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Research letter

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# Quantifying topical corticosteroid use in maintenance therapy for atopic dermatitis: results of an International Society of Atopic Dermatitis (ISAD) survey

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Dear Editor, Topical corticosteroids (TCS) remain the cornerstone of atopic dermatitis (AD) management worldwide.[1,2] Proactive intermittent treatment after disease control is widely recommended to prevent flares.[3] The fingertip unit provides a practical measurement for individual applications,[4] but evidence-based guidance on quantities prescribed over time remains limited. Since its 2018 edition, the European guideline (now EuroGuiDerm) has included expert consensus estimates of mean monthly quantities: approximately 15 g in infants, 30 g in children and 60–90 g in adolescents and adults, adjusted for affected body surface area.[1] No supporting reference accompanied these estimates, and no TCS potency was specified. Patient and carer concerns about long-term TCS use are common.[5] Our primary objective was to describe the monthly quantities of TCS recommended by clinicians for maintenance therapy across four age groups. Secondary objectives were to characterize maintenance frequency, potency selection, prescribing and follow-up practices, safety communication and perceived gaps in guidance, and to examine whether the principal patterns were reproduced in a replication cohort.

A 21-item online questionnaire was developed iteratively by the multidisciplinary author group, drawing on current guidelines and the clinical questions identified within the International Society of Atopic Dermatitis (ISAD) initiative on TCS concerns. The questionnaire was developed in parallel with the companion ISAD position statement (Cole-Adeife *et al*., submitted). The draft was reviewed within the group for content, clarity and feasibility before circulation; no formal psychometric validation was undertaken. The survey was distributed to 160 members of ISAD (Appendix S1, Tables S1–S8; see Supporting Information). Item nonresponse was permitted and expert comment was optional. Multiple selections were allowed only for questions on potency and adverse effects. All 59 submissions were retained because the 4 primary quantitative items were complete; 1 respondent omitted the maintenance schedule item. No missing data were imputed. A separate cohort of ISAD newsletter registrants and participants in the Rajka symposium ($n = 65$) completed the same survey and was analysed descriptively as a replication cohort; datasets were not pooled.

The response rate in the primary cohort was 36.9% ($n = 59/160$). Respondents comprised 51 dermatologists, 5 paediatric dermatologists and 3 allergists/immunologists; 37 of 59 (63%) worked in university hospitals. Twice-weekly proactive therapy was selected by 40 of 58 respondents (69%) who answered this item. Only 6 of 59 (10%) considered current guidelines to be quantitatively clear, whereas 34 of 59 (58%) considered them to be partially clear and 19 of 59 (32%) considered them unclear. Twelve respondents (20%) routinely specified a maximum monthly quantity. The survey did not ask which guidelines the respondents consulted;

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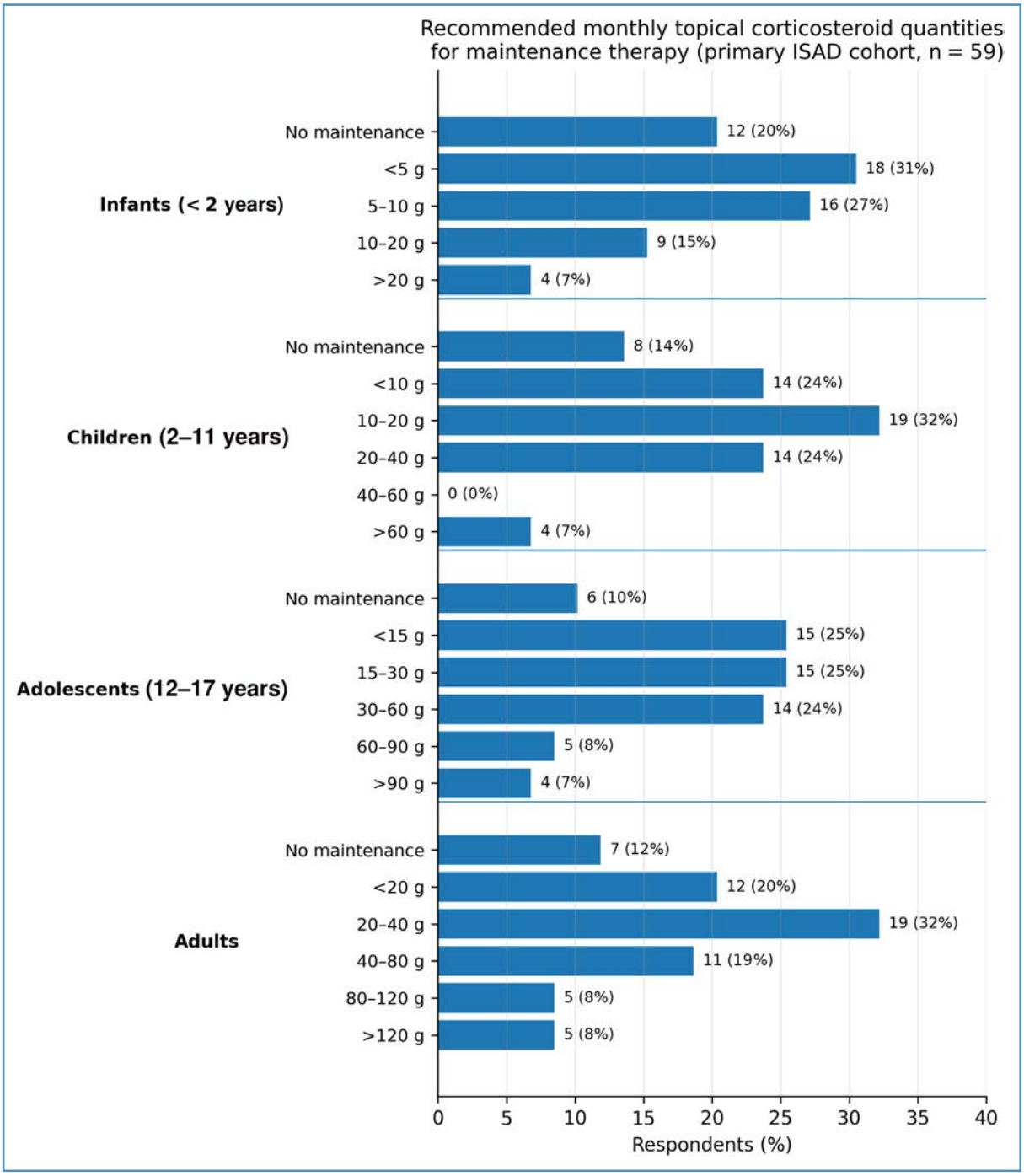



Figure 1 Distribution of recommended monthly topical corticosteroid (TCS) quantities for maintenance therapy in the primary International Society of Atopic Dermatitis (ISAD) cohort ($n = 59$). Bars show the percentage of respondents and labels show the number and frequency. Four horizontal bar chart sections show age-specific monthly TCS quantity categories for infants, children, adolescents and adults. Responses shift towards higher monthly categories with age but remain dispersed within each age group. Categories were age-specific and include open-ended intervals; they should not be interpreted as continuous or directly comparable dose distributions.

therefore, the responses reflect perceived quantitative clarity rather than the content of any named guideline.

The recommended monthly quantities showed an age-related shift but substantial within-age dispersion (Figure 1). For infants, 34 of 59 (58%) selected < 10 g monthly and 12 of 59 (20%) did not use maintenance TCS. For children, the most frequent category was 10–20 g monthly ($n = 19/59$; 32%). Adolescent responses were distributed almost equally across < 15 g, 15–30 g and 30–60 g monthly ($n = 15$, $n = 15$ and $n = 14$ respondents, respectively). In adults, 20–40 g monthly was most frequent ($n = 19/59$; 32%), while 21 of 59 (36%) selected ≥ 40 g monthly. Importantly, response categories differed by age and included open-ended intervals; thus, the data describe prescribing preferences rather than actual prescribed, dispensed or applied quantities.

Potency selection also shifted with age: low-potency TCS were selected by 33 of 59 (56%) for infants and 32 of 59 (54%) for

children, while moderate-potency TCS were selected by 40 of 59 (68%) for adolescents and 45 of 59 (76%) for adults (see Table S4). The survey concerned maintenance after disease control, not treatment of acute flares. In an exploratory comparison, potency selection did not differ significantly between European respondents ($n = 23$) and respondents from other regions ($n = 36$) (all age-specific comparisons; Fisher's exact $P \geq 0.27$).

Most respondents ($n = 54/59$; 92%) routinely discussed adverse effects. The replication cohort reproduced the predominance of twice-weekly maintenance ($n = 41/65$; 63%) and the age-related potency pattern, although quantitative responses remained dispersed. Nonuse of maintenance TCS in infants was more frequent in the replication cohort (40% vs. 20%; see Table S8).

Complete cohort characteristics and response distributions are provided in Tables S1–S8. Most respondents prescribed maintenance TCS for 1–3 months ($n = 33/59$; 56%) and reviewed patients within 1–3 months ($n = 29/59$; 49%) or 3–6 months ($n = 19/59$; 32%). Counselling focused mainly on skin atrophy ($n = 48/59$; 81%) and telangiectasia/vascular fragility ($n = 42/59$; 71%). Only four free-text comments were received across both cohorts: TCS concerns and education ($n = 3/4$), tapering or proactive schedules ($n = 3/4$), site-appropriate potency ($n = 2/4$), clearer practical guidance ($n = 2/4$) and steroid-sparing treatment ($n = 1/4$). Reimbursement, out-of-pocket costs, availability and package sizes were not assessed and may influence prescribing.

These findings should not be interpreted as quantitative dosing recommendations. Nevertheless, the overall age-related pattern is broadly concordant with the European expert consensus estimates.[1] Variability may not only reflect limited quantitative guidance, but also differences in affected body surface area, anatomical site, disease severity and phenotype, TCS potency and formulation, use of steroid-sparing treatments, health system context and follow-up practices. The 37% response rate introduces the possibility of response bias, and the predominance of academic specialists limits generalizability to community dermatology, paediatrics and primary care, and may over-represent clinicians already engaged with maintenance therapy.

This survey identifies a clinically relevant area of uncertainty and provides a rationale for formal consensus development and prospective studies linking prescribed quantities, exposure, disease control and safety.[6] It should not itself be used to derive age-specific quantitative recommendations.

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**Conflicts of interest:** L.L. has received honoraria as a speaker for Novartis and AbbVie, for conference attendance from SunPharma and L'Oréal, and as a medical education provider and an advisor for Arrotex, AbbVie, Galderma and Lilly; and has received a research grant from LEO Pharma. O.C.-A. has received honoraria as a speaker for L'Oréal and Sebamed Pharma, and conference attendance support from L'Oréal and Beiersdorf. P.S.-G. is treasurer of the International Society of Atopic Dermatitis. A.T. is president of the International Society of Atopic Dermatitis. The other authors declare no conflicts of interest.

**Data availability:** Deidentified survey data are available from the corresponding author on reasonable request.

**Ethics statement:** This anonymous survey collected no patient data; formal research ethics review was not required.

**Patient consent:** Not applicable.

# Supporting information

Additional Supporting Information may be found in the online version of this article at the publisher's website.

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