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# HIV Infection at the Stage of Primary Manifestations: Features of the Clinical Picture, Diagnosis and Antiretroviral Therapy

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**Resume.** Currently, chronic viral infections are a serious medical and social problem. The most significant pathogens include human immunodeficiency viruses (HIV infection), hepatitis B and C (HBV and HCV). Despite the progress made in studying the etiology, pathogenesis, and clinical presentation of these diseases, they are still difficult to treat, which leads to a decrease in the working capacity of the infected population and an increase in the financial costs of healthcare.

**Keywords:** hepatitis B, hepatitis C, HIV infection, CD8 T cells, heterosexual contacts.

**Relevance.** Currently, viral hepatitis C in HIV-infected patients remains an urgent problem. The unity of the ways of transmission of these infections determined the high level of frequency of their combined course. The epidemic of injection drug addiction that began in the 1990s in the CIS countries, including our country, determined a significant increase in the incidence of hepatitis C and HIV infection in the form of mono and mixed infections [2]. The nature of the course of hepatitis C in HIV-infected patients was studied mainly by foreign researchers [1]. Co-infection of viral hepatitis C and HIV greatly increases the severity of the course of viral hepatitis C and accelerates the process of formation of liver cirrhosis [3].

Characterized in the initial period by an asymptomatic course, viral infections are often not recognized in time, which contributes to their wide spread. According to WHO, there are 36.7 million people with HIV infection in the world (at the end of 2016) and 325 million infected with HBV and HCV (WHO Global hepatitis report, 2017). Often these diseases occur in combination. Thus, chronic hepatitis C is registered on average in 20% of HIV-infected people [2].

The coexistence of two or more diseases that coincide in time or are pathogenetically interconnected in one patient is called comorbidity. This condition modifies the usual clinical picture of these diseases. In most cases, in the presence of combined conditions associated with HIV infection, the human immunodeficiency virus plays a leading role in pathogenesis. Concomitant diseases also often induce immune disorders themselves, so the development of HIV infection against their background often exacerbates its course, causing the development of resistance to ongoing antiretroviral therapy [4].

Tuberculosis, viral hepatitis, mycoses, herpes zoster, secondary pyoderma are most often registered against the background of HIV infection, which is associated with the failure of the immunological response [1].

The advent of highly active antiretroviral therapy has significantly improved the quality and life expectancy of patients. At the same time, it was noted that, as patients with HIV infection age, they more often have pronounced concomitant somatic, oncological, neuropsychiatric, and dermatological diseases [5].

Skin lesions at different times of HIV infection are observed in 90% of patients. As a rule, comorbidity modifies the classical clinical picture of dermatoses. In most cases, they proceed atypically, tend to spread widely and are resistant to standard treatment [3].

It is known that HIV infection reduces the number of CD4+ lymphocytes and increases the number of CD8+ helpers, which leads to the predominance of autoimmune diseases associated with CD8+ T cells. Thus, psoriasis in HIV-infected people occurs with a frequency of up to 6%, which exceeds the value of this indicator in the population. At the same time, dermatosis proceeds severely, often with the development of generalized pustular and erythrodermic forms, and the rapid progression of arthritis [4].

The course of dermatoses can also be influenced by ongoing antiretroviral therapy. Polypharmacy that occurs during the treatment of patients with HIV infection increases the likelihood of developing local and systemic side effects of drugs. Such manifestations include the development of tardive cutaneous porphyria and melasma [2].



**Purpose of the study.** Studying the features of the course of acute HIV infection with the subsequent development of approaches for the use of HAART at this stage of the disease.

**Material and research methods.** The object of the epidemiological study was the population who underwent AH with HIV in the period 2021-2022, living in the territories of Andijan.

**Research results.** The characteristic clinical manifestations of the acute period of HIV infection were: lymphadenopathy (80.6%), fever (74.6%), increased fatigue (74.6%), polymorphic rash (50.7%), pharyngitis (50.7%), night sweats (46.3%) and headaches (34.3%). The duration of clinical symptoms averaged 5 days.

Secondary diseases in the acute period of HIV infection were diagnosed in 28.4% of patients. The severity of clinical symptoms of acute HIV infection depended on the concentration of HIV RNA and the number of CO4+ lymphocytes.

In the vast majority of patients (83.6%), HIV infection occurred through sexual contact. In 15% of patients, the cause of HIV infection was intravenous administration of psychoactive substances.

In men who have sexual contacts with men, significantly more often, compared with persons who became infected with HIV through heterosexual contact or intravenous administration of psychoactive substances, pronounced clinical symptoms of the acute period of HIV infection were observed.

A 3-month course of HAART had no significant effect on the course of acute infection. An increase in the duration of therapy up to 6 months led to a slower progression of the disease in 72% of patients after its withdrawal.

HAART was most effective when administered during the first 3 months of acute HIV infection.

**Conclusion.** As a result of the study, clinical and epidemiological criteria for establishing the diagnosis of acute HIV infection were determined. Indications for the appointment of HAART in patients with acute HIV infection have been developed. Evaluation of the dynamics of the level of HIV RNA and the number of CO4+ lymphocytes during HAART in patients with acute HIV infection made it possible to establish that the duration of therapy should be at least 6 months.

Thus, knowledge of the pathogenesis and interrelationships of associated diseases, infection alertness, in-depth history taking and adherence to the completeness of the diagnostic algorithm make it possible to timely establish the final clinical diagnosis and determine the tactics of adequate therapy.

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