diagnostics trichomoniasis. Complications. Modern treatment methods.

6. Clinic And diagnostics chlamydia. Complications. Modern methods treatment.

7. Clinic and diagnostics ureaplasmosis. Complications. Modern methods treatment.

8. Clinic And diagnostics urogenital candidiasis. Complications.

9. Modern methods treatment.

10. Clinic and diagnosis of herpetic and cytomegalovirus infection genital organs. Complications. Modern methods treatment.

5. <u>Content practical classes:</u>

8.00 - 8.05 Examination present.

8.05 - 8.30 Control initial level knowledge students. test control.

8.30 - 8.50 Independent curation of patients under control teacher.

8.50 - 9.00 Break.

9.00 - 9.50 Clinical analysis sick With teacher.

9.50 - 10.05 Break.

10.05 – 10.55 Clinical analysis of patients with a teacher. Solution of situational clinical tasks. Show slides, pictures, tables, photos, multimediaaccompaniment.

10.55 - 11.05 Break.

11.05 - 11.15 Control final level knowledge. Answers on questions.

11.15– 11.20 Instruction O content And methodology training next classes.

6. <u>Block information By topic classes:</u>

GRADE 2-GLASS SAMPLE

A PORTION URINE	PLACE INFLAMMATION		SUSPECTIVE DIAGNOSIS
1 Diffuse cloudy	2 transparent, clean	anterior urethra	Spicy front urethritis
Slightly muddy	transparent, clean	anterior urethra	Subacute anterior urethritis
transparent, with heavy threads, settling to the bottom	transparent,clean	anterior urethra	Chronic anterior urethritis
Diffuse cloudy	Diffuse-muddy	Whole urethrany channel	Total acute urethritis Urato-phosphate-oxalato-bacteriuria
transparent, With threads V form commas	transparent, with threads in the form commas	anterior urethra Prostate	
opalescent	opalescent	Prostate	Prostate

TAKE MATERIAL FOR MICROSCOPIES NATIVE DRUGS

For microscopy wet native drugs used detachable vagina at women. In men, direct microscopy of wet smears is performed in the

presence of abundant secretions from urethra with research free detachable or flush.

Vaginal sample For cooking wet (native) smear is taken V mirrors bacteriological loop with a volume of 10 µl from a specific anatomical site (posterior or side vault). Material from the urethra is taken with a 1 µl bacteriological loop. From prepuce bag material is taken cotton/dacron swab.

A drop of warm saline is placed on a glass slide (optimally 37°C). WITH). Vaginal or urethral allocation mixed up With drop physiological solution, covered with a coverslip and immediately viewed using light microscope. If the doctor does not know the method of direct microscopy, the allocation of room chasing V test tube With warm physiological solution And immediately sent V laboratory For microscopic research.

COLLECTION OF MATERIAL FOR MICROSCOPY OF STAINED PREPARATIONSTAKE CLINICAL MATERIAL At MEN

Sampled from the urethra for Gram or methylene blue staining is taken using bacteriological loops volume 1 µl. At men at availability secretions from urethra the surface of the head and the area of the external opening of the urethra should be cleaned with gauze swab and foreskin pulled back to prevent contamination. At absence free secretions necessary ask patient came down ka massage

urethra with sliding movements from the base of the penis to its head. In this case, there may be Volkmann's spoon or cotton/dacron swab was used to take the material. After the introduction of a plastic loop into the urethra by 1-2 cm, it is necessary to move the “eye” plane of the loop to the opening, slightly pressing on the walls of the urethra. It is not recommended to rotate the loop during procedures taking figurative. For patient This painful. After receiving clinical material, the loop is superimposed on the surface of the glass and moves along it several times with easy pressing. A loop must leave on glass thin stripe clinical material.

Sample from prepuce bag is taken cotton/dacron swab.

TAKE CLINICAL MATERIAL At WOMEN

A urethral specimen for Gram or methylene blue staining is taken with bacteriological loops volume 1 µl. At availability big quantity secretions the outer opening should be cleaned with a gauze swab. With absence free secretions Maybe be held easy massage urethra, performed doctor. After the introduction of the plastic loop into the urethra by 1-2 cm, the plane of the "eye" of the loop is necessary move to the opening, slightly pressing on the back and side walls of the urethra. Not recommended rotate the loop procedure time taking a sample. For female patients This painful. After receiving clinical material a loop superimposed on surface glass And moves over it several times with light pressure. The loop must leave on the glass thin stripe clinical material.

Sample from cervical channel For cooking painted drugs is taken V mirrors cotton/dacron swab, special with a brush or spoon Volkman. Necessary thoroughly clear external hole cervical channel at help big gauze swab from vaginal secretions For prevention possible contamination. After the introduction of a tampon into the cervical canal, it is 1-2 cm spin a few once. Clinical material must be rescheduled With swab on glass How Can morethin layer.

For microscopic studies of stained vaginal swabs material is taken V mirrors from the rear or side arches with a bacteriological loop of 10 µl or a Fol- kmana and thin layer distributed on the subject glass.

TREATMENT GONORRHEA At FLY

Children with gonorrhea should be treated in a hospital setting. Main antibiotic is benzylpenicillin. IN case unsuccessful treatment benzyl penicillin appoint another antibiotic. In children older 3 years, patients with chronic gonorrhea, apply go-novacine (initial dose 50-100 million microbial tel) With subsequent appointment antibiotics. children before 3 years immunotherapy is not held.

Local treatment carry out V those cases, When gonococcus disappeared But sluggish inflammatory phenomena after provocations more remain.

In persistent cases of vaginitis, vaginoscopy is recommended, followed by local treatment in compliance With discovered changes.

LOCAL TREATMENT GONORRHEA At GIRLS AFTER ANTIBIOTIC THERAPIES

fresh gonorrhea, vulvovaginitis. Warm sitz baths for 10-15 minutes 2-3 times V a day from a decoction of chamomile or a solution of potassium permanganate 1: 10,000. After external baths sexual organs dry. Foci irritation lubricate pasta Lassar. At eczematous skin lesions - lotions from 3% drilling fluid. Lubrication with 4% water solution methidene blue.

Fresh gonorrhea, urethritis. Treatment such same, How And at vulvovaginitis. IN hollow stages: instillation with an eye dropper 3-4 drops of a 0.5-1% solution of protargol, 1-2% - foot solution collargola (alternate).

DIFFERENTIAL DIAGNOSTICS BACTERIAL VAGINOSIS AND UROGENITAL DISEASES, CONDITIONED PATHOGENIC AND CONDITIONALLY PATHOGENIC MICROORGANISMS

Options	Bacterial vaginosis	Gonococcal infection	Chlamydial infection	Urogenitalth trichomoniasis	Urogenital candidiasis
Clinical manifestations:					
discharge fromvagina	homogeneous whitish gray, with unpleasant smell	Purulent-mucous or purulent without smell	Mucous - purulent without smell	Grey-yellow, foamy, with non-clear smell	thick white curdled, Sometimes creamy, with sour

					smell
hyperemia mucous shells	Rarely	Often	Advantage-vein of the neck uterus	Often	Often
itching/burning	Rarely	Often	Rarely	Often	Often
dysuria	Rarely	Often	Often	Often	Rarely
dyspareunia	Rarely	Often	Often	Often	Rarely
Microscopy smears (U, WITH, v)	Keycells	Gram negativeflax diplococci with typical morphologica lkimi properties	For verification diagnosis is notheld	PresenceT. vaginalis in clinical material	
Culturallye study	predominance G. vaginalis Andobligate anaerobic species	N. gonorrhoeae	WITH. trachomatis	T. vaginalis	colony growth Candida V titre over10^3 OE/ml
pH vaginal-foot exudate	>4.5	4.0-4.5	4.0-4.5	Maybe _more 4.5	3.0-4.0
Aminotest	Positive-ny	negativeth	negativeth	Maybe _ positive- nym	Negative

Fresh gonorrhea, proctitis or rectitis. IN direct the intestine is injected 10--10 ml 1-3% solution protargola.

Chronic gonorrhea, vulvovaginitis. Washing vagina through thin rubber catheter solution permanganate potassium 1:8000

With subsequent installation through this catheter solution protargola (1-2%) or nitrate silver (0.25-1%) V quantity 3-5 ml through

day. IN stubbornly leaking cases vaginitis — lubrication vagina through urethroscopichandset solution Lugol on glycerin, 10% protargol V glycerine through 2-3 day.

Chronic gonorrhea, urethritis. instillation V urethra 3-4 drops A protargola (2%) orsilver nitrate (0.25-0.5%).

7. *Chronic gonorrhea, proctitis or rectitis.* Enemas With 2-3 % - nym solution protorgolaBy 30-40 ml. Tasks for final control classes:

Control final level knowledge:

Instruction: For everyone question or unfinished statements you are taking onecorrect answer.

1. At treatment mixed gonorrheal-chlamydial urethritis most effective:

A. Rocefin;
B. Tarivid;
C. doxycycline;
D. Penicillin;
E. Erythromycin

2. At gonorrheal urethritis drugs listed are effective groups except:

A. Tetracycline;
B. macrolides;
C. Imidazole;
D. Fluoroquinolones
E. Cephalosporins

3. What type of provocation is most effective during the control examinationsick after treatment urethritis:

A. Chemical;
B. Mechanical;
C. Alimentary;
D. Combined
E. Biological

DIFFERENTIAL DIAGNOSTICS CANDIDOSIS VULVOVAGINITIS

Assessed options	candida vulvovaginitis	Bacterial vaginosis	Trichomoniasis
Symptoms	itching, pain, change charactersecretions, dis- pareunia	Allocations, op-driving obnoxioussmell, dyspareunia absent	purulent discharge, accompanied by non-pleasant smell, dyspareunia
physical signs	Erythema, edema vulva,cracks	Free allocation	Purulent loose discharge, erythemavulva And vagina
		Positive V 70-80% cases	
Aminotet	Negative	Positive V 70-80% cases	Usually put
Microscopy-logical study native drug	The ratio oflimorphic - nuclearleukocytes (PYAL) and vaginal epi- telial cells (EC) < 1; predominancesticks; flat cue epithelium +++; pseudohyphae (near 40%)	PYAL to EC ratio < 1; decrease in quantity sticks; increasequantity coccobacilli;key cells (> 90%)	PYAL+++; mixedFlora; mobile trichos monads (60%)
Microscopy-logical research vaginal content	pseudohyphae (ca. 70%)	Negativeresult	Negative result

DIFFERENTIAL DIAGNOSTICS WITH NON-INFECTIOUS Vaginitis

foreign body (left tampon)	Allocations, accompanied sharp continuous smell
Traumatic vaginitis (homemade)violence)	Atypical localization of excoriations, reidiv pain pain Feel, dyspareunia
Allergic vulvovaginitis	Expressed itch, erythema, edema vulva, anamnes- tic data O recent application desodo- welts, spermicidal And detergents funds

4. If the patient has a Trichomonas nature of urethritis, treatment should beconduct next drug:

A. tetracycline;

B. Tarivid;

C. Tinidazole;

D. nystatin

E. Acyclovir

Instruction: pick up relevant couples "question answer".

5. Choose for each pathogen the most informative method of laboratory testing.diagnostics:

1. Gonococcus. A. Immunofluorescence, PCR

2. Chlamydia B. Light microscopy with methylene blue staining

3. Trichomonas C. Sowing on nutritious environments

4. Ureaplasmas D. Luminous microscopy with coloration By Gram

6. For each pathogen, select the most characteristic incubation period:1. Gonococcus A. 20-30 days

2. Chlamydia B. 2-3 weeks

3. Trichomonas C. 3-7 days

4. Ureaplasma D. 10-12 days

Standards answers: 1. B; 2. C; 3. D; 4. C; 5. 1D, 2A, 3b, 4C; 6.1C, 3A, 2b, 4D.

8. List recommended literature:

Main:

- Dermal And venereal illness. Under edited by Yu.K. Skripkin. Moscow, Triad-X - 2000 -657 With.

- Dermal And venereal illness. Under edited by O.L. Ivanova. M.: Shiko, 2006 - 480s.

Additional:

- Dermal And venereal illness. Management For doctors, V 2nd volumes. Under editorial Yu.K.Skripkin. Moscow, Medicine. - 2004.

- Clinical and morphological diagnostics And principles treatment skin diseases. ManagementFor doctors. - M.: JSC "Publishing house "Medicine", 2006.- 512 With.

- Clinical recommendations. Dermatovenereology. Under editorial A.A. Kubanova. - M.:GEOTAR-Media, 2006. - 320 With.

- Atlas "Dermal And venereal disease" under ed. V.V. Vladimirova.- M..1986.

SUBJECT CLASSES NO. 8: "FINAL OCCUPATION».

1. Motivation for the topic: Knowledge of the basics and elements of dermatovenereology is necessary in daily the work of a doctor of any specialty, therefore, one of the mandatory aspects of professional training is ability to understand V these questions.

2. Target: final control level knowledge on basics diagnostics And treatment skin and venereal diseases

3. Tasks classes:

Student must know:

- Principles And methods diagnostics dermatovenerologic sick
- Scroll practical skills used For diagnostics skin And venereal sick
- Principles And methods treatment dermatovenerologic sick, including recipe And methodology applications major outdoor medicinal forms

Student must be able to:

- Apply received practical skills For diagnostics skin And venereal diseases
- write out, design recipes And explain methodology applications major medicinal funds, applied V dermatovenereology

Facilities necessary For holding classes:

- Tickets for final test control
- tables And visual benefits
- dummies
- Atlas "Dermal And venereal disease" under ed. V.V.Vladimirova.- M. 1986 2000.
- Clinical tasks

Basic knowledge:

- Chapter By histomorphology skin And venereal diseases

Clinical and morphological diagnostics And principles treatment skin diseases. Management For doctors. - M.: JSC "Publishing house "Medicine", 2006.- 512 With.

- Chapter By diagnostics morphological elements of skin diseases

Skin and venereal diseases. Guide for doctors, in 2 volumes. Edited by Yu.K. Skripkin. Moscow, Medicine. - 2004.

- Chapter By classification of skin And venereal diseases

Dermal And venereal illness. Under editorial O.L. Ivanova. M.: Shiko, 2006 - 480s.

- Chapter principles therapy skin And venereal diseases

Clinical recommendations. Dermatovenereology. Under editorial A.A. Kubanova. - M.:GEOTAR-Media, 2006. - 320 With.

4. Content practical classes:

8.00 - 11.20

At surrender offset "Practical skills" student chooses two ticket: one from section: “practical skills”, second - from section: “dermatological recipes".

After preliminary training student describes And shows technique fulfillment actually practical skills, techniques used in the process of examination, treatment and diagnostic manipulation, explains at what diseases They apply.

Then teacher checks discharged student recipe on medicinal means, student tells at what diseases it is used explains way applications.

After that, students solve situational problems using photographs, drawings in atlas, slides, dummies. In this case, the student must describe the morphological elements of the rash, make a suggestion and substantiate the diagnosis, conduct a differential diagnosis and appoint treatment, applied at given disease.

IN average every student spends on answer 12 minutes (from calculation 15 students V group).

11.00 - 11.20 At the end of the lesson, the teacher reports the results of the assessment of students' knowledge, holds analysis student stories disease, gives answers on questions.

5. Block information By topic classes:

PRACTICAL SKILLS

Playback psoriatic triad

Application: For diagnostics psoriasis And differential diagnostics similar diseases.

At scraping psoriatic papules (plaques) subject glass noted consistent triad pathognomonic morphological signs: "phenomenon stearic spots" - appearance big quantities silver white colors scales, at scraping papules. This resembles scales that occur when a drop is scraped from stearic candles; "phenomenon terminal films" - after complete removal scales a shiny translucent film appears; "the phenomenon of pinpoint bleeding or blood dew" (a symptom of Polotebnov or Auspitz) - with further scraping of the film on its surfaces droplets of blood appear due to the destruction of the capillaries of the papillary layer dermis.

With parapsoriasis, the following phenomena are observed. Symptom of a host - with careful scraping the papule, the scale covering it is removed entirely, without breaking, without forming small shavings How at psoriasis.

Symptom purpura, or symptom Brock, - after removal "wafers", at continuation scrapings, on the surface of the papule there are small intradermal hemorrhages, not disappearing at diascopies.

Reproduction of the "apple jelly" symptom and Pospelov's symptom Application: For diagnostics lupoid tuberculosis skin Symptom "apple jelly"

When pressed with a glass slide on the surface of the tuberculous tubercle, tubercle color change. At the same time, under the pressure of a glass slide, dilated vessels tubercle subside, And distinctly speaks bloodless yellowish brown coloring infiltrate like colors apple jelly.

Pospelov's symptom or "probe"

Allows detection of pathognomonic diagnostic sign for lupus erythematosus. With light pressure with a bellied probe on the surface of the tubercle, it is easily immersed in tissue depth (Pospelov symptom).

For comparison: when pressing on healthy skin near emerging pit recovering faster, how on the hillock

Symptom of Nikolsky P.V. And Asbo-Hansen

Application: For diagnostics acantholytic pemphigus And differential diagnostics bullous dermatoses.

1. When pulling with tweezers behind a piece of the bubble cover is detached upper layers epidermis V kind of gradually tapering ribbons on apparently healthy skin.

2. Friction finger (sliding pressure) By apparently healthy skin, How between bubbles, So And V distant Also enough easily causes rejection (shift) upper layers epidermis.

Note. This symptom is also found in other skin diseases in which there is acantholysis (chronic benign family pemphigus and etc.), but it is called only in lesion (regional symptom Nikolsky By N.D. Sheklakov, 1967).

Option this symptom is described at true pemphigus G. Asbo-Hansen phenomenon increase area bubble at pressure on his central Part.

Study on cells Tzanka

Application: For diagnosis of vulgaris pemphigus And differential diagnostics bullous dermatoses.

At monomorphic rashes bubbles on skin And erosion on mucous shell cavities mouthunspecified origin applied method strokes-imprints For possibledetection of acantholytic cells (Pavlova-Tzank) occurring in vulgar pemphigus. The cytological feature of true pemphigus should be considered acantholytic cells (cells Tzanka), used V quality diagnostic test. Acantholytic cells characteristic For pemphigus, But may determined And at others diseases (herpes, chicken pox, bullous variety of Darier's disease, chronic benign family pemphigus And etc.).

Technique detection: a piece sterile student's rubber bands (But Can Also tight attach To surfaces erosion fat-free subject glass) tight press down To bottom

fresh erosion and transferred to a glass slide. Usually they make several prints for 3-5 glasses. Then they are air-dried, fixed and stained according to Romanovsky-Giemsa. (like regular blood smears). Acantholytic cells are smaller than normal cells, have a very large core of intense violet or violet-blue color, occupying almost the entire cell. It has two or more light nucleoli. The cytoplasm of the cells basophilic around nuclei she light blue, A By periphery blue or dark purple ("rim concentration"). Often V cage available some nuclei. Sharp pronounced polymorphism cells And nuclei. Acantholytic cells may be single or multiple. Sometimes there are so-called "monster cells", which differ gigantic size, abundance cores, And bizarre forms. IN early diseases acantholytic cells are not found in every preparation or are not detected at all, in the height of the illness their a lot of And appear "monstrous" cells.

Try Yadasson

Application: for diagnostics dermatitis herpetiformis Dühring and differential diagnostics bullous dermatoses.

A sample with potassium iodide (Yadasson's test) in two modifications: on the skin and inside. For 1 cm2 apparently healthy skin, better than the forearm, apply an ointment with 50% under the compress for 24 hours potassium iodide. The test is considered positive if erythema occurs at the site of application, vesicles or papules. With a negative test after 48 hours, it is repeated: now the ointment applied on pigmented plot skin on place former rashes.

With a negative result, 2-3 tbsp is prescribed orally. spoons of 3-5% potassium iodide solution. Try counts positive at appearance signs exacerbations diseases.

Methodology detection scabies tick

Application: For diagnostics scabies.

A drop of 40% lactic acid is applied to the scabies element (stroke, vesicle, etc.). In 5 minutes loosened epidermis scrape off acute ophthalmic spoon before appearance capillary bleeding, slightly capturing and adjacent healthy skin. Received the material is transferred

to a glass slide in a drop of lactic acid, covered with a coverslip glass And straightaway same explore under small increase microscope. Result counts positive at discovery V preparation tick, eggs, larvae, deserted egg shells or Although would one from these elements.

Study scales, hair, nails on pathogenic fungi

Application: For diagnostics dermatomycosis And differential diagnostics similardiseases.

For research on pathogenic fungi with a scalpel, scrapings are taken from the affected areas of the skin, predominantly from peripheral their parts, Where fungal elements more. At dyshidrotic rashes take away tweezers or cut off wire cutters tires vesicles or blisters, scraps of macerated epidermis. hair from the peripheral parts of infiltrative-suppurative conglomerates or follicular-nodular elements Also take With help scalpel And tweezers. Changed plots nail records together with subungual detritus cut off wire cutters.

For express diagnostics (within 1-30 minutes) of mycoses, fast clearing agents are used. formulations. So, scrapings from the skin, after treatment with a 10% solution of sodium disulfide in ethanol in ratio of 3:1, you can microscopic material after 1 minute, sections of nails - after 5 - 10minutes.

Balzer test (iodine try)

Application: For multicolor diagnostics _ lichen And differential diagnosticssimilar diseases.

At lubrication affected plots And environmental normal skin 3-5% solution iodine or solution aniline dyes, foci defeat stained more intensively. This

connected with a large absorption of the dye due to the loosening of the horny epidermal layer fungi.

Recipe most often occurring medicinal forms V dermatology

microscopic study at diagnostics syphilis.

At primary syphilis on pale treponema explore detachable chancre or punctate of regional lymph nodes; with secondary syphilis - material from various defeats skin And mucous shells.

Material for research is obtained from the patient before treatment directly in the laboratory. For receiving material surface ulcers wipe cotton wool moistened sterile isotonic solution chloride sodium, then bottom ulcers slightly annoying glass stick or platinum loop, previously calcined on fire and cooled. For greater release of tissue fluid with fingers in a rubber glove squeeze a dense the base of the ulcer.

researched tissue liquid wand or loop contribute V drop isotonic solution sodium chloride on a slide, mix, cover with a slide and examined in an optical microscope with a dark-field condenser, a 40x objective, an eyepiece 7x, 10x, or 15x. Between

lens condenser And subject glass must be a drop distilled water. Punctate from lymphatic node receive V aseptic conditions at help syringe With thick needle, containing some drops isotonic chloride solution sodium. Fixing needle fingers V lymphatic knot, her slightly rocking For destruction environmental fabrics, introduce available V syringe isotonic solution chloride sodium, A then suck off material For research.

laboratory diagnosis of gonorrhea

Diagnosis of gonorrhea is based on the history, clinical picture, detection pathogen. Laboratory research methods are of decisive importance. If you suspect for the presence of gonococcal infection, along with generally accepted data, the discharge is examined urinary channel, paraurethral ducts, secret prostate gland, seminal vesicles, glands and lacunae of the urethra, washing water direct intestines.

By testimony research exposed scrapings And smears conjunctiva eye, others mucous membranes, synovial membrane, synovial fluid, etc. In the clinical practice For diagnostics gonorrhea more often apply bacterioscopic And bacteriological methods.

For identification gonococci use Also reactions immunofluorescence And coagglutination with mono- and polyclonal antibodies, enzyme immunoassay, etc. Most effective methods molecular biology: polymerase chain reaction, DNA-DNA-probe hybridization.

Bacterioscopic study

Most common method. Gonococci Fine stained everyone main aniline dyes. Most often, a 1% solution of eosin in 60-70 ° alcohol and 1% water solution methylene blue or stain smears By Gram.

When stained with methylene blue, intensely stained gonococci are especially clearly visible. against a pale background of leukocytes and epithelial cells, the protoplasm of which is pale blue colors, core — blue colors. This coloring It has only indicative meaning at microscopic gonorrhea diagnosis, because the all cocci stained V blue color.

Coloring smears By Gram: method based on property cellular shells gonococcus discolor with alcohol. Cocci not belonging to the genus Neisseria remain stained. Gonococci V smear, painted By Gramu, bright pink in color and stand out against pale pink background of protoplasm leukocytes. In an acute process, a large number gonococci located V leukocytes. IN more late (chronic) stages disease

discharge becomes scarce and contains fewer leukocytes, gonococci often are found with difficulty. They can be found inside epithelial cells and protozoa (Trichomonas), keeping your life activity.

laboratory diagnostics urogenital chlamydia

Sampling technique: one of the most important stages in the diagnosis of chlamydia is the material intake. Optimal for the persistence of Ch. trachomatis and its intense reproduction are certain sections of the columnar epithelium of the genitourinary tract (anterior urethra at a depth of 2.5 - 4.0 cm in men). In contrast to the principle of material sampling at others transmitted sexual through infections sick Not should recommend prolonged urinary retention. Head of the penis in the area of the external opening the urethra is treated with a cotton swab dipped in isotonic sodium chloride solution. In the presence of discharge, the first drop of freely flowing secretions that appears when pressure on urethra are removed.

laboratory diagnosis of trichomoniasis

There are three major method identifying Trichomonas:

1. Study of an unstained fresh preparation (the method was first proposed by Doppe in 1836). To identify the characteristic mobile Trichomonas, the urethral discharge is examined under microscope V drop isotonic solution chloride sodium.

2. Study of the stained preparation. They study preparations stained with 0.5 - 1% aqueous methylene blue solution, according to Gram, Romanovsky-Giemsa, according to Leishman. For accurate classification of trichomonads, the detection of the nucleus is very significant, since fragments cytoplasm, pieces slime And separate elements fabrics may stain equally With Trichomonas. IN cytoplasm Trichomonas may be observed reddish brown granules, which contributes to their detection, but only after identification cores can do conclusion, What discovered exactly these microorganisms.

3. cultural method. For the cultivation of trichomonads using a hepatic medium with cysteine peptin And maltose.

laboratory diagnosis of mycoplasmosis And ureaplasmosis

Main laboratory method research For identifying pathogen ureaplasma infection is the cultivation of microorganisms on liquid and solid nutritional environments from detachable (scrape) mucous shells urinary organs. The bacteriological method is generally accepted for the detection of U.urealiticum and M.hominis. research. At the same time, for the determination of ureaplasmas in clinical samples, the simplest is a test for urease (color test) in a liquid medium, followed by cultivation on solid medium and direct test - spot for urease with indicator - manganese sulfate or inoculation on a dense medium containing sulfate manganese.

These tests are based on the ability of ureaplasmas to break down urea to form carbon dioxide. gas and ammonia, which leads to a change in the pH of the medium from acidic to alkaline, resulting in is changing color indicator from lemon yellow before green And even blue.

In recent years, the method of immunofluorescence has been used to diagnose mycoplasmosis. main way straight (PIF), founded on monocle antibodies.

RECIPES:

Rep: Sol. Acidi borici 2% 500.0

DS Outdoor. For lotions.

Rp: Ung. Sulfurati 33% 100.0

D.S. Outdoor.

Rp: Zinci oxydi _ Amyl tritici aa 5.0 Vaselli 10.0

mf pasta.

DS Outdoor. Zinc paste. Apply on foci twice V day.

Rp: Sol. Furacillini 0.02% 500.0

D.S. External. For lotions.

Rp: Sol. Aethacridini lactatis 0.1% 500.0

DS Outdoor. For lotions.

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Chapter-2

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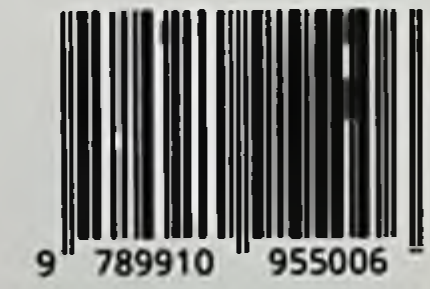
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