All groups of herpes viruses are considered as pathogenically connected with HIV-infection. Caused by herpes simplex viruses (HSV), herpes zoster (HZV), and cytomegalovirus (CMV) these infectious diseases were among the firsts, revealed in HIV-infection. The long latent phase after the acute period with ability to be activated in later time with clinical picture specific for each type of virus is the characteristic feature of this pathology. HSV types I and II causes relapses with the lesions of skin and oral mucosa, genitalia and rectal area with formation of ulcers; this virus has also the opportunity to disseminate with involvement of the central nervous system. Just with pandemic of HIV-infection the growth of genital herpes virus is connected. The viruses of this group are related to the most widespread human pathogens. According to the data of seroepidemiological investigations the antibodies to the herpes simplex virus are identified in 70–100 % of the adult population. The infectious process caused by viruses of this group is also played a leading role as the reason of direct death in the patients with AIDS. The lethality from herpetic encephalitis achieves 85 %.

The difficulty of verification of herpes simplex virus infection in the patients with AIDS is caused, first of all, by the condition that in the most of cases the viruses are in the latent form in the body, that is, asymptomatic carriage of viruses. Secondly, the viruses of this group can induce the special form of infectious process – slow infection.

The herpes simplex virus in the patients with AIDS is characterized by severe chronic (more than 1 month) process with formation of ulcerative lesion, distribution of herpetic eruptions on the various skin sites and mucous membranes. Herpetic eruptions as vesicles, very painful erosion and ulcers can be the first manifestations of AIDS. In the homosexuals, infected with HIV, the herpetic proctitis can be developed. At connection of the secondary infection herpes in such patients can have similarity with varicella or impetigo. It is necessary to note, that ulcerative herpetic lesions differ by significant tenderness [1].

The clinical course of disease can be various in relation to severity degree: from easy limited of light tenderness to the hardest, widely-distributed, gangrenous forms accompanied with strong pains.

AIDS-associated Kaposi’s sarcoma (KS) occupies the sixth place after infections induced by herpes simplex virus in the WHO bulletin «AIDS-indicated diseases». AIDS-associated KS is rare oncopathology, which in the insufficient knowledge of the doctors gives up to 40 % of the erroneous diagnoses. The diversity of the form, color, character and location of rash in HIV-associated CS results that at early stages it can simulate various dermatoses. The patient is often made by mistake the rather «harmless» diagnoses (thrombophlebitis, venous insufficiency, vasculitis, bacterial angiomatosis, hemangioma, lymphangiomata etc.) and the inadequate therapy is prescribed. In such cases the patients repeatedly refer to the doctor only in marked progress of process, presence of cosmetic defects or at difficulty of movements in the extremities due to lymphostasis. The term of the correct diagnosis is delayed. These circumstances require from the doctors to remember about oncological and AIDS cases occurrence [4, 6].

The clinics, histology and evolution of Kaposi’s Sarcoma in HIV-infected individuals has been studied.
It is known, that AIDS-associated KS develops at younger (on the average, at 37.7 years) age, than idiopathic KS, and in 95 % of cases it is accompanied by skin changes. KS is one of typical manifestations of the secondary immune deficiency, «opportunistic» tumour and is considered as «indicated» disease in HIV-infection [2, 5].

The important clinical features of the AIDS-associated type of Kaposis's sarcoma include a primary face impairment, mucous membranes and upper extremities. Favorite localization of the pathological process is the tip of the nose and hard palate. In absence of the treatment this type of sarcoma is characterized by fast distribution skin eruptions – the distribution «from above – downwards» is characteristic. The marked polymorphism of the eruption forms is characteristic feature, the tendency to distribution along the along Langer lines is clearly expressed. Often there are isolated lesions of the mucous membranes and peripheral lymph nodes. Kaposis's sarcoma has propensity to fast generalization and involvement of the internal organs. In 75 % of the patients, first of all, stomach and duodenal intestine are impaired as well as the lungs. The disease develops without skin lesions only in 5 % of patients. Viscerous lesions may be asymptomatic and can be identified only in special investigation as well as in autopsy. The high lethality at early time of disease (surveillance of the patients is from 2 months till 5 years, on the average – 18 months) is characteristic [3, 7].

Differential diagnostics is performed with Kaposis's pseudosarcoma, with capillary hemangioma, bacterial angiomatosis, angiokeratoma, fibrosarcoma, malignant leiomymoma, erythspilatous inflammation, pyogenic granuloma, hemagiopericytoma, hemangioendothelioma, hemangiosarcoma, leiomysarcoma, angiolympoma, and lichen planus. The special attention should be given to exception of mycosis fungoides (malignant lymphoreticular tumor with primary skin lesion).

In connection with above-stated there is presented clinical supervision of combination of Kaposis sarcoma and Herpes genitalis in HIV-infected patient: the patient M., date of birth 1982, admitted to the Clinic of RSSPMDKV MH RUz on July 6, 2009 with the complaints to weakness, tenderness (Fig. 4). In some days from the beginning eruption appearance the ulcer has appeared. Thinking, that the ulcer has appeared as a result of scratching, the women, on advice of the familiar doctors, used various ointments (flucinaz, gyoxizin, erithromycin, Vishnevskiy ointment, streptocide) on the surface of the focus of lesion. In some days from the beginning eruption appearance in the area of genitalia the nodular eruptions appeared on the skin of face, neck, and trunk, upper and lower extremities. The patient received hospital treatment during 10 days in the Dermatovenereallogic dispensary at the place of residence with diagnosis pyoderma. The therapy prescribed was failed.

Objectively: the general patient’s condition is satisfactory, body build is regular, normostenic. Peripherical lymph nodes in all groups are increased with the size of fine pea, not adherent to the adjacent tissues, non-tender. Body temperature was 38 °C. Auscultation of the lungs showed rigid bronchial breathing, moist rale, fine bubbling rale. The heart tones are muffled, rhythmic. Pulse was 90 beats/min; arterial pressure was 90/60 mmHg. The abdomen at palpation is soft, non-tender, the liver is extended at the costal margin, the spleen is not palpable. The Pasternatskiy’s symptom is poorly positive on the both sides. The stool tended to the constipation.

The cutaneous-pathological process has symmetrical character and is extended on the skin of face, neck, trunk, upper and lower extremities, mucosa of the hard palate, and genitalia.

On the skin of the above-mentioned sites there were found vesicles of the sizes from millet seed to pea, forming patches of sizes of 3-copy coin, of round oval outlines with well defined borders, of cyanotic-purple colour, and of dense -elastic consistence (Fig. 1—3). On the skin of the large pudendal lips with involvement of small pudendal lips and of pubic region there were noted erosive-ulcerative lesions of irregular outlines with well defined borders and covering with hemorrhagic scabs in some places. Subjectively: burning, tenderness in the focus of lesion (Fig. 4).

Laboratory examinations. General blood analysis: Hb — 70 g/l, erythrocytes — 2.4 ± 10^12/l, color index — 0.8, leucocytes — 4.0 ± 10^9/l, band neutrophils — 1 %, segmented neutrophils — 60 %, eosinophils — 2 %, lymphocytes — 35 %, monocytes — 2 %, ESR — 12 mm/h; the urine examination: specific gravity — 1.014, protein — 0.099 g/l, squamous epithelium — 5—6, renal epithelium — 1—2, leucocytes — 8—10, not changed erythrocytes — 1—2, mucus +. The biochemical blood analysis: total protein — 60 g/l, urea — 2.3 Mmol/l, creatinin — 66.8 Mmol/l, cholesterol total — 4.8 Mmol/l, bilirubin total — 12.0 Mmol/l, ALT — 18 Nmol/s/l, AST — 19 Nmol/s/l, glutasa — 4.0 Mmol/l.

Histological investigation: herpes genitalis (biopsies were obtained from the focus of lesion on
the large pudendal lips); Kaposi sarcoma (biopsies were obtained from the focus of lesion on the trunk). IFA for HIV infection with subsequent immunoblot of July 10, 2009 was positive.

Ultrasonography of the liver, the gallbladder, the spleen and the uterine adnexa was without echopathology.

The gynecologist consultation: Diagnosis: ovarian dysfunction, acute vulva ulcer.


On the basis of history of disease, clinical-instrumental examinations the patient was made the diagnosis of HIV infection IV clinical stage, AIDS, Kaposi Sarcoma, genital herpes, chronic bilateral bronchopneumonia, chronic pyelonephritis, iron-deficiency anemia stage 3.

The treatment carried out: Sol. Vit C 5 % — 2.0 ml i/m units N 5, Sol. Vit B₆ 5 % — 1.0 ml i/m units N 5, Sol. B₁ 5 % — 1.0 ml i/m units N 5, Sol. Vit B₁₂ 500 γ i/m units N 5, Sol. Gentamicini 80 mg i/m every 8 hours for 5 days, Sol. Calcii gluconatis 10 % — 10 ml + Sol. Natrii chloride 0.9 % — 200.0 ml i/m units N 5, Tab. Ulkarili 200 mg in dose 2 tab. 3 times/day for 5 days, Azitromicin 250 mg in dose 2 tab. 1 time per day for 5 days, Tab. Feropleks in dose 2 tab. 3 times/day for 5 days. Externally:

Fig. 1. Nodular-patches elements on the skin of face

Fig. 2. Macular elements on the mucosa of the hard palate

Fig. 3. Nodular-patches elements on the skin of back

Fig. 4. Erosive-ulcerative lesions on the skin of the large and small pudendal lips and of pubic region
methylene blue 2%, levamisalicylic ointment on the genitalia organs, and dermovite ointment on the other sites.

The patient was discharged with insignificant clinical improvement under the further supervision by the doctor treating AIDS.

Thus, the given example testifies that the delayed diagnosis of HIV an infection has resulted in development of various opportunistic infections, and the absence of adequate treatment has led to aggravation of the general health state and decrease of the quality of life of the patient.

This example presents specific interest for the practical doctors, firstly, increase of the amount of HIV-infected individuals will promote increase in opportunistic diseases, which dermatological manifestations are on the leading place and, secondly, as a mistake in diagnostics having important meaning role in the choice of methods and tactics of management.

References

AIDS-associated dermatosis in clinical practice: Kaposi sarcoma and Herpes genitalis

All groups of herpes viruses are considered as pathogenetically connected with HIV-infection. The herpes simplex virus in the patients with AIDS is characterized by severe chronic (more than 1 month) process with formation of ulcerative lesion, distribution of herpetic eruptions on the various skin sites and mucous membranes. AIDS-associated Kaposi’s sarcoma (KS) occupies the sixth place after infections induced by herpes simplex virus in the WHO bulletin «AIDS-indicated diseases». KS is one of typical manifestations of the secondary immune deficiency, «opportunistie» tumor and is considered as «indicatory» disease in HIV-infection. This work presents the clinical case of AIDS-associated Kaposi sarcoma in combination Herpes genitalis. Thus, the given example testifies that the delayed diagnosis of HIV an infection has resulted in development of various opportunistic infections, and the absence of adequate treatment has led to aggravation of the general health state and decrease of the quality of life of the patient.
Epidemic Kaposi Sarcoma (HIV-Associated Kaposi Sarcoma). Epidemiology. Kaposi sarcoma (KS) was first described in 1872 by the Hungarian dermatologist, Moritz Kaposi. Reduced incidence of Kaposi's sarcoma and of systemic non-hodgkin's lymphoma in HIV-infected individuals treated with highly active antiretroviral therapy. Int J Cancer 103 (1): 142-4, 2003. [PUBMED Abstract]. Grabar S, Abraham B, Mahamat A, et al.: Differential impact of combination antiretroviral therapy in preventing Kaposi's sarcoma with and without visceral involvement. Changes in Clinical Context for Kaposi's Sarcoma and Non-Hodgkin Lymphoma Among People With HIV Infection in the United States. J Clin Oncol 34 (27): 3276-83, 2016. [PUBMED Abstract]. The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for AIDS-Related Kaposi Sarcoma provide diagnosis, treatment, and surveillance recommendations for PLWH who develop limited cutaneous Kaposi sarcoma and for those with advanced cutaneous, oral, visceral, or nodal disease. Copyright Â© 2019 by the National Comprehensive Cancer Network. Publication types. Practice Guideline. Research Support, N.I.H., Extramural. MeSH terms. AIDS-Related Opportunistic Infections / diagnosis*. Methodical recommendations â€œPractical dermatologyâ€ were designed for the international students and based on the typical program in dermatology. Recommendations include tests, clinical tasks and practical skills in dermatology that arc used as during practical classes as at the examination. DED'Dš 616.5:37.022.â–²0 D'Dš 55.83p30+55.81p30. C Adaskevich UP, Valles-Kalouskaya VV, Katina MA. The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for AIDS-Related Kaposi Sarcoma provide treatment recommendations for HIV seropositive individuals who develop Kaposi sarcoma and are intended to assist healthcare providers with clinical decision-making. This Discussion section provides an overview of the literature supporting the recommendations included in the guidelines. In clinical practice the following changes of heart sounds may be met; 31. 1. Volume change of the main sounds (S1 and S2); 2. Splitting (doubling) of the main sounds; 3. Appearing of additional sounds: S3 and S4, mitral valve opening snap (OS), additional systolic sound (click) and the so-called pericardium tone. It is best heard in expiration over the aortic area and the apex. It is associated with dilatation of the aorta and can be heard in cases of hypertension, coarctation and atherosclerosis. Systolic gallop is a three-part rhythm appearing in case of additional short sound, or systolic flap, rise in the period of ventricles systole (between S1 and S2). A nonejection systolic click is heard together with a systolic murmur in association with mitral valve prolapse.