PULSE

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QUICK GUIDE

Management of corticosteroid-responsive dermatoses

Topical corticosteroids (TCS) are a key component of recommended treatment pathways for eczema and psoriasis, and alongside emollients form the cornerstone of management of these common inflammatory dermatoses.[1-4]

This article provides a pragmatic guide for GPs on the optimal use of TCS in eczema and psoriasis management, in line with current UK clinical guidance.

What can we treat with TCS?

Eczema

- Atopic eczema: a chronic, relapsing, often highly itchy inflammatory condition in children and adults. Features include erythema, scaling and lichenification (especially around flexures; (see image 1); usually seen in conjunction with a personal/family history of atopy.[5]
- Discoid eczema (nummular dermatitis): itchy, coin shaped patches on the limbs and trunk, particularly itchy and often with a yellow crust (see image 2).[6]
- Contact dermatitis: Allergic or irritant-induced, presenting with erythema, vesicles or scaling at sites of contact or exposure.[4]
- Seborrhoeic dermatitis: Greasy, scaly, erythematous patches on scalp, face or chest – the hair bearing areas of the body, often with dandruff-like flaking. Affects all ages, infant ('cradle cap') to adult (particularly common in HIV and Parkinson's disease) but usually only mildly itchy at worst.[7]

Psoriasis

- Chronic plaque psoriasis: Most common, with well-demarcated, generally symmetrical scaly, hyperkeratotic, erythematous plaques on extensor surfaces (see image 3). The scalp can be particularly troublesome to manage. Auspitz sign may be seen – pinpoint bleeding on scale removal.[8,9]
- Other forms may also require topical steroids, although less frequently:
  - Guttate psoriasis – small drop-like, erythematous lesions, with some scale across trunk and limbs, often seen as a response to stress and in particular due to streptococcal throat infections (image 4). [8-10]

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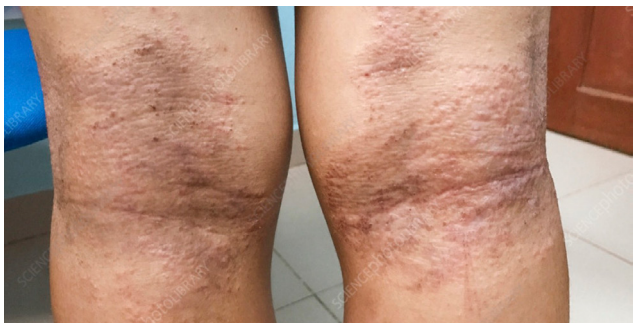

Image 1. Atopic eczema on legs of 12-year-old female patient.

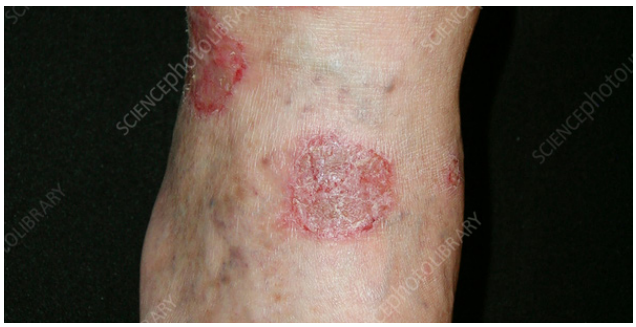

Image 2. Discoid (nummular) eczema on adult patient's foot.

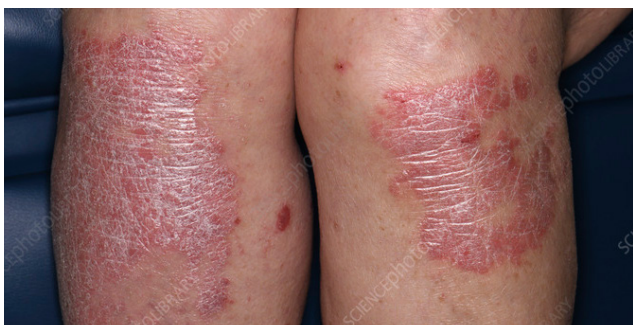

Image 3. Plaque psoriasis on knees of 72-year-old female patient.

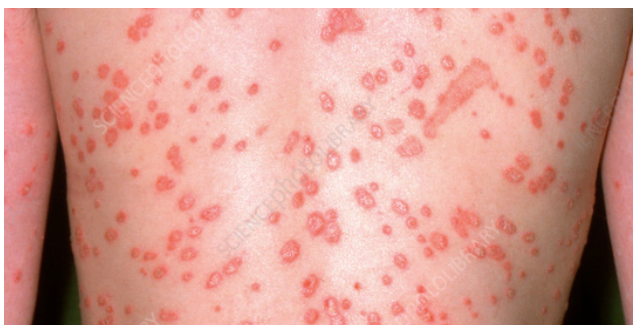

Image 4. Guttate psoriasis on back of female patient.

- Pustular psoriasis – various subtypes, from localised to hands and feet only to a more generalised state but all involving crops of sterile pustules.[10]
- Flexural psoriasis – psoriatic involvement of skin folds – groins, genitals, axillae and umbilicus, usually without the heavy scale.[8-10]

Differential diagnoses

- For eczema – consider psoriasis, fungal infections, scabies, food allergy.[11]
- For psoriasis – consider eczema, pityriasis rosea, lichen planus, secondary syphilis, cutaneous T-cell lymphoma.[12]

Key features that can distinguish between eczema and psoriasis include:

- Eczema is often lichenified from scratching, as opposed to hyperkeratotic, and is more often seen on the flexors – the antecubital and popliteal fossae.[11] Parallel creases on the lower eyelid are pathognomic for atopic eczema, and are known as Dennie-Morgan folds.[5]
- Psoriasis is more likely to be symmetrical with silvery scale and be present on the extensors – elbows and knees are common sites, as is the scalp.[9]

Do we need investigations before treatment?

In most cases of eczema and chronic large plaque psoriasis, investigations are not needed, both being largely clinical diagnoses which often have a family history of atopy or psoriasis.

Consider patch testing for a contact dermatitis,[4] and fungal skin scrapings can be useful to differentiate dermatophytic infections.[13] Biopsy may be considered for atypical presentations where we are struggling for a diagnosis, particularly in cases of treatment failure.

Core principles of TCS treatment

Mode of action. Topical corticosteroids (TCS) reduce inflammation, itch and scale through anti-inflammatory and antimitotic effects, as well as immunosuppressive effects (relevant in contact dermatitis).[16]

Whole-patient approach. All UK guidelines emphasize holistic management, with full integration of non-pharmacological measures, topical therapies and referral into secondary care where needed. TCS must be combined with emollients and control of triggers for successful treatment of inflammatory dermatoses.[2,17] Advise applying TCS after emollients (leave a gap of, eg, 15–30 minutes) to avoid dilution and document this in instructions. [18]

Matching potency to the problem. UK guidance recognizes four TCS potencies, and advises choosing a potency by severity of eczema/psoriasis and site (see Table 1) as well as age.[16-20]

In general, lower potencies should be used on thin skin (face, flexures, genitals) and in children; stronger agents are reserved for thicker skin on trunk/limbs or recalcitrant plaques.

Use once daily in most cases, for a time-limited burst. Prescribe a strength that matches the severity for once-daily use for 7–14 days,[18] continuing up to 48 hours beyond control for subclinical symptoms.[1,20] Longer or maintenance regimens can then be tailored to reduce unnecessary exposure.

Apply a thin layer and the right amount. Ensure the patient understands fingertip units (FTUs) will reduce under and over application. One FTU (from fingertip to first crease)

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treats an area of about one adult hand.[19,21]

Choose the correct formulation. Ointments are greasier, with less spreadability, but suit dry thick plaques of skin. Creams and lotions are water based, spread more easily and are good for hair-bearing or weeping areas, particularly if cosmetic acceptability is important.[14]

Proactive strategies – the use of pulse/'weekend' therapy.[18] If a patient is seeing frequent relapses of their condition after tapering down steroid use, and despite adherence to a treatment plan, it is reasonable to try intermittent therapy, with TCS application twice weekly or just at weekends to maintain control and prevent relapse. However, if long-term TCS dependence is emerging, dermatology advice may be needed.

Address 'steroid phobia'. Reassure that when used appropriately (right potency, site and time-limited), TCS are effective; risks like atrophy are rare with short, supervised use.[16] Provide patient information.[17,19-21]

Practical, pragmatic treatment regimes

1. Atopic eczema (AE)[1,2,5,11]

- First line – regular emollients and total emollient therapy, including control of bathing/cleansing regimes (eg, emollient for washing and bathing, tepid rather than hot water).
- Add TCS for red inflamed skin during flares, choosing the lowest potency that controls symptoms for 7-14 days, and continuing for 48 hours after control achieved.
- Moderate to severe AE – for trunk and limbs may need a moderate or potent TCS (eg, clobetasone butyrate 0.05% or mometasone 0.1%) to achieve control, stepping down to pulsed use once control gained.
- Face/flexures/genitals: keep to mild (eg, hydrocortisone 1%) or short courses of moderate potency if needed, with close review.
- Adjunctive treatments to be considered:
  - Topical calcineurin inhibitors such as tacrolimus, pimecrolimus can be considered for steroid sparing in sensitive areas, eg, face.
  - Antihistamines for short term use in itch control.
  - Menthol containing creams can also be useful for itch control.
  - Topical or systematic antibiotics if secondary bacterial infection is a possibility – inflamed, heated, tender skin, with yellow seeping crust often present, eg, sodium fusidate cream, flucloxacillin.

- **Escalation into secondary care to be considered for:**
  - Extensive or severe AE.
  - Diagnostic uncertainty.
  - Failure of appropriately potent TCS.
  - Consideration of phototherapy or systemic treatments such as methotrexate or biologics.

2. Discoid (nummular) eczema[6]

- Usually needs potent or very potent TCS on plaques until the redness/induration settles, which can take several months.
- Mild agents are usually insufficient.
- Usually extremely itchy.
- Combine with copious emollients and dressings for fissures.
- Re-start promptly at first sign of recurrence.
- Secondary care referral usually not needed.

3. Contact dermatitis (irritant or allergic)[4]

- Attempt to identify and avoid triggers.
- Liberal protective emollient and other shielding measures, eg, gloves.
- Consider TCS according to site/severity/age:
  i. mild for face/flexures
  ii. moderate–potent for hands/trunk in short courses.
- May need secondary referral for patch testing, especially if persistent or related to occupational issues.

4. Seborrheic dermatitis[7,14,15]

- Antifungals are first line (eg, clotrimazole 1%/miconazole cream for skin, ketoconazole 2% shampoo for scalp/beard/hairline in adults).
- Short courses of mild TCS to calm flares (typically ≤2 weeks on face/body).
- Combination antifungal/TCS creams are often used to control yeast population and itch at the same time.
- For scalp, a short course of a corticosteroid scalp application can be used for inflamed flares.
- Pimecrolimus cream is widely used off-licence and can be useful for long-term control (less irritant than tacrolimus cream).

5. Chronic large plaque psoriasis (including scalp)

- Trunk and limb psoriasis in adults:
  i. NICE guidance suggests initial use of a potent TCS with concurrent use of a vitamin D analogue, applying each daily but applied at separate times.[3]
  ii. Primary Care Dermatology Society (PCDS) guidance suggests combination product use from the outset to improve patient compliance and faster outcomes/satisfaction.[9]
- Scalp psoriasis – start with a potent TCS once daily for up to 4 weeks, usually in combination with a coal tar shampoo to assist in scale removal. If this is inadequate, consider specific scale removal/keratolytic products containing salicyclic acid, or a combined vitamin D/steroid product.[3]
- Face/flexures/genitals: avoid potent steroids; favour non-irritant calcineurin inhibitors; if any steroid is used, keep mild and brief.[3,9] (PCDS cautions on potent betamethasone on thin skin.)
- Onward referral may be needed if control cannot be achieved via topical means.[9]

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TCS potency	Suitable for
Mild (eg, hydrocortisone 1%)	Face, flexures, or mild eczema/psoriasis
Moderate (eg, clobetasone butyrate)	Moderate flares on trunk/limbs
Potent (eg, mometasone furoate, betamethasone valerate)	Thick, resistant plaques or severe eczema flares, used daily short-term (1-2 weeks) to minimize side effects like skin atrophy.
Very potent (eg, clobetasol propionate)	Rarely used in primary care unless under specialist supervision.

Table 1. Recommended TCS potency according to severity and site[16-19]

Understanding appropriate use of TCS

TCS are generally well tolerated when used appropriately, and more harm is seen from undertreatment than overtreatment in the average dermatology clinic. It remains important to understand that the risk of adverse effects rises with the following:[16-19]

- Potency – greater risk with higher potency.
- Occlusion – steroid use under occlusive dressings.
- Large surface area of application.
- Longer duration of treatment course.

It is also important to educate on potential problems in the long term, such as skin atrophy, striae, telangiectasia and tachyphylaxis, while emphasising the measures which all clinicians put in place to mitigate these risks, namely:[16-21]

- Site-appropriate choice of potency.
- Time-limited bursts of daily treatment.
- Steroid sparing intervals in combination with intermittent therapy.

The long-term goal is always to maximise disease control while minimising steroid exposure.

Tips for improving adherence

Prescribe enough. Under-supply fuels undertreatment. Use FTU-based quantities (eg, 100g daily for an adult torso flare for 1–2 weeks isn't unusual). Provide a simple FTU chart for common body areas and ages (eg, adult arm around 3 FTU; child amounts lower by age).[16,18]

Write explicit directions including safety netting. Include: site(s), frequency (OD unless specified), duration/stop criteria ('continue 48 hours after control achieved'), and what to do if not improving ('seek review if no benefit by day 7–10').

Continue to use copious emollients. Advise applying emollients liberally through the day; apply TCS after emollients, leaving a short interval to avoid dilution.

Put emollients and TCS onto repeat prescription for patients with long-standing eczema, with suitable safeguards. This ensures patients have ready access to treatment – a common problem in relapsing/remitting conditions is patients not being able to access their treatments when they need to.

Key points

In primary care, TCS can be fast, well tolerated and effective when guided by UK guidelines to:

- Match potency to site/severity.
- Prefer once-daily time-limited courses.
- Embed emollients.
- Teach FTU .
- Keep potent/very potent regimens short and site-appropriate.

When in doubt – especially for face/flexures, children, psoriasis beyond straightforward plaques, or non-response – seek dermatology advice early.

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Once Daily
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mometasone furoate 0.1%
CREAM, OINTMENT & SCALP LOTION

How could Elocon® help your patients with psoriasis and atopic dermatitis?[1-3]

Consider Elocon®, a once-daily treatment for relief of inflammatory and pruritic manifestations of psoriasis (excluding widespread plaque psoriasis) and atopic dermatitis[1-3†]

† Elocon® Scalp Lotion is indicated for the treatment of inflammatory and pruritic manifestations of psoriasis and seborrhoeic dermatitis of the scalp[3]

Elocon®: a once-daily treatment[1-3]

In a randomised, single-blind, parallel-group, two-centre study (n=72) investigating the efficacy of once-daily Elocon® compared with twice-daily betamethasone valerate for 8 weeks:[4]

A total of 91% of patients receiving treatment with Elocon wanted to use the ointment again in the treatment of psoriasis, compared with 58% of patients receiving betamethasone treatment (n=68, p=0.0003)[4]

Elocon® treatment for **atopic dermatitis**

Once-daily Elocon® Cream 0.1% significantly reduced total sign/ symptom scores in patients with atopic dermatitis compared with twice-daily betamethasone valerate 0.1% (n=117, p<0.01)[3]

Percentage improvement in total sign/symptom severity scores compared to baseline values in atopic dermatitis

Elocon® treatment for **psoriasis**

In psoriasis vulgaris, once-daily Elocon® Ointment 0.1% was more effective than twice-daily betamethasone valerate ointment (n=68, p=0.03)[4]

Percentage reduction (improvement) in individual and total disease sign scores at each visit compared to baseline

Elocon®: safety profile comparable to hydrocortisone cream

- Well-established safety profile comparable to hydrocortisone 1% cream and ointment[4]
- Generally well tolerated[1-3]
- Local adverse reactions reported infrequently with topical dermatological corticosteroids include: skin dryness, irritation, dermatitis, perioral dermatitis, maceration of the skin, millaria and telangiectasia .[1-3]
- Long-term continuous or inappropriate use of topical steroids can result in the development of rebound flares after stopping treatment (topical steroid withdrawal syndrome) [1-3]
- Use of topical corticosteroids in children or the face should be limited to no more than 5 days .[1-3]
- Elocon is not recommended for children under 2 years of age.[1-3]

Percentages of patients who wanted to use treatment again[4]

91% Elocon® (n=32) (n=29)

58% Betamethasone (n=36) (n=21)

p=0.0003 | Adapted from Svensson A et al, 1992[4]

For full safety precautions of use, please refer to the Elocon Summary of Product Characteristics (SmPC)

Elocon Cream SmPC › **Elocon Ointment SmPC ›** **Elocon Scalp Lotion SmPC ›**

Adverse events should be reported. Reporting forms and information can be found at https://yellowcard.mhra.gov.uk or search for MHRA Yellow Card in the Google Play or Apple App Store. Adverse events should also be reported to Organon, UK (Tel: 02081 593593). By clicking the above link you will be taken to the MHRA website.

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