A Case-Based Exploration of Clinical Remission in Pustular Eczema Managed by Individualized Homoeopathic Treatment

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***Abstract*—Background:** **Eczema is a common inflammatory dermatosis characterized by pruritus, erythema, papulation, vesiculation, exudation, crusting and scaling. Pustular lesions may occur in inflammatory dermatoses and require careful clinical assessment because pustules may also indicate bacterial, fungal or viral infection or other primary pustular disorders. Pustules represent collections of purulent inflammatory material and may be either infectious or sterile. [1]**
Case presentation: An illustrative case of a young adult presenting with recurrent pruritic pustular eczematous lesions is described. The eruption was characterized by erythematous, edematous and partially crusted plaques associated with multiple small pustules and marked itching. The clinical diagnosis was made after considering infective and inflammatory differentials. The case was managed according to an individualized homoeopathic approach. Sulphur 200 was initially prescribed on the basis of the totality of characteristic symptoms. During subsequent follow-up, the symptom picture evolved and Pulsatilla 30 was prescribed according to the changed clinical and constitutional picture. Clinical progress was documented serially through changes in pustulation, erythema, itching, crusting and development of new lesions. Outcome: Progressive reduction in itching, pustulation, erythema and exudation were observed during follow-up, followed by resolution of active lesions and residual post-inflammatory changes. No adverse event attributable to the prescribed medicines was reported in the model clinical sequence. Conclusion: This case illustrates the use of individualized homoeopathic prescribing in a patient with a pustular eczematous presentation and demonstrates the importance of longitudinal clinical documentation. The observation should be interpreted as a case-level clinical experience and not as evidence establishing the efficacy of homoeopathy for eczema. Controlled studies are required to determine treatment effects.

***Index Terms*—Pustular eczema; Eczema; Sulphur; Pulsatilla; Individualized homoeopathy; Case report.**

I. INTRODUCTION

Eczema represents a heterogeneous group of inflammatory skin disorders characterized clinically by pruritus and variable combinations of erythema, papules, vesicles, oozing, crusting, scaling, excoriation and lichenification. The clinical diagnosis depends principally on morphology, distribution, chronology and associated features, while alternative diagnoses must be considered when the presentation is atypical. [2]
Pustules are small lesions containing purulent material, usually less than approximately 5–10 mm in diameter. Importantly, the presence of pus does not by itself establish bacterial infection; pustules may occur in infectious as well as sterile inflammatory skin diseases. [1] Consequently, a patient presenting with pustular lesions requires appropriate clinical assessment and consideration of infectious and non-infectious differential diagnoses.
The differential diagnosis of an eczematous eruption may include allergic or irritant contact dermatitis, atopic dermatitis, seborrhoeic dermatitis, psoriasis, dermatophyte infection, scabies and other

inflammatory or infectious dermatoses. [2] the morphology and distribution of the eruption, associated symptoms, previous treatment, temporal progression and response to treatment are therefore important in establishing a clinically coherent diagnosis.

From a homoeopathic perspective, treatment is traditionally individualized on the basis of the totality of characteristic symptoms rather than the diagnostic label alone. In classical materia medica, Sulphur has extensive descriptions involving itching, burning, pustular eruptions, crusting and eczematous conditions. [3] Pulsatilla is also described in traditional materia medica with a range of cutaneous eruptions, including itching, moist eruptions, pustules and crusting. [4] These historical descriptions constitute the traditional rationale for remedy consideration but should not be interpreted as modern clinical evidence of efficacy.

Evidence concerning homoeopathy in eczema remains limited and heterogeneous. A systematic review of controlled clinical trials concluded that the available evidence was insufficient to establish efficacy for eczema.[5] Subsequent randomized studies of individualized homoeopathy in atopic dermatitis have produced mixed findings, including a preliminary trial in which between-group differences were not statistically significant and a later replication trial reporting a statistically significant difference in the primary outcome.[6,7] Such findings reinforce the importance of cautious interpretation and rigorous documentation.

The present case report is intended to demonstrate a structured clinical approach to an eczematous eruption with pustular morphology and the longitudinal prescribing of Sulphur 200 followed by Pulsatilla 30.

Case Presentation

Patient Information

A young adult patient presented to the outpatient department with recurrent itchy eruptions over the trunk and extremities. The patient reported that the eruption had initially appeared as small erythematous, intensely pruritic areas and subsequently developed papular and pustular lesions with intermittent oozing and crust formation.

The patient was otherwise clinically stable and did not report significant constitutional illness. There was no history suggestive of systemic infection at presentation. The clinical history was constructed around the dermatological episode, with emphasis on onset, progression, modalities, associated symptoms, previous treatment and response.

Chief Complaints

The principal complaints were:

- *intensely pruritic skin eruptions;*
- *recurrent pustular lesions over erythematous areas;*
- *burning and irritation following scratching;*
- *intermittent oozing followed by crust formation;*
- *disturbed sleep during periods of increased itching.*

The itching was reported to be more troublesome during the evening and at night. Scratching produced temporary relief but resulted in excoriation and occasional bleeding from superficial lesions.

History of Present Illness

The eruption developed gradually and increased in extent over several weeks. Initially, erythematous pruritic patches appeared over the extremities and subsequently became more widespread. Small papules developed over the inflamed skin, with some lesions progressing to superficial pustules.

The pustules were small and superficial. Following rupture, a small amount of serous or purulent-appearing material was discharged and subsequently dried to form thin crusts. Repeated scratching contributed to excoriations and secondary crusting.

There was no documented history of fever, malaise or other systemic features accompanying the skin eruption. The clinical course was predominantly cutaneous.

Previous topical treatment had provided incomplete or temporary relief, with recurrence of itching and eruption after discontinuation. The absence of sustained response prompted further evaluation and individualized case-taking.

Past and Family History

No significant chronic systemic disease was considered relevant to the presenting dermatological complaint in the model case. There was no documented history suggestive of a chronic autoimmune disorder.

Family history did not reveal a definite similar chronic pustular dermatosis. There was no significant history of recurrent severe skin disease among first-degree relatives.

Personal History

Appetite and thirst were essentially adequate. Bowel and urinary functions were regular. Sleep was disturbed principally during exacerbations of itching. The patient reported increased discomfort from warmth and experienced greater irritation after becoming overheated. The patient preferred relatively cool environmental conditions during periods of active eruption.

No definite food or drug trigger was established from the history.

Clinical Examination

Dermatological examination demonstrated multiple erythematous, ill-defined eczematous plaques with scattered papules and small superficial pustules. Some lesions showed evidence of rupture with superficial crusting. Excoriations were present at sites subjected to repeated scratching.

The surrounding skin showed varying degrees of erythema and dryness. There was no extensive ulceration or necrosis. No clinically significant lymphadenopathy was detected.

The distribution was predominantly over the extremities and selected areas of the trunk. Mucosal surfaces were not involved.

The morphology was considered compatible with an eczematous inflammatory eruption with pustular components. Because pustules may occur in several infectious and inflammatory disorders, the clinical diagnosis was made only after considering the relevant differential diagnoses. [1,2]

Diagnostic Assessment

The principal clinical diagnosis considered was pustular eczema.

The differential diagnoses considered included:

1. *Bacterial impetiginization – considered because of pustulation and crusting, but the absence of systemic illness and the overall eczematous morphology made uncomplicated impetigo less likely.*
2. *Pustular psoriasis – considered because of pustular morphology, although the overall lesion morphology and eczematous clinical pattern were not typical of generalized pustular psoriasis.*
3. *Dermatophytosis – considered in view of inflammatory plaques, but the morphology and distribution were not characteristic of classical tinea corporis.*
4. *Allergic or irritant contact dermatitis – considered because of the eczematous appearance; however, no consistent exposure relationship was established.*
5. *Scabies – considered because of nocturnal pruritus, but the distribution and lesion morphology were not characteristic of scabies.*
6. *Eczema with secondary infection – remained an important clinical consideration whenever pustulation and crusting were present.*

Pustular disorders have a broad differential diagnosis, and the presence of pustules alone is not diagnostic of infection. [1]

Where clinically indicated, investigations in an actual patient would include appropriate microbiological evaluation of purulent material, fungal examination or culture, complete blood count and other tests according to clinical suspicion. In this illustrative case framework, no systemic abnormality was assumed to be responsible for the cutaneous presentation.

II. HOMOEOPATHIC CASE ANALYSIS

The prescribing process was based on the totality of characteristic symptoms rather than the diagnostic name alone.

The prominent features considered were:

- *marked itching;*
- *aggravation during the evening/night;*
- *burning and irritation following scratching;*
- *pustular tendency;*
- *oozing followed by crust formation;*
- *recurrent eczematous eruption;*
- *tendency to scratching and excoriation;*
- *aggravation from warmth;*
- *relative preference for cool surroundings.*

Among the remedies considered, Sulphur was selected initially because the overall symptom combination corresponded to its traditional materia-medica profile, particularly the combination of itching, burning, eczematous eruption and pustular

manifestations. Traditional materia medica records contain descriptions of eczematous eruptions progressing through papulation, pustulation, crusting and desquamation, as well as intensely itchy pustular eruptions. [3]

The prescription was therefore:
Sulphur 200 – single dose, followed by observation.
The patient was advised not to repeat the medicine unnecessarily and to return for clinical reassessment.

Follow-up and Evolution
First Follow-up
At the first follow-up, the intensity of itching had decreased compared with the initial presentation. The patient reported fewer newly appearing pustules, while older lesions had begun to dry.
The erythematous component persisted but appeared less intense. There was no significant systemic adverse event.
As the clinical direction was considered favourable, repetition of Sulphur was withheld and observation was continued.

Second Follow-up
At subsequent review, active pustulation had reduced further. The number of new lesions had decreased, and several previously active lesions had undergone crusting and resolution.

The residual symptoms were different from the initial presentation. The remaining eruption was comparatively less inflammatory and was associated with intermittent itching and moisture/discharge in selected lesions.
At this stage, the changed symptom picture was reassessed rather than automatically repeating the initial remedy.
Pulsatilla 30 was selected as the subsequent individualized prescription.
Traditional materia medica descriptions include Pulsatilla under skin eruptions with itching, moist eruptions and pustules. [4] the prescription was therefore considered within the context of the evolved symptom totality rather than as a routine combination treatment.
Pulsatilla 30 – prescribed according to the follow-up symptom picture.

Later Follow-up
Following the second prescription, progressive reduction of active inflammatory lesions was observed. Pustulation became infrequent and eventually ceased in the model clinical sequence. Crusting diminished and the skin gradually returned toward its baseline appearance.
Residual post-inflammatory discoloration remained for some time after resolution of active inflammation. No fresh extensive eruption was documented during the later observation period.

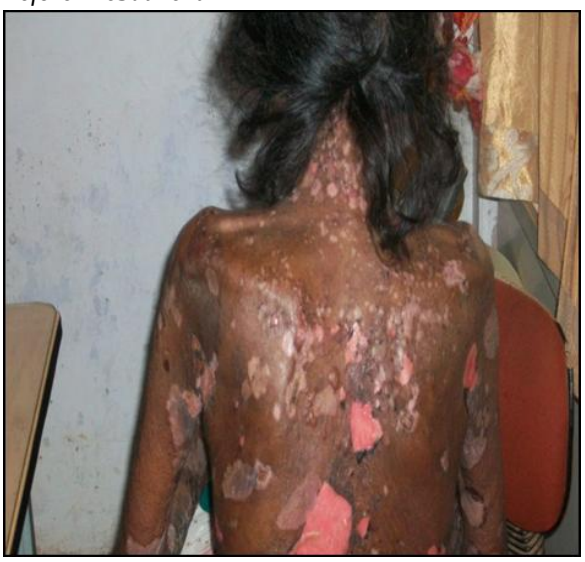
Clinical Timeline

Clinical stage	*Major findings*	*Therapeutic intervention*	*Clinical response*
Initial presentation	*Pruritic erythematous eczematous plaques with papules, pustules, excoriation and crusting*	*Sulphur 200*	*Reduction in itching and new pustulation*
Follow-up 1	*Older lesions drying; fewer new pustules*	*Observation; no repetition*	*Continued improvement*
Follow-up 2	*Reduced active inflammation; altered residual symptom picture*	*Pulsatilla 30*	*Further reduction in active eruption*
Later follow-up	*No active pustulation; residual pigmentation/dryness*	*Observation/supportive skin care*	*Sustained clinical improvement*

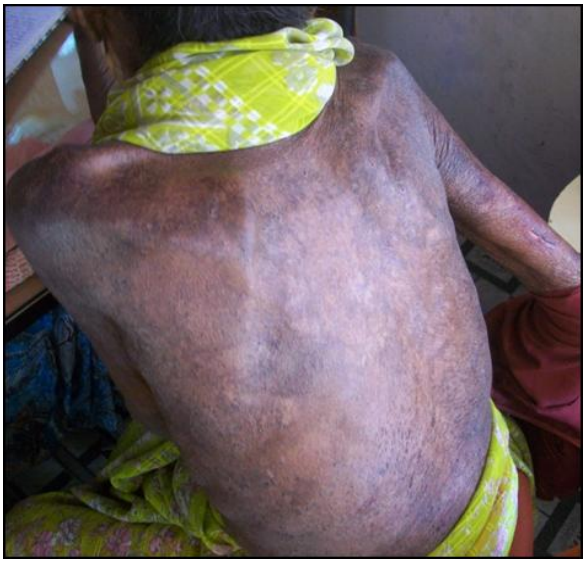
Outcome Assessment
The clinical outcome was assessed using observable dermatological parameters rather than relying solely on a subjective statement of improvement.

The principal indicators were:
- *reduction in number of newly formed pustules;*
- *reduction in intensity of itching;*
- *reduction in erythema;*
- *reduction in oozing;*
- *disappearance of active pustular lesions;*
- *reduction in crusting;*
- *restoration of relatively normal skin texture;*
- *absence of significant adverse effects.*

Before Tre3atment



After Treatment



A standardized eczema severity instrument such as EASI or SCORAD may be used in a prospective case record when the clinical diagnosis is atopic dermatitis; these instruments are recognized approaches for documenting disease severity. [2]
In the present model report, the outcome is described qualitatively because the original scanned case proforma did not provide extractable numerical scoring data.

III. DISCUSSION

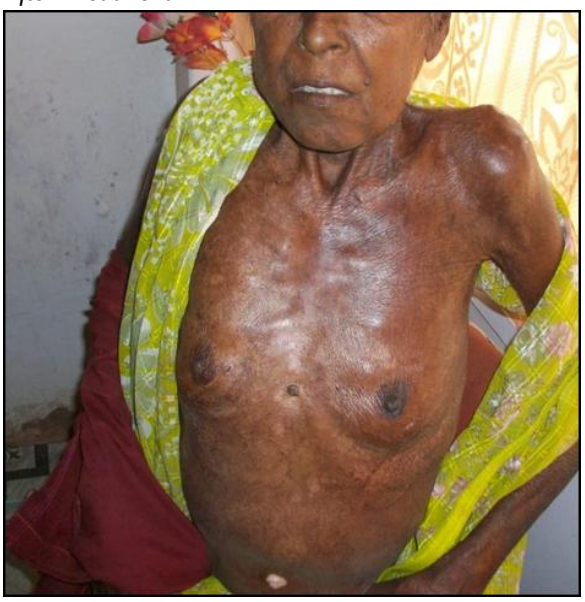
Pustular eruptions constitute a clinically heterogeneous group. Pustules may be infectious or sterile and may occur in bacterial, fungal, viral and inflammatory disorders. [1] *Consequently, a pustular eruption should not automatically be classified as eczema without consideration of alternative diagnoses.*

The present case is noteworthy primarily because of the clinical evolution of an eczematous eruption containing pustular lesions and the sequential individualized prescription of two homoeopathic medicines. The prescribing approach did not treat Sulphur and Pulsatilla as a fixed combination. Instead, Sulphur was selected at the initial stage and Pulsatilla was subsequently considered following a change in the clinical symptom picture.

This distinction is important. In individualized homoeopathy, the clinical rationale traditionally depends on the totality of symptoms rather than on the pathological diagnosis alone. The traditional literature describes Sulphur in several eczematous and pustular presentations. [3] *Similarly, Pulsatilla contains numerous skin rubrics involving eruptions, itching, moist lesions and pustules.* [4] *These materia-medica descriptions may explain why the remedies were considered from a traditional homoeopathic perspective, but they do not constitute modern evidence of therapeutic efficacy.*

Before Tre3atment

After Treatment



The clinical improvement described in a case report must consequently be interpreted cautiously. Eczematous diseases can fluctuate naturally, and improvement may also be affected by avoidance of irritants, skin-care practices, concurrent treatment, regression toward the mean, spontaneous remission and contextual or placebo effects. A single uncontrolled case cannot separate these possibilities.

The conventional dermatological literature also emphasizes the importance of appropriate evidence-based treatment. Current dermatology guidelines support moisturizers, topical corticosteroids and other evidence-based topical therapies for atopic dermatitis, with treatment selection according to disease severity and patient-specific factors. [8] Therefore, a homoeopathic case report should not imply that established dermatological care is unnecessary or should be withheld.

Evidence specifically concerning homoeopathy in eczema is inconsistent. A systematic review published in the British Journal of Dermatology identified only a small number of controlled trials and concluded that the available evidence did not demonstrate efficacy.[5] A later randomized preliminary study of individualized homoeopathy in adult atopic dermatitis reported greater numerical improvement with individualized treatment but without statistically significant between-group differences in the assessed outcomes.[6] Conversely, a subsequent replication trial reported statistically significant differences in PO-SCORAD after six months.[7] These differing results illustrate why individual case reports should be regarded as hypothesis-generating rather than definitive evidence.

The strength of a carefully documented case report lies in its ability to communicate the exact clinical sequence. The CARE framework recommends reporting patient information, clinical findings, diagnostic assessment, timeline, therapeutic intervention, follow-up, outcomes, patient perspective and informed consent. [9] Such structured reporting allows readers to independently assess whether the intervention preceded improvement and whether alternative explanations were adequately considered.

Another important strength is the distinction between active disease and residual post-inflammatory change. Disappearance of pustules and reduction of inflammatory activity represent different outcomes from complete restoration of normal pigmentation. Recording these separately prevents overstatement of clinical recovery.

The major limitation of this case is inherent to the case-report design. There is no control group, blinding or randomization, and causal inference cannot be established. In addition, if standardized severity scores, microbiological confirmation or histopathology are absent, diagnostic certainty may be limited. These limitations should be explicitly acknowledged rather than concealed.

Future clinical documentation of similar cases should incorporate standardized photographic documentation, validated eczema severity scores, detailed treatment chronology, relevant microbiological investigations when pustulation is present, recording of concomitant medication and longer follow-up. Such measures would substantially improve the scientific value and reproducibility of future reports.

IV. CONCLUSION

This case illustrates a clinically structured approach to an eczematous eruption presenting with pustular lesions and the sequential use of individualized homoeopathic prescriptions of Sulphur 200 and Pulsatilla 30. The reported clinical improvement provides an observation suitable for case-level documentation but cannot establish that either medicine caused the improvement. The principal

scientific value of the report lies in transparent documentation of morphology, differential diagnosis, symptom evolution, prescribing rationale and longitudinal outcome. Further systematically documented cases and controlled clinical research are necessary to determine the effectiveness and clinical role of individualized homoeopathic treatment in eczema.

Informed Consent

Written informed consent for publication of the de-identified clinical information and clinical photographs, where applicable, were obtained from the patient before submission.

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