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## STEROID-INDUCED ROSACEA AS A RESULT OF UNCONTROLLED SELF-MEDICATION

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### **Introduction.**

Dermatology is a safe practice: we register unpredictable outcomes so rarely. Topical treatment complications are still a significant concern nowadays because some adverse reactions are the issue of self-treatment.

For steroid-responsive skin conditions, such as allergodermatoses, papulo-squamous disorders, alopecia area, vitiligo, discoid lupus, bullous pemphigus, and pemphigoid, topical steroids play a significant role in the therapy: a constantly rising misuse of topical steroids is the consequence of this. Patients tend to overuse them, prolonging the time limited by the clinician or repeating previous prescriptions without taking an appointment with their dermatologist.

Depending on the steroid potency, delivery vehicle, and frequency of applications- it should not be used continuously for longer than three weeks on the skin of the face due to well-known side effects: erythema, telangiectasia, atrophy, xerosis, rebound phenomenon, photosensitization, steroid-induced acne, or rosacea. A combination of topical steroids and antibiotics also increases the risk of antibiotic resistance. Patients are always informed about it; nevertheless, these deplorable consequences are increasingly common in our practice.

### **Materials and methods.**

We present a clinical case and wish to emphasize the importance of the controlled application of topical steroids.

A woman, 60-year-old, applied for dermatological help with complaints about the appearance of multiple painful papulous rashes, itching, and constant pronounced redness of the face, which have worsened a few days before.

This patient has had a "similar allergy" 2 years before. A dermatologist has recommended a cream with betamethasone and gentamycin for three weeks. The rash was regressed. After a short period, itching and redness caused discomfort, the woman initiates to use of this cream again: For 1 year, constantly, every day, she used this medicine as she was satisfied with "a very helpful cosmetic."

### **Results.**

On examination: the patient was depressed. We noted that persistent erythema, open and closed comedones, and visible blood vessels in a spiderweb pattern are on the facial skin. The nasolabial triangle is free from rashes; on the cheeks- thick or has signs of atrophy areas. Laboratory tests are without significant changes.

We have begun our treatment with cream withdrawal, a prescription of antihistamines, and recommendations of cosmeceuticals for irritated and sensitive skin.

Despite the patient tolerating this treatment well, we have registered a flare after 2 weeks. Edema, multiple papulopustular rashes with itching and burning, and single conglobates have appeared again.

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Systemic broad-spectrum antibiotics and topical metronidazole were our next step.

At that moment, the patient is under control in our clinic. We achieved a moderate result, but we were ready for this.

**Discussion.**

Complications in dermatology are a considerable part of our specialty. The patient's negligence, disregard for the doctor's recommendations, and self-treatment are the principal causes. Determined results may be irrecoverable, and this clinical case confirms this statement.

In the pursuit of skin health, the role of a doctor and patient in it is equal. Topical steroids are not safe medicine. It must be used only strictly according to the indications and limited by time.

The withdrawal of topical steroids leads to repeated flares of photosensitivity, erythema, papulopustular rash, itching and burning, and the appearance of rosacea or other acne-form dermatoses. Management of such conditions requires time and patience, specific skills in treatment, and communication with the patient. Nevertheless, we are ready for the challenges. Timely side-effect recognitions, a correct managing tactic, the ability to gain the patient's trust, modern methods of treatment, and laser technologies are the key to success in steroid-induced complications management

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