Original Article

Effectiveness of 'Fingertip Unit' as a Standard Measure in Improving the Efficacy and Safety of Topical Corticosteroids in Eczematous Dermatosis in Indian Population

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Abstract

Background: Topical corticosteroids are central to eczema management, but variable application practices can affect both efficacy and safety. The fingertip unit (FTU) offers a simple, standardized dosing method, yet its clinical impact in Indian patients with eczematous dermatoses has not been adequately evaluated. To assess whether FTU-based dosing of clobetasol propionate 0.05% improves efficacy and safety compared with conventional application in adults with chronic eczematous dermatoses. **Material and Methods:** This prospective, randomized, open-label, comparative study was conducted in a tertiary-care dermatology outpatient department over one month (15 June–14 July 2019). Sixty adults (18–65 years) with chronic eczematous dermatoses were randomized to FTU-based dosing (n=30) or conventional dosing (n=30) of clobetasol propionate 0.05% applied twice daily for 30 days. Eczema severity was assessed at baseline, days 10, 20, and 30 using Eczema Area and Severity Index (EASI), Investigator's Global Assessment (IGA), and pruritus scores. Outcomes were analyzed per protocol (FTU: n=27; Conventional: n=25). Adverse effects were recorded at each visit. **Results:** Both groups showed highly significant within-group reductions in mean EASI and IGA scores at all follow-up visits ($P<0.001$). Between-group differences in EASI and IGA were not statistically significant ($P>0.05$), though percentage reduction in EASI consistently favoured the FTU group (78.79% vs 73.58% at day 30). Cure rates based on IGA were 55.56% in the FTU group and 48.00% in the conventional group. Pruritus reduction was slightly greater with conventional dosing. Adverse effects were more frequent with conventional dosing (40.0%) than with FTU dosing (18.52%), predominantly mild perilesional hypopigmentation and irritation. **Conclusion:** FTU-based dosing of clobetasol propionate 0.05% provides comparable or marginally better disease control with fewer adverse effects than conventional application. Incorporating FTU guidance can standardize dosing, enhance safety, and support rational use of topical corticosteroids in eczematous dermatoses.

Keywords: fingertip unit, topical corticosteroids, clobetasol propionate, eczematous dermatoses, eczema, adverse effects, Indian population.

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Introduction

Topical corticosteroids (TCS) are among the most commonly prescribed medications in dermatology outpatient departments, dating back to their introduction in the 1950s.[1,2] TCS has a more significant influence on the dermatology department than any other category of medications. They have made it considerably simpler to treat several dermatoses that formerly caused considerable morbidity in the general population.

However, over time, TCS are being abused by both doctors and patients. Not only are they used for well-known indications, but they are also used in cases of undiagnosed skin rashes by dermatologists and general physicians.[3] This is because they quickly alleviate the symptoms and indicators of a variety of skin conditions. Apart from this, many patients are also using them by their non-medical advisers, like friends, and neighbours, to use them as fairness creams and for acne,[4,5] To

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make things worse, these drugs are easily available without a valid prescription at every pharmacy. All the aforementioned issues, although reported from many countries worldwide,[6-8] have a significant impact in our country, as they are readily available over the counter (OTC) medications without the need for a prescription.

Even though they can be used in a myriad of dermatological disorders, they are associated with significant adverse effects. Due to the overuse of TCS, there has been an increase in these adverse effects. The main reason TCSs are utilised is due to their anti-inflammatory qualities; however, the same processes that make them effective also cause their negative side effects.[9]

When two individuals get the same TCS for a comparable reason, there are often significant differences in the clinical effectiveness or side effect profile. The same TCS administered for a similar reason in two distinct persons may usually have radically varied clinical efficacy and/or side event profiles. This is because, in the absence of appropriate guidance, patients vary widely in how much, how often, and how long they take TCS, resulting in variations in the effectiveness and adverse effect profile they encounter. Usually, one patient will finish the prescribed tube (container) of TCS in 5 days, while another patient with the same TCS and for the same indication uses it for 15-20 days. The most common reason for this is the way they use TCS in terms of the quantity they apply each time. Some will apply more, and some will apply less.

The rational use of TCS can help mitigate unnecessary adverse effects resulting from improper usage. The Fingertip Unit (FTU) is a relatively new entity that is a standardised measure for the amount of ointment or cream of topically used medications necessary for a specific anatomic area, devised by Long and Finlay.[10] It has been commonly used in developed countries for the past few years. The quantity that can be squeezed with a 5 mm diameter nozzle from the tip of the finger to the first crease of the finger is known as an FTU. One FTU is equivalent to 0.5g of cream or ointment when using a normal nozzle tube.[11]

One of the important advantages of using TCS as Fingertip units is that it automatically corrects for body size. Depending on the body area being treated, different FTU dosages will be advised. This is because some bodily regions have thinner skin, making them more vulnerable to the impacts of TC. The recommendations for the quantity of ointment required in adults depending on certain anatomic locations are shown in [Table 1]. Around the globe, FTU is heavily advocated as a way to increase medication adherence and lessen variance in TCS use.

Table 1: Fingertip Unit (FTU) Guidelines for adults as adapted from Long & Finaly

Anatomic Area	FTU required
Face & Neck	2.5
Anterior/Posterior Trunk	7
Arm	3
Hand	1
Leg	6
Foot	2

As no study was done to evaluate the effect of using TCS as Finger Tip Units in our Country, we have decided to conduct the present study to evaluate the effectiveness of Finger Tip Units (FTU) as a standard measure in improving the efficacy and safety of topical corticosteroids in eczematous dermatosis in the Indian Population. We have selected eczematous dermatosis as it was the most common disorder with which patients are coming to the dermatology OPD, and we have chosen Clobetasol propionate as the drug because it was the most commonly prescribed drug in eczema in our hospital. So we have chosen the most common disease in our dermatology OPD, and the most common drug used for that disease in our study.

Aims & Objectives: The present study aimed to evaluate the effectiveness of the Fingertip Unit (FTU) as a standard measure in improving the efficacy and safety of topical corticosteroids in Indian patients with eczematous dermatitis.

Primary objective: To evaluate the effectiveness of the Fingertip Unit (FTU) as a standard measure in improving the efficacy of topical corticosteroids in chronic eczematous dermatosis.

Secondary Objective: To compare the adverse effect profile in patients taking TCS as FTU and as conventional.

Materials and Methods

The present investigation was conducted as an interventional study adopting a prospective, randomised, open-label, comparative design. The study was conducted in the Department of Dermatology at Vinayaka Missions Medical College, Karaikal. Eligible participants were enrolled after obtaining written informed consent and were randomly assigned to respective treatment groups to ensure unbiased comparison of therapeutic outcomes. The open-label format was deemed appropriate considering the clinical nature of the interventions and the practical setting of the dermatology outpatient department. The study was conducted over one month, from June 15, 2019, to July 14, 2019, during which baseline assessments, treatment administration, and follow-up evaluations were systematically performed in accordance with the Institutional Ethics Committee and established research protocols.

Study Population: The study population consisted of adult patients of either sex who were clinically diagnosed with eczematous dermatoses and visited the Dermatology Outpatient Department during the study period. A total of 60 participants fulfilling the inclusion and exclusion criteria were recruited. The concise study duration was designed to assess short-term therapeutic efficacy and safety while minimising the influence of environmental or seasonal variations that may affect eczema

severity. All enrolled participants were evaluated under standardised conditions, ensuring consistency and adherence to ethical research protocols throughout the study.

Inclusion Criteria:

All adult patients (Age:18-65 years) diagnosed with chronic eczematous dermatosis attending the Dermatology Outpatient Department of our Hospital and who have given consent to participate in the study were included in the study.

Exclusion Criteria:

1. Patients with significant concomitant illness, e.g., malignancies or hepatic, psychiatric, endocrine, or other major systemic diseases
2. Pregnant and lactating women will be excluded.
3. Children (age less than 18 years) and older people (age more than 65 years)

All the eligible participants were randomised by using computer generated random list and after randomisation, 30 patients have used topical corticosteroid (Clobetasol Propionate 0.05%) as fingertip units whom will be designated from now onwards as 'FTU group' and other 30 patients have used the same topical corticosteroid (Clobetasol Propionate 0.05%) conventionally whom will be defined from now on as 'Conventional group', both for a period of 30 days. Both patient groups were instructed to use Clobetasol propionate 0.05% cream twice daily to their eczematous skin, using enough to gently cover the whole affected region, without the use of an occlusive bandage. We have provided patients in the FTU group with comprehensive directions on how to apply the cream, as shown in [Table 1]. Patients were instructed not to use the product on any skin that was atrophied or ulcerated. Throughout the research, emollients were allowed.

Following an explanation of the patient's medical condition, the nature and goals of the suggested therapy, and the advantages and disadvantages of the recommended drug use, all patients who were part of the research provided written informed consent. Before commencing the study, prior approval was obtained from the Institutional Ethics Committee.

Basic demographic data, including age and sex, and a clinical examination of the eczematous lesions, were collected and noted for all study participants. Efficacy was assessed using the Eczema Area and Severity Index (EASI) and the Investigator's Global Assessment (IGA) of eczema severity. EASI is a composite index, which includes an evaluation of the disease extent and percentage of body surface area involved, converted to a proportional factor (scale of 0.6), in four body regions (head and neck, lower limbs, upper limbs, and trunk). It will be used to assess changes in eczema severity and the area affected by treatment. The extent, form, and severity of skin lesions were evaluated at each follow-up examination and during the enrolment interview. Skin lesions were classified according to their shape: lichenification (L), excoriation (Ex), erythema (E), and induration/population (I). None, mild, moderate, and severe were represented by the severity scores of 0, 1, 2, and 3, respectively. Lesion area scores of 0, 1, 2, 3, 4, 5, or 6 indicated that the skin lesions impacted 0%, less than 10%, 10%–29%, 30%–49%, 50%–69%, 70%–89%, or 90%–100% of each body region area, respectively. The following formula was used to compute the Eczema Area and Severity Index (EASI): Head/neck lesion area score × total head/neck severity score (E+I+Ex+L) × 0.1 +upper limb lesion area scores × total upper limb lesion severity score (E+I+Ex+L) × 0.2 +trunk lesion area scores × total trunk lesion severity score (E+I+Ex+L) × 0.3 + lower limb lesion area scores × total lower limb lesion severity score (E+I+Ex+L) × 0.4). A case report form for EASI is being attached in the attachments section.

At every visit, an Investigator's Global Assessment (IGA) of eczema severity was conducted using a 1-6 scale. Eczema severity was categorised as follows: 1, normal and clear skin; 2, almost clear skin; 3, mild dermatitis; 4, moderate dermatitis; 5, severe dermatitis; and 6, extremely severe dermatitis. Using a three-point rating system, the severity of itchiness was evaluated at each of the four visits. 0 denoted no severity, one mild, two moderate, and three severe. Response to treatment was divided into three categories based on the severity of eczema measured by the IGA scale: cure (achieving a grade of 1 or 2 or a reduction of two or more grades in IGA at the end of treatment), progress (reduction of one grade with therapy), and rejection (no variation or rise in the IGA grade at the end of treatment). All side effects, whether or not they were thought to be directly caused by the study medication, were recorded and monitored until they were resolved, or no further improvement was anticipated.

All the above parameters were assessed at four visits in total, consisting of visit 1 (baseline measure, start of therapy), visit 2 (day 10), visit 3 (day 20), and visit 4 (day 30).

Statistical Analysis: For statistical analysis, a paired t-test was used for comparison within the groups, and an unpaired t-test was used for comparison between groups, with a significance level of $P < 0.05$ and $P < 0.001$ considered highly significant. These analyses were performed using IBM SPSS Statistics for Windows, Version 21. The decrease in the pruritus score was expressed as percentage values, and the incidence of adverse effects was given as the absolute number of patients who experienced them. The decrease in the mean scores of EASI and IGA was also expressed as percentage values.

Ethical Approval: The study protocol was reviewed and approved by the Institutional Ethics Committee of Vinayaka Missions Medical College, Karaikal, before the initiation of the research work. Every procedure was carried out strictly in compliance with the Declaration of Helsinki's ethical guidelines. All participants received a thorough description of the study's goals, methods, potential benefits, and potential risks before providing their written informed consent. Participants were guaranteed the ability to resign from the research at any time without affecting their continued medical treatment, and patient data confidentiality was maintained throughout the investigation.

Results

After 92 individuals with persistent eczema underwent screening, 60 were accepted into the trial based on their willingness to participate an adherence to the inclusion and exclusion criteria. The research was conducted over the course of one month, from

June 15, 2019, to July 14, 2019. Of the 60 patients who took part in the research, only 52 patients (27 in the FTU group and 25 in the conventional group) completed the study entirely, as three patients in the FTU group and five patients in the traditional group dropped out at different stages during the study period.

Two of the three patients in the FTU group who did not finish the research perished to follow-up while receiving therapy, and one patient dropped out and rejected treatment. (noncompliance). Four of the five participants who did not finish the research in the conventional group failed to follow up while receiving therapy, and one patient dropped out and rejected treatment(noncompliance). Statistical analysis was performed only for patients who had completed the study in its entirety.

Out of the total 52 patients who completed the study, 23 (44.23%) were male and 29 (55.77%) were female. The average age of the overall patients in both groups was found to be 33.69, whereas the average age in the FTU group was 34.89, and the average age of patients in the Conventional group was 32.4.

Table 2: Eczema area and severity index (EASI) scores in both the Groups at various visits

Visits	FTU group			Conventional group			P value (Between the groups)
	Mean±SD	% reduction from baseline	P value (Within group)	Mean±SD	% reduction from baseline	P value (Within group)	
Visit 1	3.96 ± 2.61			4.05 ± 2.59			0.9013
Visit 2	2.40 ± 1.89	39.39 %	<0.001	2.73 ± 1.71	32.59%	<0.001	0.5133
Visit 3	1.37 ± 1.21	65.40 %	<0.001	1.49 ± 1.35	63.21%	<0.001	0.7368
Visit 4	0.84 ± 0.77	78.79%	<0.001	1.07 ± 0.98	73.58%	<0.001	0.3493

Efficacy parameters: EASI score was evaluated at baseline (visit 1), visit 2, visit 3, and visit 4. The paired t-test was used to analyse the change in EASI score at visits 2, 3, and 4 compared to the baseline. Within each group, when the EASI scores at visit 2, visit three and visit four were compared to baseline EASI score, a highly significant reduction ($P < 0.001$) was observed in both FTU group and Conventional group but when the Mean ± SD EASI scores were compared between the groups by unpaired t test, there was no statistically significant difference ($P > 0.05$) [Table 2].

In the FTU group, the reductions in the mean EASI scores at visits 2, 3, and 4 were 39.39%, 65.40%, and 78.79%, respectively, compared to the mean EASI score at the baseline visit. In the conventional group, the corresponding values were 32.59% (visit 2), 63.21% (visit 3), and 73.58% (visit 4). [Figure 1]

IGA scores: Within each group, when the IGA scores at visit 2, visit 3 and visit 4 were compared to baseline IGA score, a highly significant reduction ($P < 0.001$) was observed in both FTU group and Conventional group but when the Mean ± SD IGA scores were compared between the groups by unpaired t test, there was no statistically significant difference ($P > 0.05$) [Table 3].

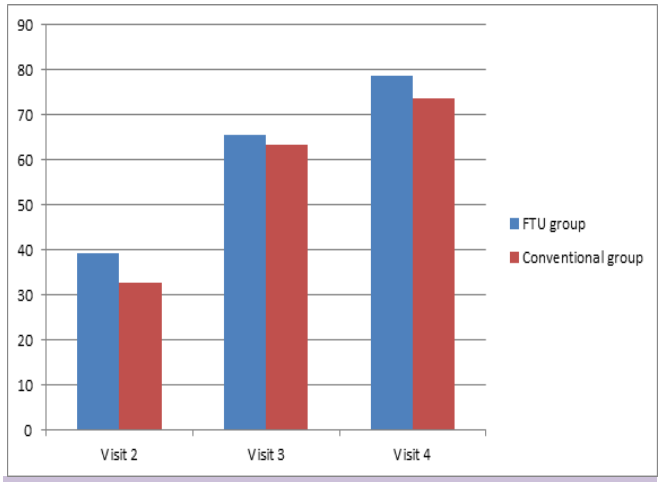

Figure 1: Percentage reduction in the Mean EASI scores in both the groups at various visits

Table 3: Investigator's global assessment (IGA) Scores of Eczema severity in both the Groups at various visits

Visits	FTU group			Conventional group			P value (Between the groups)
	Mean±SD	% reduction from baseline	P value (Within group)	Mean±SD	% reduction from baseline	P value (Within group)	
Visit 1	4.31 ± 0.80			4.17 ± 0.69			0.4741
Visit 2	3.16 ± 0.68	26.85 %	<0.001	3.29 ± 0.70	21.10%	<0.001	0.5002
Visit 3	2.63 ± 0.71	39.12 %	<0.001	2.81 ± 0.73	32.61%	<0.001	0.3718
Visit 4	2.35 ± 0.72	45.60 %	<0.001	2.24 ± 0.61	46.28%	<0.001	0.5565

In the FTU group, the reductions in the mean IGA scores at visits 2, 3, and 4 were 26.85%, 39.12%, and 45.60%, respectively, compared to the mean IGA score at the baseline visit. In the conventional group, the corresponding values were observed to be 21.10% (visit 2), 32.61% (visit 3), and 46.28% (visit 4). [Figure 2]

According to the predefined parameters for Cure, Improvement, and Failure, which are based on the reduction of IGA scores, 55.56% of patients were cured, 40.74% of patients showed improvement, and 3.7% of patients experienced failure in the FTU group. In the Conventional group, 48.00% of patients had a cure and improvement, and 4% had a Failure. [Figure 3]

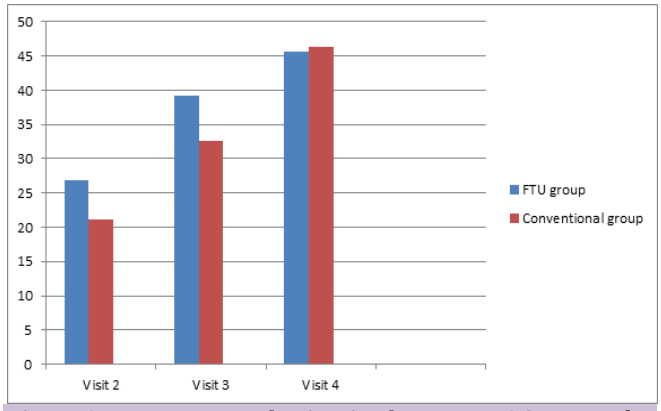

Figure 2: Percentage reduction in the Mean IGA scores for Eczema severity in both the groups at various visits

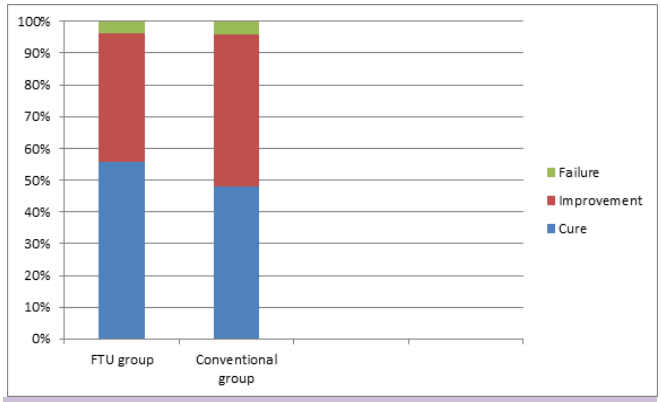

Figure 3: Percentage of patients with Cure, Improvement and Failure based on IGA scores in both the groups

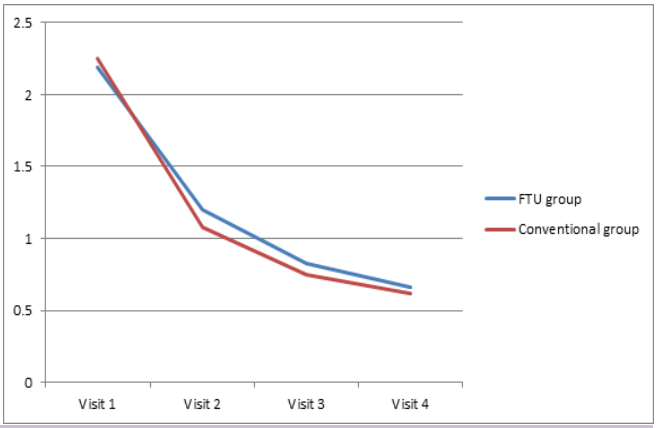

Figure 4: Mean Pruritic scores at various visits in both the groups

The mean pruritic scores in the FTU group at visit 1 were 2.19, at visit two were 1.20, at visit three were 0.83, and at visit four were 0.66, whereas in the conventional group, the mean pruritic scores were 2.25 (visit 1), 1.08 (visit 2), 0.75 (visit 3), and 0.62 (visit 4). [Figure 4]

The reduction in the mean pruritic scores was 45.21% at visit 2, 62.10% at visit 3 and 69.86% at visit 4 when compared to baseline score in FTU group and 52.00% at visit 2, 66.67% at visit 3 and 72.44% at visit 4 in Conventional group. [Figure 5]

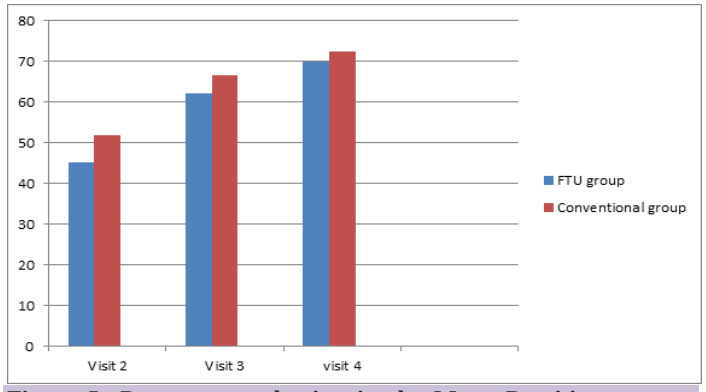

Figure 5: Percentage reduction in the Mean Pruritic scores at various visits in both the groups

Safety parameters: Patients in both groups tolerated the topical corticosteroid used in our study, specifically Clobetasol propionate 0.05%, well. Perilesional hypopigmentation was the most commonly observed adverse effect in our research. A total of 11 patients (40.74%) developed hypopigmentation in both groups combined. Out of these, seven patients were from the Conventional group, and four patients were from the FTU group. A total of four patients (14.82%) complained of irritation during the course of the study, combined across both groups, with three patients from the Conventional group and one patient from the FTU group.

Overall, 40% of patients (i.e., 10 out of 25 patients) in the conventional group developed adverse effects, and 18.52% of patients (i.e., 5 out of 27 patients) in the FTU group developed adverse effects. All the observed adverse effects were mild in nature only. None of the patients developed any serious adverse effects during the study.

Discussion

Despite being one of the most often recommended drugs for dermatological conditions, topical corticosteroids (TCS) have several negative side effects when used excessively. The same TCS administered for a comparable reason in two distinct persons might have wildly varied clinical effectiveness and/or side event profiles. This is because, in the absence of appropriate guidance, patients vary widely in how they administer TCS in terms of dosage, frequency, and duration, resulting in variations in the effectiveness and adverse impact profile they experience. Adopting appropriate criteria in this area is necessary for rational usage.

To determine the appropriate quantity of TCS for a particular anatomical region, the "fingertip unit" (FTU) technique developed by Long and Finley,[10] is advised. An FTU is the quantity that can be extracted from the fingertip to the first fissure of the finger using a nozzle with a diameter of 5 mm. One FTU is equivalent to 0.5 g of cream/ointment when using a standard orifice tube. Eleven. The concept of FTU is being actively promoted worldwide to minimize the variation in TC use and to encourage adherence to therapy, thereby lowering the wide interpatient disparity in effectiveness and adverse effect profile. However, in India, it is only in the primordial stage and is not being implemented by numerous practicing dermatologists.

We wanted to analyze whether using TCS as finger-tip units would have any increase in efficacy and any reduction in the adverse effect profile compared to the conventional usage of TCS. For this, we have selected the most common dermatological disorder in our OPD setting, Chronic eczema, and selected the most common TCS given in our hospital for that disorder, Clobetasol propionate 0.05%.

Eczema is a chronic inflammatory skin disease that is extremely prevalent, afflicting up to 20% of children and 10% of adults in industrialized countries.[12] Clinical features of eczema include erythema, edema, lichenification, excoriations, oozing, and crusting. Pruritus is a crucial and dominant feature of Eczema and generates comorbidities such as sleep loss and psychological distress, creating a continuing disease burden for patients, parents, and siblings. Topical Corticosteroids (TCS) remain the mainstay of treatment in eczematous dermatoses.[13]

Regarding the efficacy parameters, a reduction in EASI scores was found to be highly significant in both the FTU group and the conventional group, but not significantly different between the groups. But when the percentage reduction in mean EASI scores were compared, at all the three visits [Visit 2, 3 & 4 compared to the baseline visit (visit 1) score], there was a higher reduction seen in FTU group compared to the Conventional group (39.39% vs 32.59% at visit 2, 65.40 % vs 63.21% at visit 3, 78.79% vs 73.58% at visit 4) which indicates that efficacy was better in FTU group compared to conventional group.

Regarding the IGA scores of eczema severity, a highly significant reduction was observed in both groups; however, the difference was not substantial when comparing the groups. Here again, the percentage reduction was better in the FTU group at two visits, i.e., at visit two and visit 3 (26.85% vs. 21.10% at visit 2 & 39.12% and 32.61% at visit 3). Still, at visit 4, there was a slightly higher decrease in the Conventional group compared to the FTU group (45.60% in the FTU group vs 46.28% in the conventional group), which can be attributed to chance occurrence, as the difference was very minor.

According to the predefined parameters for Cure, Improvement, and failure, based on the reduction of IGA scores, more patients were cured in the FTU group (15 out of 27) compared to the conventional group (12 out of 25), which also indicates better efficacy in the FTU group compared to the traditional group. There was one patient in both groups who had failure.

Regarding the mean pruritic scores, a higher percentage reduction was observed in all visits in the conventional group compared to the FTU group (52.00% vs 45.21% at visit 2, 66.67% vs 62.10% at visit 3, and 72.44% vs 69.86% at visit 4). This was different from other efficacy parameters, as the reduction in pruritus was greater in the Conventional group compared to the FTU group. This may be due to the higher usage of cream/ointment in patients who used TCS conventionally, where they might have applied more cream/ointment compared to the FTU group patients, which might have resulted in a higher reduction of mean pruritic scores in the conventional group.

Regarding the adverse effects, the FTU group patients had a lower incidence of both adverse effects observed in our study, namely, perilesional hypopigmentation and irritation. This also favours the use of topical corticosteroids in finger-tip units. The use of Topical corticosteroids as finger-tip units is being practiced in some developed countries,[14] but in our country, it is very rarely used.

One significant advantage of utilizing TCS as fingertip units is its automatic adjustment for body size. Consequently, one FTU (approximately 500 mg) adequately covers two adult palms, and three FTUs should suffice for a single application to one arm, regardless of the individual's size.[15]

The FTU is used in some booklets in developed nations, such those created by Patient UK, to assist patients in determining the appropriate amount of cream to apply.[16] For instance, one FTU is advised for the treatment of the fingers, palm, and dorsal surface of a grown-up hand, or for the whole arm and hand of an infant aged three to six months. Nonetheless, the use of FTUs by doctors and the knowledge of them among patients is not prevalent. Informing patients about the FTU system will not fully resolve the issue until it is articulated with clarity and precision. Investing time to ensure that patients, or the guardians of children, are proficient in administering topical medicines is valuable.

Finally, the use of TCS as FTU may be more extensively implemented in both primary and secondary care to assist patients in understanding dosages. Patients might get a personalised chart detailing the appropriate quantity and frequency of cream application, along with a body chart indicating the specific locations for treatment and the corresponding number of FTUs to be administered. This will significantly enhance TCS's efficiency and reduce its unfavourable impact profile.

Conclusion

The topical corticosteroid (Clobetasol propionate 0.05%) has significantly reduced the efficacy parameters, such as EASI score and IGA score of eczema severity, in both the FTU group and the Conventional group (within the group comparison). After the group comparison was conducted, there was no statistically significant difference between the FTU group and the conventional group for both EASI scores and IGA scores. Still, there was a higher reduction in mean EASI scores (39.39% vs 32.59% at visit 2, 65.40 % vs 63.21% at visit 3, 78.79% vs 73.58% at visit 4) and IGA scores (26.85% vs 21.10% at visit 2 & 39.12% and 32.61 % at visit 3) seen in FTU group compared to the Conventional group which indicates that efficacy was better in FTU group compared to conventional group. An exception to this was the reduction in the IGA score found at visit 4 (45.60% in the FTU group vs 46.28% in the traditional group), even though it was a very minor difference.

About the mean pruritic scores, there was a higher percentage reduction observed in all the visits in the conventional group compared to the FTU group (52.00% vs 45.21% at visit 2, 66.67% vs 62.10% at visit 3 and 72.44% vs 69.86% at visit 4) which can be ascribed to the usage of more quantity of the cream

in conventional group than in the FTU group. Regarding the adverse effects, the FTU group patients had a lower incidence of both adverse effects observed in our study, namely, perilesional hypopigmentation and irritation. Therefore, we can conclude that using topical corticosteroid cream/ointment as Fingertip Units has better efficacy and safety compared to the same treatment prescribed conventionally. Finally, increasing awareness of the FTU concept for the application of topical corticosteroids in both the patient and doctor communities can go a long way in improving efficacy while reducing the incidence of adverse effects of topical corticosteroids.

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Conflicts of interest

There are no conflicts of interest.

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