

NEW METHODS IN THE TREATMENT OF SECONDARY SYPHILIS

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Annotation: Secondary syphilis is the period of syphilis following the primary one, which is characterized by a disseminated rash with a large polymorphism of elements (roseoli, papules, vesicles, pustules), damage to somatic organs, the musculoskeletal system, the nervous system, and generalized lymphadenitis. Diagnosis of secondary syphilis is carried out by detecting pale treponema in the discharge of skin elements, punctate lymph nodes and spinal fluid; setting serological reactions. Treatment includes penicillin therapy and symptomatic treatment of internal organ damage.

Key words: fever, chills, headache, infection, inflammation.

The period of secondary syphilis begins 2-3 months after pale treponemas enter the body and is associated with their entry into the blood and lymph. Through the blood and lymphatic vessels, pathogens of syphilis spread to the internal organs, lymph nodes and nervous system, causing their defeat. Under the influence of the body's immune response, pale treponema can form spores and cysts, in which it remains in a non-virulent form, causing the development of a latent period of secondary syphilis. With a decrease in the activity of immune mechanisms, the pathogen can again transform into a pathogenic mobile form, causing a relapse of secondary syphilis.

Fresh secondary syphilis-develops after primary syphilis and is manifested by a profuse disseminated small polymorphic rash, the presence of a solid chancre in the resolution stage and polyadenitis. Duration 2-4 months.

Latent secondary syphilis-characterized by the disappearance of clinical symptoms and is detected only by positive results of serological studies. Lasts up to 3 months or more.

Recurrent secondary syphilis-there is an alternation of recurrent syphilis with latent periods. During relapses, the rash appears again. However, unlike fresh secondary syphilis, it is less abundant, larger and arranged in groups, forming arcs, rings, garlands and semi-rings.

The development of secondary syphilis often begins with general symptoms similar to SARS or flu. This is malaise, fever, chills, headache. A distinctive feature of secondary syphilis is arthralgia and myalgia, which increase at night. Only a week after the appearance of these prodromal symptoms, skin manifestations of secondary syphilis occur.

Secondary syphilis rashes — secondary syphilis — are characterized by significant polymorphism. At the same time, they have a number of similar characteristics: a benign course without peripheral growth and destruction of surrounding tissues, a rounded shape and a clear delineation from the surrounding skin, the absence of subjective symptoms (occasionally a slight itching is noted) and anti-inflammatory signs, healing

without scarring. Secondary syphilides contain a high concentration of pale treponemes and cause a high infectious risk of a patient with secondary syphilis.

The most common form of rash in secondary syphilis is syphilitic roseola or spotted syphilis, which is manifested by rounded pale pink spots up to 10 mm in diameter. They are usually localized on the skin of the limbs and trunk, but can be on the face, feet, and hands. Roseoli in secondary syphilis appear gradually in 10-12 pieces per day for a week. Typically, the roseola disappears when pressed on it. More rare forms of roseolus rash in secondary syphilis include scaly and raised roseoli. The first one has a slight depression in the center and is covered with lamellar scales, the second one rises above the general level of the skin, which makes it look like a blister.

The second most common type of secondary syphilis is papular syphilis. Its most typical form is lenticular, which has the appearance of dense elastic papules with a diameter of 3-5 mm of pink or copper-red color. Over time, peeling begins in the center of the secondary syphilis papule, which spreads to the periphery. Characteristic is "Bietta collar" - peeling along the edge of the papule while in the center it has already ended. Resolution of papules ends with the formation of long-term hyperpigmentation. More rare forms of papular syphilis include seborrheic, coin-shaped, psoriasis-like, wet syphilis, papular syphilis of the palms and soles, as well as broad warts.

A rare form of secondary syphilis rash is pustular syphilis. Its appearance is usually observed in debilitated patients (tuberculosis patients, drug addicts, alcoholics) and indicates a more severe course of secondary syphilis. Pustular syphilis is characterized by the presence of purulent exudate, which dries up to form a yellowish crust. The clinical picture resembles the manifestations of pyoderma. Pustular syphilis of secondary syphilis can have the following forms: impetiginous, acne-like, ectymatous, smallpox-like, rupoid.

With recurrent secondary syphilis, pigmented syphilis (syphilitic leukoderma) can occur, appearing on the side and back of the neck in the form of rounded whitish spots, called the "Venus necklace".

Cutaneous manifestations of secondary syphilis are accompanied by generalized enlargement of the lymph nodes (lymphadenitis). Enlarged cervical, axillary, femoral, and inguinal lymph nodes remain painless and are not soldered to the surrounding tissues. Violation of nutrition of the hair roots in secondary syphilis leads to hair loss with the development of diffuse or focal alopecia. Often there are lesions of the mucous membranes of the oral cavity (syphilis of the oral cavity) and larynx. The latter cause a characteristic hoarseness of the voice in patients with secondary syphilis.

On the part of somatic organs, mainly functional changes are observed, which quickly pass during treatment and are absent during periods of latent secondary syphilis. Liver damage is manifested by its soreness and enlargement, violation of liver tests. Gastritis and gastrointestinal dyskinesia are often observed. On the part of the kidneys, proteinuria and the occurrence of lipid nephrosis are possible. Damage to the nervous system is manifested by irritability and sleep disorders. Some patients with secondary syphilis have syphilitic meningitis, which is easily treatable. Possible damage to the bone system with the development of osteoperiostitis and periostitis, manifested by nocturnal pain mainly in the bones of the extremities and proceeding without bone deformities. In some cases of secondary syphilis, otitis media, dry pleurisy, retinitis, and neurosyphilis may occur.

Diagnosis of secondary syphilis

The diverse clinical picture of secondary syphilis dictates the need to conduct research on syphilis in every patient with a diffuse rash combined with polyadenopathy. First of all, this is a study of the discharge of skin elements for the presence of pale treponema and setting up

an RPR test. Pale treponema can also be detected in the material taken during a puncture biopsy of the lymph node. Examination of cerebrospinal fluid obtained by lumbar puncture during the period of fresh secondary syphilis or relapse also often reveals the presence of the pathogen.

With secondary syphilis, most patients have positive serological reactions (RIBT, RIF, RPGA). The exception is only 1-2% of cases of false-negative reactions due to too high an antibody titer, which can be reduced by diluting the serum.

Clinical manifestations of internal organs may require additional consultation with a gastroenterologist, urologist, optometrist, neurologist, otolaryngologist; ultrasound of the abdominal cavity, gastroscopy, pharyngoscopy, ultrasound of the kidneys, X-ray of the lungs, etc.

Differential diagnosis of secondary syphilis

The pronounced polymorphism of rash elements in secondary syphilis causes a large list of diseases with which it is necessary to conduct its differential diagnosis. These are infectious diseases accompanied by a rash (rubella, measles, typhoid fever, typhoid fever, chickenpox, etc.), dermatological diseases (toxicoderma, psoriasis, lichen planus, skin tuberculosis, acne), fungal diseases (pityriasis pityriasis rosea, candidiasis), infectious skin lesions (vulgar ectima, streptococcal impetigo). Broad condylomas of secondary syphilis should be differentiated from genital warts caused by HPV. Mucosal lesions are differentiated with aphthous stomatitis, leukoplakia, glossitis, SLE, angina, laryngitis, thrush.

Treatment of secondary syphilis

In the treatment of secondary syphilis, the same drugs are used as in the treatment of primary syphilis. When somatic organs are affected, symptomatic agents are additionally used. The most effective treatment of secondary syphilis is considered to be water-soluble penicillins, during which the required concentration of penicillin in the blood is constantly maintained. But such therapy can only be carried out in a hospital setting, since intramuscular administration of the drug is required every 3 hours.

Failure to follow an adequate treatment regimen or sufficient duration of therapy leads to further development of the disease and its transition to the next stage — tertiary syphilis.

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