

vs 36 ppb) among EMG patients, consistent with our overall results.

We believe that a potentially important driver of the higher inflammatory profile among EMG patients reported in our study is less effective use of asthma treatment, as it is known that T2 biomarkers are highly corticosteroid responsive.⁴ Consistent with our results, recent evidence from the RASP-UK program has demonstrated that minority ethnicity was associated with a lower likelihood of following treatment advice, even within the strict confines of a randomized controlled trial.⁵ This is perhaps unsurprising given that patient self-management strategies are often designed from the perspective of the majority population without tailoring to the health and cultural beliefs of EMGs.⁶

However, with regard to the general issue of ethnicity as a potential cause for bias or delay in asthma diagnosis, we wholeheartedly agree that this is an important question. Ultimately, there are a series of steps in the patient journey in severe asthma before initiation of appropriate treatment. First, a patient must recognize that he or she has ill-health requiring medical assessment, and secondly, he or she must be able to access health services. Thirdly, a correct diagnosis of asthma must be made. Fourthly, its severity must be recognized and referral made to a severe asthma center, and fifthly, specialist therapies such as biologics commenced. In our recent paper, we aimed to specifically address the later steps and would agree with Mwasuku et al¹ that potential inequalities by ethnicity in the earlier steps of this patient journey require further investigation.

We agree that bias by ethnicity in the diagnosis of asthma versus COPD is of particular interest given that they share many treatable traits. Although inhaled therapies are similar between asthma and COPD, in most health care systems, only patients with a diagnostic label of asthma have access to biologic therapies (although there is emerging evidence that they may also be beneficial in COPD). Delays in diagnosis are also of underappreciated importance for our patients. Although delays are not known to affect T2 biomarkers, they may result in long-term lung function decline and increased levels of steroid-related morbidity. We agree that there is much further research to do.

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Severe topical corticosteroid withdrawal syndrome or enigmatic drug eruption?



To the Editor:

We recently read with great interest the report authored by Nguyen et al¹ regarding a possible severe topical corticosteroid (TCS) withdrawal syndrome (TCWS) case presenting in an adult with chronic atopic dermatitis using low-dose topical corticosteroids. TCWS is a rare entity, with the current literature remaining sparse and exhibiting low quality of evidence. As discussed in the National Eczema Association systematic review of topical corticosteroid withdrawal, this distinct clinical adverse event is likely correlated to the improper use of TCSs.²

As with the use of any medication, common and rare adverse events are important points of discussion. TCSs consistently demonstrate efficacy in improving skin lesion severity and quality of life in patients with inflammatory skin conditions.³ They are considered the first-line therapy for patients with atopic dermatitis and with appropriate step-up and step-down approaches have an excellent safety profile—this is especially true for low-potency TCSs such as class VII hydrocortisone used in the highlighted case.

In spite of TCWS being a poorly characterized disorder, there is a growing presence in social media. Importantly, there is a need to mitigate the spread of misinformation, which can lead to unnecessary avoidance of an important treatment mainstay of several dermatologic conditions and delay in diagnoses and increase unnecessary anxiety. Importantly as stated above, TCWS is a rare disorder lacking clear diagnostic criteria and should be considered a diagnosis of exclusion. Indeed, it is a diagnosis that requires careful consideration because overdiagnosis may lead to health care professionals avoiding prescribing safe and inexpensive TCSs and negatively impact patient adherence and acceptance of an important therapeutic option.

Clinically, TCWS tends to present predominantly with burning/stinging as the primary symptom, rather than the intense pruritis with oozing and crusting, fever, and malaise as described

in the patient in this article. In making the diagnosis of TCWS, it is important to note other clinical entities in the differential diagnosis including flaring atopic dermatitis, allergic contact dermatitis, drug hypersensitivity reactions, infectious causes, and cutaneous T-cell lymphoma, all of which are possibilities in the referenced patient. Patch testing may be warranted given the possibility of an allergy to the steroid molecule itself or a cream excipient versus other potential triggers. Histopathology may also be helpful and is essential for excluding some entities in the clinical differential diagnosis. Although it is possible that the case presented by Nguyen et al is an atypical presentation of a rare disorder, we have concerns that in this particular case the correct diagnosis was not established given the lack of diagnostic evaluation such as biopsy or patch testing.

Clinical guidelines support that TCSs, when used appropriately, remain key to the management of inflammatory skin conditions. Given the rarity of this condition and lack of high-quality evidence, the diagnosis of TCWS should remain a diagnosis of exclusion handled with caution to avoid unnecessary deviation from the standard of care.

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Reply to "Severe topical corticosteroid withdrawal syndrome or enigmatic drug eruption?"



To the Editor:

We thank Tracy et al¹ for their comments regarding our report on topical corticosteroid withdrawal syndrome (TCWS) as it provides an opportunity to further elaborate on TCWS as a diagnosis.

As allergists and immunologists, we are no strangers to the use of corticosteroids via all routes of administration. We certainly continue to use corticosteroids on a day-to-day basis for our patients for a myriad of conditions. This relative comfort with our mainstay of therapy, however, should not leave us complacent. The many risks of systemic corticosteroids including withdrawal are well known. As much as we would like to believe that topical use of steroids negates many of these risks, our trust in this ostensible safety profile simply due to an alternate route of administration may ultimately prove misplaced.²

In their correspondence, the authors suggested that the diagnosis of TCWS might be inaccurate due to lack of diagnostic biopsy or patch testing. To answer the commentor: patch testing at the time of our subject's presentation would not have been feasible given the severity and extent of body surface involved. Furthermore, subsequent positive patch test result to other agents now will not exclude our clinical diagnosis then because they can be concomitant anyway. In addition, the utility of patch testing against crisaborole when our subject is currently using it regularly, would have little academic nor clinical utility now. Not having been updated in recent years, neither the current American Academy of Dermatology nor American Academy of Allergy, Asthma & Immunology/American College of Allergy, Asthma, and Immunology atopic dermatitis guidelines mention topical steroid withdrawal as a potential concern with topical steroid use.^{3,4} There is currently no consensus on specific diagnostic criteria nor have pathognomonic histologic findings been defined.^{5,6} Therefore, even if a biopsy was performed, this would still have been a clinical diagnosis in the end.

The purpose of the case presentation was to bring forth a clinical observation and raise awareness. We agree that TCWS should remain a diagnosis of exclusion and should be handled with caution. Because clear diagnostic criteria are lacking for TCWS, although many providers question its prevalence or even its existence, more awareness and research is warranted, or it will continue to be missed.

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