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Effectiveness of the Treatment of Chronic Eczema of the Hands and Soles

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ABSTRACT

this article attempts to reveal the main reasons to compare and evaluate the effectiveness of re-D3-PUVA (a combination of PUVA, oral isotretinoin, a synthetic analogue of vitamin D3 - external calcipotriol), PUVA techniques, conservative therapy in the treatment of chronic eczema of the palms and soles. To carry out scientific work, the author conducted a study of 73 patients aged 16–67 years (40 women and 33 men). The duration of the disease ranged from 2 to 25 years, the form of the disease was severe, the course was torpid, and there was no remission for the last 6 months. The severity of the disease and treatment outcomes were assessed by the clinical picture and dermatological indexes: determining the prevalence and severity of eczema (EASI), dermatological symptom scale index (DSSI), dermatological quality of life index (QLI). The problem in question is still little studied, therefore, requires more thorough research.

Introduction: Eczema (ancient Greek ἔκζεμα - rash on the skin, from ἐκζέω - I boil) is an acute or chronic (recurrent) non-contagious skin disease caused by severe inflammation of the predominantly papillary dermis and focal spongiosis of the papillary epidermis, manifested by a polymorphically itchy rash.

The term "eczema" has been used for a long time (two centuries BC), but to refer to various acute dermatoses. Only in the first half of the 19th century, Willen (1808), Bateman (1813), Race (1823) and other scientists singled out eczema as a separate nosological form. The occurrence of eczema is promoted by genetic and various external (mechanical, chemical, thermal, etc.) and internal (diseases of the liver, kidneys, gastrointestinal tract, endocrine, nervous system, etc.) factors. According to the etiology (that is, depending on the cause), localization (location) and the nature of skin manifestations, several forms of eczema are distinguished.

At different stages of the development of the doctrine of eczema, the nervous system, endocrine and metabolic disorders, infectious and allergic factors, genetic burden and immune deficiency were of paramount importance in the etiology and pathogenesis of the disease. Since the decisive importance of certain endogenous and exogenous influences remains controversial, and more often they act in complex relationships, it is customary to consider eczema a polyetiological disease. Currently, allergic processes are interpreted as a pathological immune reaction, accompanied by damage and inflammation of body tissues, therefore, in the pathogenesis of the eczematous process, various immune shifts are of primary importance. It has been established that dysgammaglobulinemia (excess IgG, IgE and deficiency of IgM) is expressed in patients with eczema, the number of functionally active T-

lymphocytes is reduced, the total number of T-cells is reduced, the ratio of helper and suppressor subpopulations is changed, and therefore the number of B-lymphocytes is increased. The most pronounced immunopathology was found in patients carrying isoantigens A, M, N and Rhesus D+. Weakness of immunity in the presence of infectious antigenic stimuli is manifested by the persistence of microbial and bacterial antigens with the formation of chronic recurrent inflammation in the epidermis and dermis. In this case, pathological circulating immune complexes arise that damage their own microstructures with the formation of a series of autoantigens that initiate the formation of autoaggressive antibodies. However, for a long time there is an understanding of eczema as a neurogenic disease. The most convincing factor indicating the role of the nervous system in the pathogenesis of eczema is the possibility of its occurrence due to damage to peripheral nerves. An example is the so-called post-traumatic eczema that occurs around the wound surface. In the light of modern ideas about the relationship between the immune system and the functional state of the central nervous system, vegetative-vascular processes, it should be recognized that the pathogenetic process of eczema formation includes a complex of neuroimmunovegetodistonic, infectious-allergic and metabolic mechanisms that complement each other, rather than competing.

The formation of eczema on the basis of a genetic predisposition, which depends on the presence of an immune response gene in the chromosomes, creates the prerequisites for its inheritance in subsequent generations. In this case, polygenic multifactorial inheritance takes place with pronounced gene expression and penetrance.

Purpose: to compare and evaluate the effectiveness of re-D3-PUVA (combination of PUVA, oral isotretinoin, topical synthetic analogue of vitamin D3 - calcipotriol), PUVA techniques, conservative therapy in the treatment of chronic eczema of the palms and soles.

Materials and Methods: The study involved 73 patients aged 16–67 years (40 women and 33 men). The duration of the disease ranged from 2 to 25 years, the form of the disease was severe, the course was torpid, and there was no remission for the last 6 months. The severity of the disease and treatment outcomes were assessed by the clinical picture and dermatological indexes: determining the prevalence and severity of eczema (EASI), dermatological symptom scale index (DSSI), dermatological quality of life index (QLI). All patients underwent histological examination of the skin. Patients were divided into 3 groups: I (n=20) who received re-D3-PUVA therapy, II (n=23) who received PUVA therapy and III (n=30) group of patients who were on conservative therapy (antihistamines and glucocorticosteroid drugs).). The duration of therapy is 1-4 months.

Results: Comparing the dynamics of dermatological indices after 6 weeks from the start of therapy, significant differences in the results obtained were established. So, against the background of re-D3-PUVA therapy, the EASI index decreased by 87% ($p<0.001$), DISH by 80% ($p<0.001$), DIVC by 83% ($p<0.001$), while against the background of PUVA therapy without systemic retinoids, their values decreased, respectively, EASI by 60% ($p<0.001$), DISH by 63% ($p<0.001$), DIC by 52% ($p<0.001$), in group III, relapses were observed in the short term. Comparison of these indicators between groups showed a significant decrease in dermatological indices in patients receiving re-D3-PUVA therapy; this explains the more rapid regression of symptoms in this group, the early onset of remission. Important: further monitoring of patients after the end of the course of treatment for 12 months revealed an increase in the duration of remission in the group of patients who received re-D3-PUVA therapy. The median relapse time after PUVA therapy was observed after 3 ± 0.5 months, while in the group of patients on re-D3-PUVA therapy, the first exacerbations of symptoms were observed after 6 ± 1 months. The possibility of further use of calcipotriol externally without glucocorticosteroids after therapy provides a relatively safe opportunity to prolong remission.

Conclusions: the method that gives the greatest remission and allows you to most effectively control the course of chronic hyperkeratotic eczema - re-D3-PUVA.

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