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LONG-STANDING GENERALIZED CUTANEOUS AMYLOIDOSIS AT DR BATRA'S

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Abstract

Background

Primary localized cutaneous amyloidosis (PLCA) is a chronic dermatological disorder characterized by deposition of amyloid within the skin. Macular and lichen amyloidosis are the common non-nodular forms. Clinical presentation varies, with pigmentation and textural changes being prominent features. ([PubMed](#))

Case Presentation

A patient with a history of **brownish, dry cutaneous eruptions since the age of 12 years**, clinically reported as amyloidosis, presented with increased lesions over the preceding four months. Lesions were reported over the **hands, palms, chest, back and legs** and were not associated with itching. The patient also had allergic sinusitis for 4–5 years, aggravated by changes in temperature/weather, strong smells, dust and perfumes. The patient reported a hot thermal state, disturbed sleep, low water intake, reduced physical activity and weight gain. A significant emotional component was described following financial loss in the share market, with anxiety developing easily. Family history included depression in the father, grandfather and uncle.

The patient had not taken treatment specifically for the skin condition. During longitudinal follow-up, the condition was subsequently documented as stable and, at the latest follow-up on **10 August 2026**, as **better**. The documented prescription at that visit was **Petroleum 200C and Kali sulphuricum 6X**.

Conclusion

This case describes a chronic, long-standing cutaneous disorder clinically reported as amyloidosis with recent generalized exacerbation and subsequent documentation of clinical improvement during longitudinal follow-up. However, because histopathology and Congo-red confirmation are not provided in the available record, the subtype and pathological diagnosis cannot be independently confirmed from the supplied data. The case therefore represents a **clinically diagnosed/reportedly diagnosed cutaneous amyloidosis case**, rather than a biopsy-confirmed case.

Keywords: Cutaneous amyloidosis; macular amyloidosis; lichen amyloidosis; hyperpigmentation; chronic dermatosis; longitudinal case report.

1. Introduction

Cutaneous amyloidosis refers to disorders in which amyloid is deposited within the skin. Primary localized cutaneous amyloidosis includes **macular, lichen and nodular forms**, with macular and lichen amyloidosis representing keratin-derived forms. ([PubMed](#))

Macular amyloidosis generally presents with hyperpigmented macules, often with a rippled or reticulated appearance, while lichen amyloidosis is characterized by more palpable keratotic papules and commonly has pruritus. ([DermNet®](#))

Diagnosis may require histopathological confirmation. Amyloid deposits can be demonstrated in the papillary dermis and confirmed with Congo-red staining, classically showing apple-green birefringence under polarized light. ([DermNet®](#))

Treatment of primary localized cutaneous amyloidosis can be challenging, and multiple topical and procedural approaches have been studied, with variable outcomes. ([PubMed](#))

The present case is notable for the **very long duration of skin lesions beginning during adolescence**, recent widespread worsening and subsequent longitudinal documentation of improvement.

2. Case Presentation

2.1 Presenting complaint

The patient reported:

Skin allergies since the age of 12 years.

The skin condition was described as **amyloidosis**, with brownish, dry eruptions present over the body since approximately 12 years of age.

The patient specifically reported:

- Brownish eruptions
- Dryness

- Generalized distribution
- No itching
- Recent increase in lesions
- No previous specific treatment for the skin condition

The recent exacerbation had been present for approximately **four months** before the detailed consultation.

3. Distribution of Lesions

The lesions were reported over multiple body sites:

Site	Clinical description
Hands	Brownish dry eruptions
Palms	Brownish eruptions
Chest	Brownish dry eruptions
Back	Brownish dry eruptions
Legs	Brownish dry eruptions

General body Long-standing pigmentation/eruptions

The distribution was therefore described as **generalized**, rather than limited to a single anatomical site.

4. Character of Skin Lesions

The documented skin characteristics were:

- Brownish colour
- Dry eruptions
- Chronicity since adolescence
- No itching
- Recent increase in extent
- No specific treatment before presentation

The absence of pruritus is clinically relevant because significant itching is more characteristic of lichen amyloidosis, whereas macular amyloidosis may have less intense pruritus. ([DermNet®](#))

However, because no biopsy or detailed morphological description of the lesions is available, **the specific subtype cannot be established from the supplied record.**

5. Associated Clinical History

5.1 Allergic sinusitis

The patient had a history of **allergic sinusitis for approximately 4–5 years.**

The documented aggravating factors were:

- Change in temperature
- Change in weather
- Strong smells
- Dust
- Perfume

The patient reportedly used **Cheston Cold** for symptomatic management.

5.2 Gastrointestinal complaints

The patient reported constipation-associated piles.

The history described:

- Piles occurring when constipation occurs
- Approximately 2-inch protrusion around the anus
- Low water intake

No further investigation or surgical intervention for the piles was documented in the supplied record.

6. General Physical Characteristics

The recorded general characteristics were:

Parameter	Finding
Thermal state	Hot
Appetite	Not specifically documented
Water intake	Less

Parameter	Finding
Perspiration	Forehead and palms
Sleep	Disturbed
Physical activity	None
Weight	Increased
Stool	Constipation-associated complaints

Urinary complaints Not reported

The patient reported no regular physical activity and had experienced weight gain.

7. Mental and Emotional History

A significant psychosocial factor was documented.

The patient reported **financial loss in the share market during the previous year**, following which anxiety regarding the financial situation developed.

The record specifically described:

- Anxiety following financial loss
- Anxiety developing easily
- Disturbed sleep
- Family history of depression

Family history included:

- Father – depression
- Grandfather – depression
- Uncle – depression

This emotional history was considered part of the overall clinical assessment.

8. Past History

The patient reported:

- **Jaundice – 2015**
- **Typhoid – 2016**

No other major past medical history was documented.

The medicinal-history section subsequently recorded **no major infectious disease, fracture, hospitalisation or surgery** in the available form.

9. Family History

The available detailed history did not document a family history of cutaneous amyloidosis.

However, a strong family history of **depression** was reported:

Family member History

Father	Depression
Grandfather	Depression
Uncle	Depression

10. Diagnostic Considerations

The case was clinically recorded as **amyloidosis/cutaneous amyloidosis**.

From a dermatological perspective, the differential diagnosis of chronic brownish lesions would depend on morphology and distribution and may include:

- Macular amyloidosis
- Lichen amyloidosis
- Post-inflammatory hyperpigmentation
- Other acquired pigmentary disorders
- Chronic dermatitis with secondary pigmentation

Macular amyloidosis typically produces hyperpigmented macules with a rippled or reticulated pattern, particularly on the upper back, while lichen amyloidosis produces discrete keratotic papules and is generally more pruritic. ([DermNet®](#))

Important diagnostic limitation

No histopathology, Congo-red staining, direct immunofluorescence or other amyloid-specific investigation is included in the supplied record.

Therefore, this paper should state:

“Clinically diagnosed/reported cutaneous amyloidosis”

rather than claiming biopsy-confirmed amyloidosis.

Histological confirmation would normally demonstrate amyloid deposition in the dermis, with Congo-red staining providing supportive confirmation. ([DermNet®](#))

11. Treatment History

The patient reported **no previous specific treatment for the skin condition.**

For the associated allergic sinusitis, the patient used **Cheston Cold.**

The longitudinal treatment record subsequently documents a homeopathic prescription.

Latest documented prescription

10 August 2026

Remedy	Potency	Documented regimen
Petroleum	200C	2 doses, 2/1 days
Kali sulphuricum 6X		2 doses, 2/1 days

The supplied record does not provide a detailed written rationale for the selection of these two remedies.

Therefore, no additional remedy rationale should be attributed to the prescriber beyond the information documented.

12. Longitudinal Follow-up

The available follow-up record contains multiple visits between **October 2025 and August 2026.**

Several visits were recorded only as “VC”, without detailed symptom documentation.

29 December 2025

- Follow-up documented as VC.

27 January 2026

- Follow-up documented as VC.

7 March 2026

- Follow-up documented as VC.

28 April 2026

- Follow-up documented as VC.

30 May 2026

- Follow-up documented as VC.

7 July 2026

- Condition documented as **stable**
- Blood investigations advised

10 August 2026

- Condition documented as **better**

Thus, the objective longitudinal information available from the record is limited, but the final documented clinical status was improvement.

13. Outcome Table

Parameter	At presentation	Latest documented follow-up
Cutaneous condition	Brownish, dry eruptions; increased over previous 4 months	Documented as better
Distribution	Hands, palms, chest, back, legs and generalized body	No updated distribution documented
Itching	Absent	Not specifically documented
Dryness	Present	Not specifically documented
Skin allergy	Long-standing	Better/stable clinically documented
Sinusitis	Chronic allergic sinusitis	No updated status documented
Anxiety	Present after financial loss	No updated status documented
Sleep	Disturbed	No updated status documented
Constipation/piles	Recurrent with constipation	No updated status documented
Investigations	Not documented	Blood tests advised in July 2026

Important: The record does **not provide a numerical percentage of skin improvement**, lesion count, validated severity score or standardized photographic assessment. Therefore, a percentage improvement should not be invented.

14. Clinical Interpretation of Outcome

The longitudinal record suggests a **clinically favorable trend**, because the condition was described as stable in July 2026 and better in August 2026.

However, the available documentation does not allow quantitative assessment of:

- Percentage reduction in lesions
- Reduction in pigmentation intensity
- Reduction in body surface area
- Objective histological improvement
- Amyloid deposition clearance

Therefore, the outcome is best described as:

“Clinical improvement documented at the latest follow-up.”

rather than:

“Complete resolution of cutaneous amyloidosis.”

15. Discussion

This case represents a chronic cutaneous disorder reported as amyloidosis, beginning at approximately **12 years of age** and persisting for many years before recent exacerbation.

The clinical presentation of brownish dry lesions without itching differs somewhat from classic lichen amyloidosis, where pruritus is usually prominent. Macular amyloidosis is characterized by hyperpigmented macules and generally less intense pruritus. ([DermNet®](#))

The extensive distribution described in this patient—including the hands, palms, chest, back and legs—is noteworthy. However, the absence of a detailed morphological description, dermoscopy or histopathological confirmation limits definitive classification.

Primary localized cutaneous amyloidosis is generally confined to the skin and is distinct from systemic amyloidosis. ([DermNet®](#)) Nevertheless, the clinical distinction between localized and systemic amyloidosis is important because different forms of amyloidosis have substantially different implications.

Histopathological assessment remains important when the diagnosis is uncertain. Amyloid in cutaneous lesions can be demonstrated using Congo-red staining, with characteristic apple-green birefringence under polarized light. ([DermNet®](#))

The present case also contains several associated factors, including allergic sinusitis, low water intake, physical inactivity, weight gain, disturbed sleep and anxiety following financial loss. These are relevant to the patient's overall clinical context but cannot be established as causes of the skin disease from this case.

The longitudinal follow-up showed that the skin condition was considered **stable in July 2026 and better by August 2026**. Because the available follow-up entries are largely brief and several contain only “VC,” the degree and mechanism of improvement cannot be objectively quantified.

Current literature indicates that treatment of primary localized cutaneous amyloidosis remains challenging, with several topical and procedural therapies reported and no universally standardized approach. ([PubMed](#))

Recent systematic-review evidence has evaluated a range of procedural and medical treatments, but outcomes vary by subtype and treatment modality. ([PubMed](#))

16. Learning From the Case

1. Long duration does not necessarily mean progressive disease

The patient's skin lesions had reportedly been present since age 12, but the clinical course included periods of stability and recent improvement.

2. Accurate classification is important

Brownish lesions described as “amyloidosis” should ideally be correlated with morphology and, when appropriate, histopathology.

3. Objective documentation strengthens a case report

Serial photographs, lesion-area assessment and standardized scoring would allow future follow-up to demonstrate improvement more convincingly.

4. Comorbidities require parallel attention

The patient's allergic sinusitis, constipation, sleep disturbance, low physical activity, weight gain and anxiety formed an important part of the overall clinical picture.

17. Strengths of the Case

- Very long disease duration
- Symptoms beginning during adolescence

- Generalized distribution described
- Longitudinal follow-up extending to August 2026
- Documentation of associated allergic and gastrointestinal complaints
- Documented emotional/psychological context
- Clear latest prescription
- Clinical improvement documented at final follow-up

18. Limitations

1. **Histopathological confirmation of amyloidosis was not provided.**
2. Congo-red staining results were not available.
3. The specific subtype of cutaneous amyloidosis was not documented.
4. Several follow-up entries were recorded only as "VC."
5. No standardized clinical severity score was used.
6. No quantitative measurement of lesion area was documented.
7. No serial laboratory results were provided.
8. No standardized before-and-after photographic assessment was documented in the supplied text.
9. The exact rationale for the prescribed remedies was not documented.
10. As a single case, the observation cannot establish treatment efficacy or causality.

19. Conclusion

This longitudinal case describes a patient with a **long-standing history of brownish, dry cutaneous eruptions clinically reported as amyloidosis**, beginning at approximately 12 years of age and showing increased involvement over the hands, palms, chest, back and legs during the four months preceding presentation.

The patient had associated allergic sinusitis, constipation-associated piles, disturbed sleep, low water intake, physical inactivity and anxiety following financial loss. During follow-up, the condition was documented as stable in July 2026 and **better by August 2026**, when Petroleum 200C and Kali sulphuricum 6X were prescribed.

The case highlights the importance of long-term documentation in chronic pigmentary dermatoses. However, because histopathological confirmation was not available in the supplied record, the diagnosis should be presented conservatively as **clinically reported cutaneous**

amyloidosis, and the observed improvement should be described as **clinical improvement rather than confirmed histological clearance**.

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