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OPEN ACCESS JOURNALS

Archives of Clinical & Experimental Dermatology

Clinical Image | Vol 2 Iss 1

Primary Localized Cutaneous Amyloidosis

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Received: May 02, 2020; **Accepted:** May 15, 2020; **Published:** May 22, 2020

***Keywords:** Cutaneous amyloidosis; Family; Macular pigmentation*

1. Clinical Image

A 54 year-old women, suffering from Hashimoto's thyroiditis which currently required only clinical monitoring, presented to our Clinic for the management of a pruritic pigmented lesion of the back. This macule appeared about 20 years before without paraesthesia, opposite the right scapula, with similar history in his family. She denied photosensitivity or any history of excessive sun exposure. Dermatological examination showed confluent macular not infiltrate to the touch, smooth surface, no scales, pigmented seat in the upper back, especially opposite the scapula, about 15 cm, (FIG. 1). She was of Fitzpatrick skin type 4. Dermoscopy showed a homogeneous linear pigmentation, no erythema (FIG. 2). Histology revealed hyperkeratosis and in the papillary dermis the presence of acidophilic intracellular, amorphous and flaky deposits pushing the cell nuclei to their periphery. There is also superficial melanic pigmentary incontrince. These deposits had affinities to amyloid stain. These deposits are PAS positive and are enhanced by the purple crystal. A certain superficial melanic pigmentary incontinence is associated with them. Elsewhere, the dermis is slightly fibrous. other family members, all female, also had pruritic, hyperpigmented patches on the trunk. Genetic testing was not indicated because it was felt that it would not alter the management of the patient and her family. The patient is treated with dermocorticoid and antihistamine, with regression of pruritus but persistence of pigmentation.

Primary localized cutaneous amyloidosis (PLCA), first described in 1970 [1], is characterized by amyloid deposition in the superficial dermis without systemic manifestations. The precise etiology of PLCA remains poorly understood, although several risk factors have been identified, e.g., South American or Asian heritage, female sex, family history, atopy, sun exposure, and frictional epidermal damage [2]. Most cases of PLCA are sporadic, but a family history is present in approximately 10% [3]. It typically presents as gray or brown pruritic macules, which coalesce to form patches with a rippled pattern. The upper back, chest, and arms are commonly involved, sparing the hands, feet, and face in most cases, with no predisposition

for sun-exposed sites [4]. The treatment is on breaking the itch scratch cycle; the topical corticosteroids and antihistamines are recommended first line [1], Other treatments, including systemic retinoids, phototherapy, and ciclosporin, have all demonstrated benefit in case reports and small case series, but requires further study to prove their effectiveness [4]. cutaneous amyloidosis it can be an autosomal dominant hereditary disease requires several genetic studies to look for new mutations and explains the pathophysiology [5].

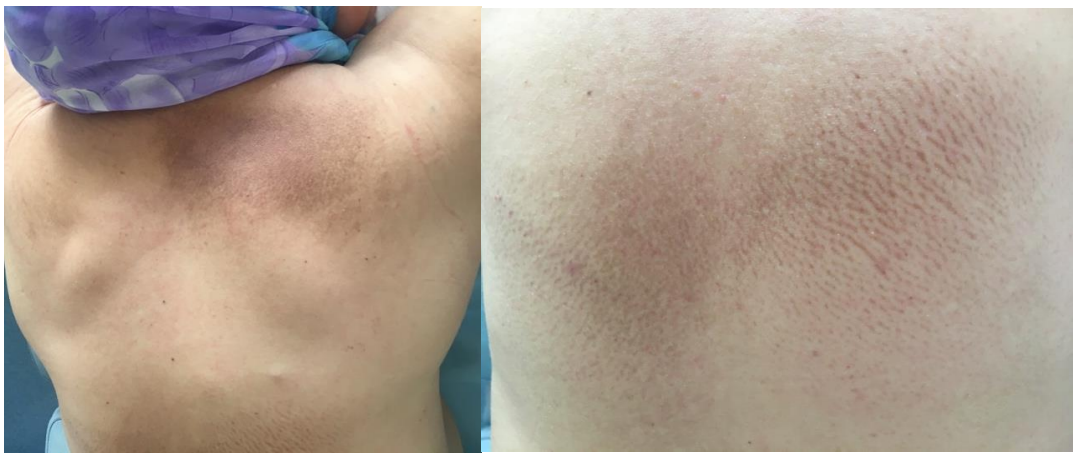

FIG. 1. **Macular hyperpigmentation on the upper back.**

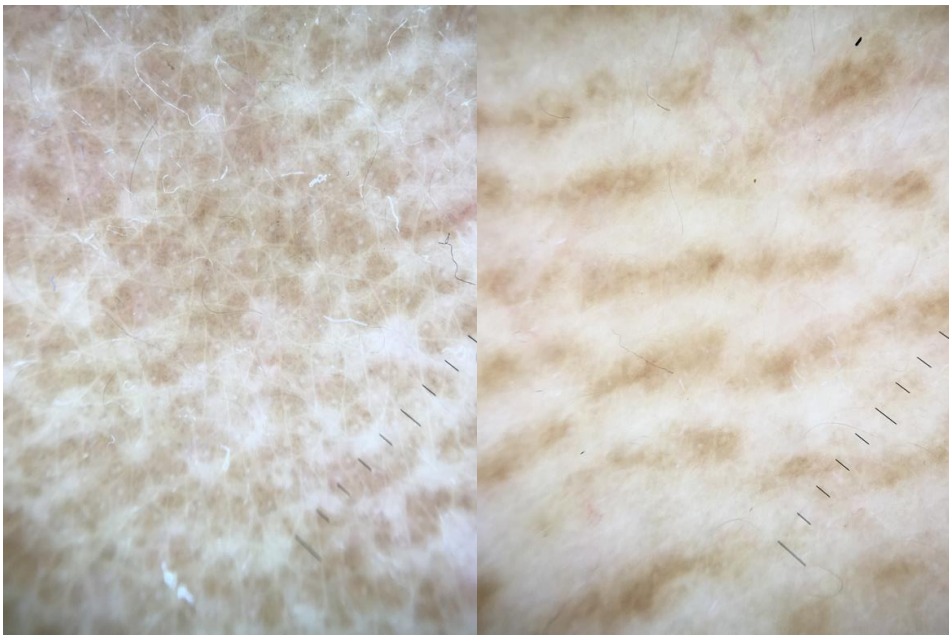

FIG. 2. **Dermoscopy with a homogeneous linear pigmentation, no erythema.**

2. Consent

The examination of the patient was conducted according to the Declaration of Helsinki principles.

3. Declaration of Interests

The authors declare that they do not have any conflicts of interest by relationship with this article.

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