



DEVELOPMENT OF A SCORING SYSTEM FOR ASSESSING THE RISK OF A RECURRING COURSE IN HERPES SIMPLEX INFECTION

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Relevance. Current guidelines recommend suppressive therapy for patients with more than six recurrences per year, that is, the decision rests on the number of episodes already recorded. The absence of criteria allowing patients at high risk of a recurring course to be identified in advance restricts the preventive approach, particularly at the primary care level, where laboratory facilities are limited.

Aim. To develop and substantiate a scoring system for assessing the risk of a recurring course of herpes simplex infection on the basis of epidemiological factors alone.

Materials and methods. Epidemiological data were collected from 240 participants using a standardised seven-section questionnaire administered under identical conditions by a single investigator. Assessment proceeded in two stages. At the first stage, single-factor analysis was performed for each factor: intergroup frequencies were compared using the χ^2 test, and odds ratios (OR) with 95% confidence intervals were calculated by Woolf's method.

At the second stage, all factors significant at $p < 0.10$ in single-factor analysis were entered into a multivariate logistic regression model, with age and sex included as mandatory adjusting variables. Model quality was assessed by the Hosmer–Lemeshow test.

Results. Six factors with confirmed independent significance were identified: hypothermia (OR=4.8; 95% CI 2.6–8.9), chronic or acute stress (OR=3.9; 95% CI 2.1–7.3), intercurrent respiratory infections (OR=3.4; 95% CI 1.9–6.2), hormonal



changes in women (OR=3.1; 95% CI 1.7–5.8), chronic comorbidity (OR=2.7; 95% CI 1.3–5.5) and insolation (OR=2.6; 95% CI 1.3–5.1).

A transparent scoring rule was adopted: factors with an adjusted OR of 3.5 or above were assigned 2 points, and those below 3.5 were assigned 1 point. This stratification simplifies the system and facilitates its use in primary care while preserving the relative weight of the factors. The Epidemiological Risk Index (ERI) is calculated as the simple sum of the points recorded and ranges from 0 to 8.

On the basis of the index value, participants were stratified into three categories: low risk (below 3 points), intermediate risk (3–5 points) and high risk (6 points or more). Boundaries between the categories were selected from receiver operating characteristic analysis at the maximum value of Youden's index.

Conclusion. The proposed Epidemiological Risk Index is based exclusively on questionnaire data and existing medical records, requires no laboratory facilities or specialist training, and can therefore be applied by a family physician or at a rural medical post. Determining its prognostic accuracy will require a prospective study with baseline measurement followed by observation.