Correct use of corticotherapy to improve compliance

ATOPY | BASIC

Topical corticosteroids (TCS) have been used to treat AD for over sixty years. They are generally the standard to which other topical anti-inflammatory therapies are compared.[1]

TCS are the most widely used anti-inflammatory treatment option applied to inflammatory skin as required (pruritus, sleeplessness, new flares, etc.).[2]

TCS: Treatment mainstays and potential risks

TCS are considered the treatment mainstays in AD, but reliance on these drugs carries potential risks, particularly in children (i.e. cutaneous atrophy characterized by a thinner epidermis, increase in transepidermal water loss, decrease in epidermal ceramides, cholesterols and free fatty acids, etc.).[3]

Even short-term therapy (three days) with a potent CT administered topically adversely impacts the epidermal structure and function.[3]

Addressing concerns over the use of TCS

Although the judicious use of TCS is clearly warranted, recognition of undertreatment as a result of steroid phobia is also important. One survey of 200 dermatology outpatients with AD found that 72.5% were worried about using TCS on their own or their child's skin, with 24% admitting noncompliance with therapy as a result of these concerns. Other studies have shown that patient knowledge of steroid class potencies is poor and leads to inappropriate use. To achieve good response, therefore, it is important to address such fears and misbeliefs. The risks associated with TCS use appear low with appropriate application and choice of potency, combined with periods of nonuse.[1]

Use of topical corticosteroids for the tratment of atopic dermatitis: the recommendations of the American Academy of Dermatology.[1]

- Topical corticosteroids are recommended for AD-affected individuals who have failed to respond to good skincare and regular use of emollients alone.
- A variety of factors should be considered when choosing a particular topical corticosteroid for the treatment of AD, including patient age, areas of the body to which the medication will be applied, and other patient factors such as degree of xerosis, patient preference.
- Twice-daily application of corticosteroids is generally recommended for the treatment of AD; however, evidence suggests that once-daily application of some corticosteroids may be sufficient.
- Proactive, intermittent use of topical corticosteroids as maintenance therapy (1–2 times/week) on areas that commonly flare is recommended to help prevent relapses and is more effective than use of emollients alone.
- The potential for both topical and systemic side effects, including possible hypothalamic-pituitary-adrenal axis suppression, should be considered, particularly in children with AD in whom corticosteroids are used.
- Monitoring by physical examination for cutaneous side effects during long-term, potent steroid use is recommended.
- No specific monitoring for systemic side effects is routinely recommended for patients with AD.
- Patient fears of side effects associated with the use of topical corticosteroids for AD should be recognized and addressed to improve adherence and avoid undertreatment.

Emollients: an effective way to improve compliance

Intermittent use of topical corticosteroids to treat the signs and symptoms of atopic dermatitis, in conjunction with emollients, is standard disease management for atopic dermatitis.[4]

Numerous clinical trials have shown that the use of an emollient as an adjunct to topical corticosteroid therapy provides a steroid-sparing alternative to single-agent TCS while minimizing the likelihood of flares.[5]

Therefore, according to the International Consensus Conference on Atopic Dermatitis, TCS should be applied in conjunction with emollients during flares and emollients applied even without apparent disease symptoms (during periods of remission) to spare TCS and avoid steroid-related side effects.[6]

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