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FEATURES OF SCABIES AND NEW APPROACHES TO ITS DIAGNOSIS AND TREATMENT IN THE REGION OF ANDIJAN

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Abstract:

The article presents a review of domestic and foreign medical literature, reflecting the current state of epidemiology, various clinical forms of scabies and the reasons for failures in its treatment.

Keywords: Scabies, Clinical Picture, Epidemiology, Treatment.

INTRODUCTION

Risk groups are of great practical importance in the epidemiology of scabies. The highest risk coefficient is represented by young people (17–21 years old), which is 9% of the entire population of Uzbekistan or from ¼ to ⅓ of the total incidence of scabies [1]. The relatively high incidence of scabies over the past two decades has created a certain problem for practical health care, which is due to a number of not only socio-economic, but also medical factors. Of the social factors, the most significant are the decline in living standards, changes in moral and ethical foundations in society among young people, migration and low culture of the population. Among the medical factors, an important role in the spread of infection belongs to errors in the diagnosis of the disease, incomplete involvement of sources of infection and contact persons in examination and treatment. Primary care healthcare workers (district therapists, pediatricians, general practitioners), as well as those from preschool institutions, boarding schools, nursing homes, etc., are poorly involved in detecting scabies. The unfavorable epidemiological situation with scabies is maintained by patients seeking medical care late. The average duration of one case of the disease from the moment the first clinical signs of the disease appear until the patient seeks medical attention is 10–13 days. Patients seeking medical attention late is most often associated with self-medication and diagnostic errors.

MATERIALS AND METHODS

Over the past two decades, there have been significant changes in the epidemiology and clinical picture of scabies: rashes on the hands and wrists are minimal, predominantly localized on closed areas of the body. This clinical variant of the typical form of the disease is most characteristic of medical and social workers, employees of the education and catering sectors, which is explained by frequent hand washing, often with the use of disinfectants and detergents. The course of the disease in these individuals is often protracted and persistent. The proportion of atypical forms of scabies has increased significantly: postscabies lymphoplasia, scabies of the "clean", Norwegian scabies, the clinical manifestations of which imitate a number of infectious and non-infectious dermatoses and often lead doctors to diagnostic errors [2]. In this regard, it seems necessary to increase the awareness of doctors of all specialties about the clinical manifestations of various forms of the disease for the purpose of timely diagnosis and implementation of therapeutic and anti-epidemic measures. In addition, it is necessary to dispel the stereotypical thinking of a doctor who believes that the main diagnostic symptom of scabies is "paired elements" representing the entrance and exit of the mite. When diagnosing scabies, doctors look not for scabies passages, which are the main symptom of the disease, but for "paired elements", which are numerous in any disease accompanied by itching. We conducted a retrospective analysis of 423 outpatient cards of primary care of patients with scabies (217 men, 206 women) aged 12 to 82 years. The typical form of the disease was observed in 319 patients (75.4%), scabies of the "clean" in 78 (18.4%), postscabies lymphoplasia in 13 (3.1%), complicated by allergic dermatitis with eczematization in 8 (1.9%), scabies without burrows in 5 (1.2%). It should be noted that scabies complicated by pyoderma was diagnosed in 14.9% of patients. In the practice of a dermatologist, the various clinical forms of scabies encountered can be classified and presented as follows:

- typical scabies;
- scabies of "incognito", "clean" or "cultured";
- scabies without burrows;
— postscabies lymphoplasia (nodular);
— urticarial scabies;
— Norwegian scabies;
— scabies associated with corticosteroid therapy;
— pseudosarcoptosis;
— scabies complicated by pyoderma;
— scabies complicated by allergic dermatitis;
— eczematized scabies;
— scabies in infants and young children.

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RESULTS AND DISCUSSION

Scabies of the "clean", or "incognito", ranks second in frequency among all forms of the disease, clinically characterized by scanty rashes on the skin in the form of small itchy vesicles and hemorrhagic crusts, located mainly in the abdomen, lower back and buttocks, as well as barely noticeable scabies passages. In some cases, the rash may be represented only by single bloody crusts or individual elements of post-scabies lymphoplasia of the same localization. The clinical picture of the disease corresponds to typical scabies with minimal severity of manifestations. Despite the minimal rashes on the skin, patients are bothered by moderate or severe itching. The latter circumstance significantly complicates diagnosis. This form of the disease occurs not only in individuals who frequently wash at home in the evening or due to the nature of their work (which facilitates the mechanical removal of a significant portion of the pathogen population from the patient's body), but also in patients who self-medicate with both antihistamines and sleeping pills, as well as glucocorticosteroid ointments and acaricidal agents [3]. Scabies "incognito" is most often observed in socially adapted and financially secure strata of the population in the age group from 30 to 40 years and is characterized by a duration of the disease from 3 weeks to 10 months, being in epidemiological terms a hidden reservoir for the emergence of numerous foci of infection [1].

Scabies without burrows is relatively rare and is diagnosed mainly during active examination of individuals who have been in contact with patients with scabies. The rash is characterized by single follicular papules located on the skin of the trunk and limbs, and individual non-inflammatory vesicles on the hands without scabies burrows. In this form of the disease, infection occurs not by fertilized female mites, but by larvae, which require 2 weeks to transform into adult females capable of making burrows and laying eggs. Post-scabies lymphoplasia (nodular scabies) occurs in almost half of patients and persists after full treatment from 2 weeks to 6 months. The pathogenesis of the disease is based on a special predisposition of the skin to respond to an irritant with reactive hyperplasia of lymphoid tissue in places of its greatest accumulation [4]. This form of scabies is clinically represented by intensely itchy lenticular papules and nodular rashes of a purple-blue color up to 1 cm in diameter, dense to the touch. Sometimes the elements are located close to each other, partially merging, forming dense plaques with scaling or crusts on the surface. Persistent nodules are reactive variants of scabies passages. The rashes are localized on the skin of the trunk (armpits, abdomen, buttocks), male genitals, female mammary glands and elbows. In children, similar nodular elements are found in the neck, auricles, and in boys - on the skin of the scrotum and penis. With reinvasion, postscabies lymphoplasia recurs in old places. Thus, according to V. I. Albanova, post-scabious lymphoplasia most often develops with improper treatment with acaricidal agents [9].

CONCLUSION

Thus, the conducted analysis of the literature and our own observations indicate a significant increase in recent years in the proportion of atypical and rare forms of scabies, the clinical manifestations of which imitate a number of other dermatoses and often lead doctors to diagnostic errors. In this regard, there is a need to inform doctors of all specialties about the features of the clinical manifestations of various forms of scabies for the purpose of timely clinical and laboratory diagnosis of the disease and the implementation of therapeutic and anti-epidemiological measures.

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