

ALL CORTICOSTEROIDS IN ANY FORMULATION ARE NOT INNOCUOUS AND BEG TO BE HANDLED WITH CARE

Many short courses (bursts) of oral corticosteroids (OCS) are commonly prescribed for indicated and non-indicated conditions. These bursts are perceived to be safe and are usually given by prescription for less than 14 days at a time.¹ The global corticosteroid market was USD 5.7 billion in 2023, and with a projected annual growth rate of 4.6% across all regions, reflects its widespread use.² Published data of OCS use in South Africa are difficult to find, yet parents of children attending a clinic for immune deficiencies frequently report repetitive prescriptions.

Doctors who treat allergies rely on corticosteroids to control aberrant inflammation but all formulations affect the transcription of numerous genes in cells, including healthy cells, leading to numerous and significant side effects.

Data from Taiwan confirms that OCS are often prescribed for non-indicated conditions such as general skin rashes and respiratory infections.^{3,4} The same studies highlight troubling associations between short OCS bursts (as brief as three days) and severe adverse events such as pneumonia, septicaemia, gastrointestinal bleeding and new-onset heart failure in adults and children.^{3,4} Long-term observational data links cumulative lifetime OCS exposure to a long list of downstream health sequelae.⁵ These associations become more pronounced with as few as four lifetime OCS bursts.

The Global Strategy for Asthma Management and Prevention [Global Initiative for Asthma (GINA)] now specifically warns that 4–5 lifetime courses of OCS in adults 'are associated with a significantly increased dose-dependent risk of diabetes, cataract, heart failure, osteoporosis and several other conditions'.⁶

The body does not always 'forget' previous exposure!

This issue of the Journal includes articles on vaccine allergy and occupational asthma and is dedicated to the judicious use of corticosteroids. A series of insightful articles will reinforce our understanding and emphasise evidence-



based OCS use. Cordier et al explore corticosteroids' impact on the immune system, while McDougal et al examine both the immediate and cumulative long-term adverse effects of OCS bursts. Mopeli et al review the evidence supporting OCS use in airway disease, and Zampoli et al discuss best practices for inhaled corticosteroid therapy.

Delport warns against a 'laissez-faire' approach to systemic corticosteroid prescribing, which can lead to overexposure that often begins before birth and continues relentlessly under medical supervision after birth. I had to look up the exact meaning of 'laissez-faire'. We need corticosteroids in an era of rising aberrant inflammation, but a 'let-it-be' or 'happy-go-lucky' attitude toward repeated OCS bursts is indefensible in light of the growing evidence of harm and the increasing availability of alternative treatments. Ethical prescribing principles must guide our decisions, as Kling reminds us.

The onus is on prescribers and societies like ALLSA to join a growing global call for exogenous corticosteroid stewardship.

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