Role of Clinical Pharmacist in Cosmeto-vigilance of Misuse and Abuse of Topical Corticosteroids

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Sir,

Topical preparations containing various strengths of corticosteroids are used by doctors of all disciplines, mainly dermatologists. The misuse and abuse of such medicines are particularly rampant in India, where most of the drugs are available over-the-counter from the pharmacies, bypassing the need of a prescription. The combination of social media, peer pressure, and unethical marketing has magnified the problem and people are increasingly falling prey to the misuse of topical corticosteroids. The most common misuse and abuse of these preparations are in the form of prolonged use as “fairness creams.” This has seen to be resulting in serious complications such as acne, steroid dependence, atrophy, rosacea, and perioral dermatitis.[1,2]

With the ratio of doctor or specialist to patient being very low, the patient tends to easily fall prey to wrong information and quackery. The busy clinician may not have time to explain the adverse effects of prolonged unsupervised use and in such situations, the clinical pharmacist can play a vital role.

A clinical pharmacist is a qualified postgraduate pharmacy professionals with Pharm D degree or M Pharm in Pharmacy practice, with ample training and expertise to explain the untoward effects of a drug, if used over a prolonged period of time. His/her work is at the interface with the patient, at the dispensing level and is ideally placed to play a vital role in predicting and preventing the dangers of misuse and abuse of medications. The role of a clinical pharmacist in driving the system in the right direction has been studied and documented previously too.[3] They can also give the right guidance when an untoward event is noticed. It is high time that the dermatologist realizes the relevance of clinical pharmacists and start involving them more meaningfully in patient care. This reduces the burden on the clinician who can dedicate more of his time for patient care.

Some measures that can be undertaken further include counseling patients and other health care professionals (and paramedics) regarding the side effects of unsupervised drug use, distributing educational leaflets, conducting awareness classes, plays, and other mass media activities. Patients affected may have to be adequately treated and rehabilitated and a clinical pharmacist can play a major role this segment too.[6] The intervention of the clinical pharmacist in the healthcare saves on the resources and helps the economic aspects of therapeutics and has been reported earlier and a notification system at the clinical pharmacist level can also help to curb the menace.[5] IADVL’s taskforce against topical steroid abuse has been a pioneer in India against topical steroid abuse mainly on the face, and their efforts have resulted a government action.[6] Ban of Steroid Containing Fixed Drug Combinations by the Government of India is a very welcome step toward judicious use of corticosteroids containing creams.[7]

To conclude, multi-pronged disciplinary approach, we can look forward to revive the distorted face of topical steroid abuse in India and other developing countries, to a categorical extent. The day is not far when clinical pharmacists will play a more active role in health-care delivery and prevent misuse and abuse of various medications.

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Conflicts of interest

There are no conflicts of interest.

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Sir,

A 16-year-old girl presented to us with asymptomatic hyperpigmented lesions over the left side of her chin since the past 6 months. According to the patient, it started as a small black discoloration of the skin which gradually increased in size. There was no history of preceding trauma, redness or tightness of the skin, associated systemic complaints, or family history of similar illness. Cutaneous examination revealed three broad unilateral linear hyperpigmented atrophic lesions, with depressed margins along Blaschko's lines without any sign of inflammation or induration [Figure 1a and b]. The surface of the atrophic lesions was wrinkled. A 4 mm punch biopsy was taken from the margin of the lesion. Histopathologic examination (HPE) with hematoxylin and eosin staining showed epidermal atrophy along with dense melanin deposition along the basal layer with apparently normal subcutaneous tissue [Figure 2]. Sparse perivascular and periappendageal lymphocytic infiltrate with slight thickening of collagen bundles was present in the dermis. There was no evidence of sclerosis or atrophy of the appendages [Figure 3]. The difference with the normal epidermis could be seen in the HPE [Figure 4]. Verhoeff–van Gieson stain showed normal elastic tissue [Figure 5]. On the basis of the clinical and histopathologic findings, we diagnosed the case as linear atrophoderma of moulin (LAM).

LAM is a rare dermatosis characterized by a hyperpigmented atrophoderma that follows Blaschko’s lines with onset usually during childhood and adolescence. [1]