Complex Therapy of Patients with Atopic Dermatitis

Introduction: Atopic dermatitis is a chronic relapsing inflammatory skin disease with a complex pathogenesis, involving genetic predisposition, immunological and epidermal barrier dysfunction, and environmental factors. The main symptom is itching; skin rashes range from mild erythema to severe lichenification and erythroderma. Diagnosis includes history taking and examination. Treatment includes advice on proper skin care, avoidance of triggers, and topical corticosteroids and immunosuppressants. It is also important to treat itching and superinfections. In severe cases, systemic immunosuppressive therapy may be required. Atopic dermatitis that develops in childhood often regresses or its manifestations are significantly weakened in adulthood.

Atopic dermatitis mainly affects children living in large cities or developed countries, the prevalence of this disease has increased over the past 30 years; up to 20% of children and 10% of adults in developed countries are affected. Most people develop the disease before the age of 5 years, many before the age of 1 year; however, atopic dermatitis can begin even in late adulthood. According to the as yet unconfirmed hygiene hypothesis, reduced exposure to infectious agents during childhood (for example, with greater hygiene in the home) may increase the incidence of atopy and autoimmune disorders targeting self-proteins.

Many patients or family members with atopic dermatitis also have allergies, asthma, and/or immediate hypersensitivity, such as allergic seasonal or perennial rhinoconjunctivitis. The triad of atopic dermatitis, allergic rhinoconjunctivitis and asthma is called atopy or atopic diathesis. Other dermatologic signs of atopy include xerosis, ichthyosis/palmar hyperlinearity (i.e. increased skin pattern on the palms), follicular keratosis, lower eyelid crease (Denny-Morgan fold), sparse brow flanks (Hertog's sign), hair intolerance (irritation and itching caused by skin-to-hair contact), white

Abstract: this article summarizes the study under observation were 21 patients with atopic dermatitis aged 21 to 56 years, including 17 women and 4 men. In all patients, atopic dermatitis was first registered at the age of 4 to 6 months. When collecting an anamnesis, it was stated that 19 patients had a chronically relapsing course of AD, and in the last 4-5 years it became persistent. In two men, atopic dermatitis was initially severe, and from the age of 14, signs of broncho-obstructive syndrome appeared. The aim of our work was to determine the effectiveness of complex therapy of patients with atopic dermatitis with the use of antifungal drugs.

Key words: atopic dermatitis, treatment.
dermographism (vasoconstriction causing skin to turn white in response to scratching), and increased transepidermal water loss (in both unaffected and affected skin).

**Purpose:** to determine the effectiveness of complex therapy of patients with atopic dermatitis using antifungal drugs.

**Materials and Methods:** 21 patients with atopic dermatitis aged 21 to 56 years were under observation, including 17 women and 4 men. In all patients, atopic dermatitis was first registered at the age of 4 to 6 months. When collecting an anamnesis, it was stated that 19 patients had a chronically relapsing course of AD, and in the last 4-5 years it became persistent. In two men, atopic dermatitis was initially severe, and from the age of 14, signs of broncho-obstructive syndrome appeared. Over the past year, 7 patients have repeatedly been treated in a hospital without visible results. In a follow-up study of outpatient records of patients included in the study, it was found that patients were constantly treated according to standard methods, including external and systemic corticosteroids, antihistamines, desensitizing agents, and 15 patients received specific and non-specific immunotherapy under the supervision of immunologists-allergists. In the clinical assessment of patients, the average level of the SCORAD index was 64.7+2.7 points, which corresponded to the moderate and severe course of atopic dermatitis.

All patients, in combination with non-specific anti-inflammatory therapy, were prescribed terbinafine - tablets of 250 mg per day for 4 weeks and 1% Exifin cream once a day for a month. The main criterion for prescribing Exifin to patients with atopic dermatitis was the detection of specific IgE to Malassezia, the microscopic detection of mycelial forms of yeast-like fungi and active yeast growth in the material taken from the surface of the skin in the affected foci. Before the start of the studies, the average level of specific IgE to Malassezia was 37.4+4.2kUA/L, in all patients included in the study, yeast-like fungi were found during microscopic examination, mainly in mycelial form, and active yeast growth of M. sympionoidalis and M. globosa.

**Results:** in all patients on the 5-7th day of therapy, the intensity of itching decreased by more than 70%. The SCORAD index decreased gradually: before treatment 64.7+2.7 points, two weeks after the start of the study 48.3+3.6, after treatment 23.5+0.2, three weeks after the end of therapy 6.4+ 0.8 points.

Thus, a decrease in the SCORAD index was registered not only during and after treatment, but also three weeks after the therapy, which, apparently, was due to the high keratophilicity of Exifin and confirms the data of Russian and international studies on the prolonged therapeutic effect of Exifin after stopping treatment.

The values of specific IgE as a result of complex therapy decreased not so intensively from 37.4+4.2 kUA/L to 21+3.8 kUA/L, which explains the genetically determined predisposition to fungal antigens. In a laboratory study of microscopic and cultural material taken from the surface of the skin of AD patients with predominant localization on the skin of the head, neck and/or limbs, a decrease in mycelial forms of the fungus and moderate yeast growth were registered. The presence of fungi of the genus Malassezia on the skin and the detection of specific IgE in patients with atopic dermatitis after complex therapy with the use of Exifin indicates the complex multifactorial nature of AD, which causes the chronic course of dermatosis. This indicates the need to develop not only new methods of therapy, but also measures to prevent recurrence of the disease in this category of patients.

It should be noted that all patients tolerated the treatment well, no allergic reactions were observed, negative dynamics from the peripheral blood and in the biochemical analysis were not registered when using Exifin.
Conclusions: the data obtained indicate the efficacy and safety of Exifin when used in the complex therapy of patients with atopic dermatitis with hypersensitivity to fungi of the genus Malassezia, which was expressed in the rapid relief of itching and positive dynamics of the SCORAD index.

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