Clinical and Experimental Dermatology, 2026, 00, 1–2
https://doi.org/10.1093/ced/llag412
Published: 17 September 2026
Letter to the Editor

CED OXFORD
Clinical and Experimental Dermatology

Topical steroid withdrawal: old problem, new terminology and diagnostic inflation in the social-media era

Mohammed Shanshal

Department of Dermatology, Imperial College Healthcare NHS Trust, London, UK
Correspondence: Mohammed Shanshal. Email: m.shanshal@imperial.ac.uk

Dear Editor, Topical steroid withdrawal (TSW) has moved rapidly from patient forums into regulatory warnings, clinical consultations and mainstream dermatology debate. The discussion is often polarized between two unhelpful positions: that TSW is either a newly discovered disease or merely an internet myth. A more productive framing is that contemporary TSW functions as a social-media-amplified umbrella label for heterogeneous steroid-related phenomena, some well-characterized and others incompletely defined, whose boundaries have expanded faster than the evidence.

Post-steroid worsening is not new. Older descriptions include steroid addiction, red burning skin syndrome, steroid rosacea, periorificial dermatitis, rebound erythema, tachyphylaxis and relapse of the underlying dermatosis. These entities predate the current online debate. Hajar *et al*.[1] later concluded, in a systematic review, that TSW was probably a distinct adverse effect, characterized mainly by burning or stinging and erythema, with reports clustered around prolonged exposure to potent agents, particularly on the face and genital area. Social media has changed more than visibility and terminology: online encouragement to stop treatment abruptly may contribute to the florid post-cessation phenotype now labelled TSW, although the underlying steroid-related reactions predate the current online debate.[2]

This distinction matters because TSW is increasingly asked to carry several diagnoses at once: expected rebound, relapsing eczema, allergic contact dermatitis, infection, steroid-induced rosacea or periorificial dermatitis, erythroderma, and the narrower withdrawal phenotype after prolonged frequent use of moderate-to-high potency corticosteroids. The joint statement of the British Association of Dermatologists, British Dermatological Nursing Group and National Eczema Society acknowledges TSW while cautioning that the label covers recognized steroid adverse effects and that alternative diagnoses may account for some presentations.[3] The Medicines and Healthcare products Regulatory Agency (MHRA) similarly recognizes TSW reactions, while noting that flaring after stopping is not unusual, reactions are thought to be rare and they are usually seen after very frequent or long-term use of strong topical steroids.[4]

The contemporary problem is therefore not invention but diagnostic inflation. Social media has offered validation and community to patients who often feel dismissed; it has also created an environment in which a symptom-based label can spread faster than its diagnostic boundaries. The joint statement linked increased awareness partly to online patient experiences and highlighted more than 1.1 billion TikTok views for '#TSW' at the time of publication.[3] Orr *et al*.'s evidence gap map found that TSW remains medically contested, with a limited research base and rapidly expanding patient community awareness online.[2] This is not a reason to dismiss patients; it is a reason to avoid phenotype-free diagnosis.

The clinical consequences cut both ways. Overdiagnosis may intensify corticosteroid phobia, reduce adherence and leave active eczema undertreated; dismissing all TSW concerns as internet-driven risks missing genuine severe steroid-related reactions and eroding trust further. The issue is not whether TSW exists but whether post-cessation suffering is being classified with sufficient discipline and practical tools.

A pragmatic approach is to diagnose TSW only when exposure history, phenotype and temporal sequence are compatible, rather than applying the diagnosis to any worsening during topical corticosteroid treatment or after reduction or cessation (Figure 1). At minimum, clinicians should document potency, duration, frequency, sites, prior response pattern, morphology, distribution, the exact timing of symptom onset relative to continuing treatment, reduction or cessation, the subsequent clinical course and exclusion of diagnostic mimics. A recently proposed nomenclature distinguishes steroid-dependent eczema and early TSW during continued topical corticosteroid use, classic TSW as the acute reactive state within days to weeks after cessation and later relapsing or recovered states.[5] Compatible supportive features, not standalone criteria, include prolonged frequent corticosteroid use, escalating corticosteroid requirement or loss of response, burning pain disproportionate to itch, morphology or distribution incongruent with the original dermatosis, erythema or dyschromia extending beyond treated sites, desquamation, oedema or thickened wrinkled skin, and a temporal course atypical for the

Accepted: 11 September 2026
© The Author(s) 2026. Published by Oxford University Press on behalf of British Association of Dermatologists. All rights reserved. For commercial re-use, please contact reprints@oup.com for reprints and translation rights for reprints. All other permissions can be obtained through our RightsLink service via the Permissions link on the article page on our site—for further information please contact journals.permissions@oup.com.

Downloaded from academic.oup.com/ced/advance-article/doi/10.1093/ced/llag412/8812733 by IMPERIAL user on 04 November 2026

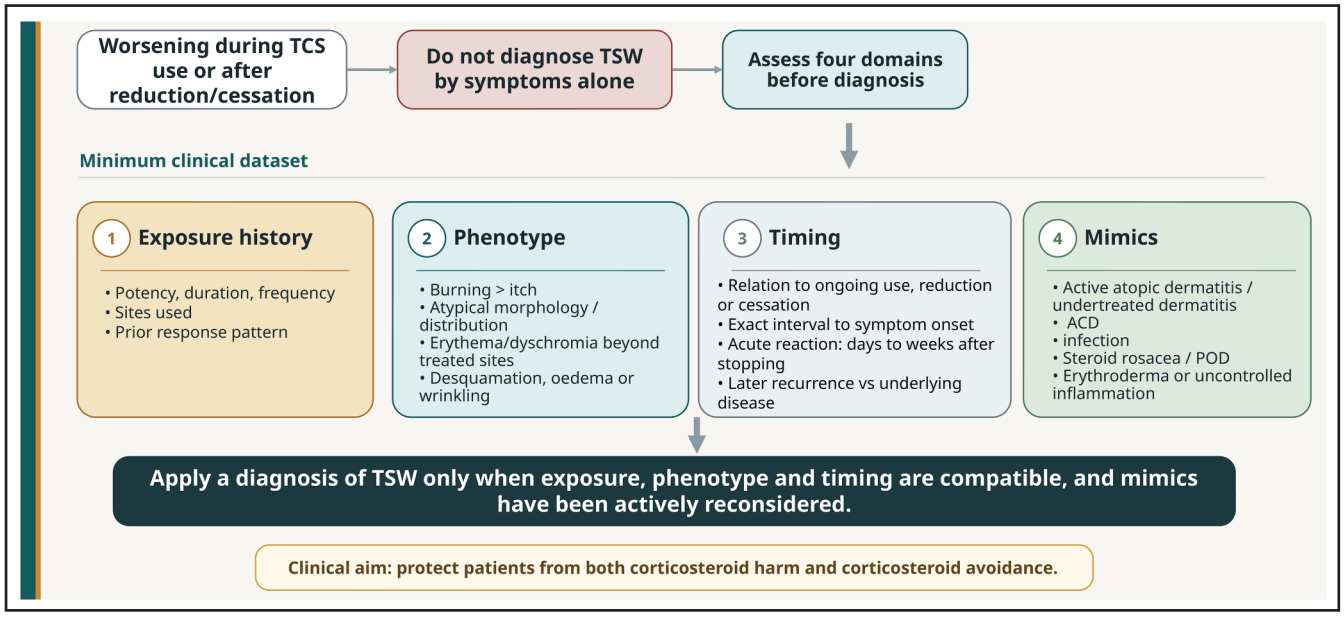


Figure 1 Pragmatic framework for diagnosing 'topical steroid withdrawal' (TSW). Worsening during topical corticosteroid (TCS) treatment or after reduction or cessation should not be classified as TSW by symptoms alone. Exposure history, phenotype, temporal sequence and diagnostic mimics should be assessed before applying the diagnosis. Supportive features are not standalone diagnostic criteria. ACD, allergic contact dermatitis; POD, perioriificial dermatitis.

underlying condition. Before making the diagnosis, clinicians should actively reconsider active atopic dermatitis, infection, allergic contact dermatitis, erythroderma, steroid rosacea, perioriificial dermatitis and inadequately controlled inflammatory dermatosis. The recent modified Delphi work is important because it moves the field from impressionistic labelling toward preliminary consensus-based diagnostic criteria.[6]

Dermatology needs neither defensive dismissal nor uncritical validation. TSW should be recognized as a possible adverse reaction but not allowed to become a catch-all diagnosis for every post-steroid flare. The challenge is not whether TSW exists but whether the term is being applied with enough specificity to protect patients from both corticosteroid harm and corticosteroid avoidance.

Author contributions: Mohammed Shanshal (Conceptualization, Writing—original draft, Writing—review & editing [lead])

Funding sources: This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Conflicts of interest: The author declares no conflicts of interest.

Data availability: No new data generated.

Ethics statement: Not applicable.

Patient consent: Not applicable.

References

1 Hajar T, Leshem YA, Hanifin JM *et al.* A systematic review of topical corticosteroid withdrawal 'steroid addiction' in patients with atopic dermatitis and other dermatoses. *J Am Acad Dermatol* 2015; **72**:541–9.e2.

2 Orr N, Rogers M, Stein A *et al.* Reviewing the evidence base for topical steroid withdrawal syndrome in the research literature and social media platforms: an evidence gap map. *J Med Internet Res* 2024; **26**:e57687.

3 National Eczema Society, British Dermatological Nursing Group, British Association of Dermatologists. *Topical Steroid Withdrawal: Joint Statement by the National Eczema Society, the British Dermatological Nursing Group, and the British Association of Dermatologists*. London: National Eczema Society, 2024. Available from: https://www.bad.org.uk/topical-steroid-withdrawal-joint-statement (last cited 5 July 2026).

4 Medicines and Healthcare products Regulatory Agency. *Topical steroids: introduction of new labelling and a reminder of the possibility of severe side effects, including topical steroid withdrawal reactions*. London: MHRA, 2024. Available from: https://www.gov.uk/guidance/topical-corticosteroids-and-withdrawal-reactions (last cited 5 July 2026).

5 Moss C, Mills RM. Clarifying the terminology of topical steroid withdrawal. *Clin Exp Dermatol* 2026; **51**:1756–7.

6 Hsu C, Guo L, Adams D *et al.* Topical steroid withdrawal syndrome: developing diagnostic criteria through a modified Delphi method. *Br J Dermatol* 2026; **194**:768–78.

Downloaded from academic.oup.com/ced/advance-article/doi/10.1093/ced/llag412/8812733 by IMPERIAL user on 04 November 2026