Topical steroids – dispelling common myths

Topical steroids form an important part of the treatment plan for most people with atopic eczema.

When eczema flares up, topical steroids reduce inflammation, ease soreness and irritation, reduce itching and the need to scratch, allowing the skin to heal and recover.[1] However, patient perceptions about steroids can sometimes prevent them from using this treatment. Surveys have shown:[2]

- More than half of parents of children with eczema believe that topical steroids should only be used to treat severe eczema[2] – this is not the case, steroids are considered the first-line treatment for flare-ups.[3]
- One fifth of parents believe that topical steroids are too dangerous to use on their children[2] – it is essential that parents/carers are provided with reassurance about the value of topical steroids when used appropriately.[4]
- More than a quarter of parents have not used prescribed topical steroids as a result of their concerns about this treatment[2] – if education is provided during the consultation process and their concerns are addressed, this can positively influence treatment adherence.[2]

Fears about using topical steroids are often based on misconceptions about how steroids work and their potential side effects. Addressing these issues can help people to better understand and adhere to treatment.

Myth 1: Topical steroids cause skin damage, e.g. thinning, ageing, scarring and stretch marks

The Reality:

Topical steroids inhibit fibroblast proliferation and collagen formation, so they may thin the skin and make it lose its elasticity.

However, you can reassure your patients that steroids will not cause skin damage if:

- They use their topical steroid(s) as prescribed – As a rough guide, steroid use should be limited to a few days to a week for acute eczema and up to 4–6 weeks to gain initial remission for chronic eczema.[4]
- Adults use a mild topical steroid on delicate areas such as their face and groin.[5]
- The elderly and children use a mild steroid on all parts of their body because their skin is more delicate.[5]

When a potent topical steroid is needed, there are differences between the various preparations in terms of adverse effects. Some potent steroids such as Elocon (mometasone), for example, have a side effect profile no different from that of the mild steroid, hydrocortisone 1%.[6]

Myth 2: Topical steroids are absorbed into the body, causing stunted growth and development and reduced immunity to infections

The Reality:

Potent topical steroids can cause growth retardation in children but this is rare and only occurs if potent steroids are used continuously, in excess, for an extended period of time. Milder potencies rarely pose a threat.[5]

To allay concerns about this myth, HCPs can help by providing information and answering any concerns about using a short-course of steroids to treat flares. Pharmacists can help by reiterating the nature of a short course of steroids, as well as ensuring that tubes are clearly labelled and usage instructions explained as part of the provision of information.

Myth 3: Topical steroids cause hormonal side effects, leading to increased body hair, impotence and dependency

The Reality:

For some people, the word ‘steroid’ is automatically associated with anabolic steroids. If a patient expresses this concern, reassure them that topical corticosteroids are a completely different type of steroid.

Side effects are rarely seen when using mild steroids and, although potent topical steroids pose some risk, this is rarely seen, as those prescribing know the risks and restrict the amounts prescribed.[5]

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Myth 4 Long-term use of topical steroids can make them less effective or can make eczema worse

The Reality:

Some patients may be worried about 'becoming immune' to steroids after repeated courses. This may stem from a mistaken idea that all drugs lose their effect if used too often; some patients may become tolerant to certain drugs but there is no evidence of tolerance to steroids.

Explaining that the body will not 'become immune' to steroids will prevent these misconceptions from interfering with steroid treatment.

Myth 5 Topical steroids should not be used on broken skin

The Reality:

Sometimes patients will avoid applying a steroid cream or ointment to cracked and broken skin because they are afraid the steroid will be absorbed into their body and cause unwanted side effects. However, steroids are the first-line treatment for eczema flare-ups, when the skin often becomes cracked.[3]
NICE recommends that steroids are applied to areas of active eczema, including broken skin.[2]

You can reassure your patients that if they use their steroid as directed (once or twice a day, and only for limited periods) it can be applied to cracked or broken skin.

Myth 6 Effective use of emollients means that patients shouldn't need a topical steroid

The Reality:

Emollients are the foundation of treatment for atopic eczema because they restore the skin's natural barrier function, helping to reduce the frequency and severity of flare-ups.[3]
In fact, many people with mild to moderate eczema can control their condition using emollients alone.[7]

However, many patients will need to use a steroid cream or ointment during a flare-up to calm and restore their skin, and so topical steroids remain the first-line treatment for managing flares.[3]

Explaining to patients the important role that both emollients and steroids play in managing their eczema, and how and when to use each, will help them understand and adhere to treatment.[2]

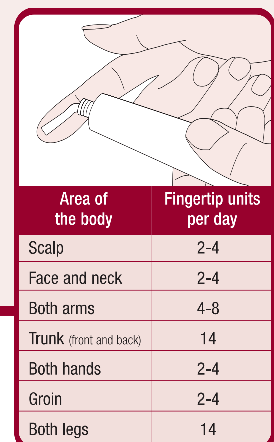
Myth 7 Topical steroids should only be applied in small quantities

The Reality:

Patients are often advised to use their steroid cream or ointment sparingly which can lead to the perception that only a small amount should be used.

In part, this is true; steroids should be applied in much smaller volumes than emollients – a ratio of 10:1 emollient to steroid.[4] However, patients need to apply enough to cover all areas of active eczema, therefore the amount they need will depend upon how much of their body is affected.

You may find it useful to explain to patients how much steroid to use in terms of finger tip units (see chart).



Area of the body	Fingertip units per day
Scalp	2-4
Face and neck	2-4
Both arms	4-8
Trunk (front and back)	14
Both hands	2-4
Groin	2-4
Both legs	14

References

1. Ward, S (2004) Practice Nursing. Vol.4 No.15 pp 378-383. **2.** National Collaborating Centre for Women's and Children's Health. Clinical Guideline December 2007 (NICE Eczema Full Guideline). **3.** NICE Technology Appraisal 81. (August 2004) NICE. **4.** Primary Care Dermatology Society & British Association Dermatologists (2006) Guidelines for the management of atopic eczema. Vol. 28. Available form: http://www.eGuidelines.co.uk/. **5.** Graham- Brown, R. & Burns, T. (2009) Dermatology – Lecture Notes. 9th Ed. Blackwell Publishing: London. **6.** Katz HI *et al.* Int J Dermatol 1989;28:342-344. **7.** Cork MJ. (1997) The Importance of Skin Barrier Function. J Dermatol Treat, 8, S7-S13

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