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Conflicts of interest

None disclosed.

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Risk of rebound psoriasis flare from systemic corticosteroid use in patients with psoriasis: A retrospective cohort study

To the Editor: Use of systemic corticosteroids in patients with psoriasis is controversial because of the association between withdrawal of systemic steroids and flares of psoriasis.[1] Four recent publications have questioned this association.[2-5] This retrospective cohort study compares patients with psoriasis treated with systemic corticosteroids to age, sex, and severity-matched controls.

We identified 16 patients with a history of psoriasis (PSO) and/or psoriatic arthritis (PsA) who reported recent oral corticosteroid use when seen at the Mount Sinai Hospital Dermatology Faculty Practice between April 2021 and May 2022, along with 16 age- and sex-matched control patients (Table I). All patients were known to the investigators, and all but one was on biologic therapy for psoriasis at the beginning of the study period. Psoriasis treatments, corticosteroid dosing, and reasons for corticosteroid use are depicted in Supplementary Tables I and II, available via Mendeley at https://data.mendeley.com/datasets/8s4pv78c8g/1. Psoriasis exacerbation was defined as 10% or greater increase in body surface area (BSA), a change in psoriasis type from plaque to pustular or erythrodermic, or worsening of PsA. Following steroid use and taper, 9 patients suffered from increased BSA, with one of them also developing worsening arthritis, 8 of these patients required a change in therapy. Two other patients developed PsA alone and required a change in therapy. Five patients did not experience psoriasis flares. One control patient experienced a psoriasis flare while 2 experienced worsening arthritis. Two of these patients required a change in therapy. Most flares occurred between 3 and 7 weeks from steroid taper and there were no other identifiable causes for the flare. Systemic steroid exposure was associated with an increased incidence of psoriasis flare ± PsA compared to patients without systemic steroid exposure ($P = .003$).

Our data support the observation that systemic use of corticosteroids in patients with psoriasis is associated with worsening of PSO or PsA. While the other studies conclude that steroids do not cause a significant number of adverse effects in patients with psoriasis, these studies were literature reviews or anonymous electronic medical record searches, apart from a trial in which patients were also treated with methotrexate (Supplementary Table III, available via Mendeley at https://data.mendeley.com/datasets/8s4pv78c8g/1).[2-5] Our retrospective cohort study of patients allowed us to collect recent histories, including BSA and psoriatic arthritis exacerbations. Its results support the conclusion that the discontinuation or tapering of systemic corticosteroids can cause psoriasis flares and should be done with caution. Furthermore, education is necessary about the unique complications that occur when treating pustular psoriasis with systemic steroids.[1]

Given our small study size and the lack of prospective data, further analysis with a larger cohort is warranted. Until then, our results support the notion that systemic corticosteroid use should be avoided in these patients, with the

Table I. Characteristics of patients with psoriasis who were and were not treated with systemic corticosteroids

Treated with oral corticosteroids	Median age (IQR)	Gender (% male patients)	% patients with increase in BSA	Range of increase in BSA reported*	% PSO patients who also have PsA	% of PsA patients with worsening of PsA	% All patients requiring Change in Therapy
Yes (n = 16)	64.5 (47.5-72)	50%	56.3%	10%-75%	62.5%	30%	62.5%
No (n = 16)	62.5 (49-71)	50%	12.5%	8%-15%	50%	25%	12.5%

BSA, Body surface area; *IQR*, interquartile range; *PsA*, psoriatic arthritis; *PSO*, history of psoriasis.
*Change in BSA was calculated by subtracting initial precorticosteroid % BSA from postcorticosteroid taper % BSA.

understanding that their avoidance is not always possible. Finally, education is necessary in the nondermatological community about the dangers of prescribing steroids to patients with PSO and PsA.

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Conflicts of interest

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Keratinocyte carcinoma resected by Mohs micrographic surgery in individuals with skin of color: An observational study

To the Editor: Despite a lower frequency of keratinocyte carcinoma (KC), morbidity and mortality are disproportionately high in individuals with skin of color (SOC).[1] Studies have emerged on this topic; however, most participants are White Hispanics.[2] Herein, we compare characteristics of KC resected by Mohs micrographic surgery in a uniquely diverse population, most with Fitzpatrick skin types (FST) IV to V.

This retrospective cohort study took place at a single academic institution in the Bronx, New York.