development programmes and microfinance initiatives in Bangladesh, such as those involving Grameen Bank, have mobilised women.[10] Rural healthcare initiatives by non-governmental organisations using community based healthcare workers[11 12] have caused a major rethink of public health programmes in India and Pakistan. In addition, many philanthropic initiatives provide public sector services in difficult fields such as urology, transplantation, eye care, and cancer treatment. A recent outpouring of public sympathy and sentiment around the successful heart operation of a Pakistani girl in Bangalore, India, did much to promote peace between the two countries.

At a meeting in Karachi in early September representatives from Afghanistan, Bangladesh, India, Nepal, Pakistan, and the *BMJ* planned a theme issue for March 2004 to be written by South Asians, to deal exclusively with the region's problems and, importantly, offer solutions. In the issue we will discuss a wide range of health challenges such as reproductive health, malnutrition, HIV/AIDS, the population explosion, and demographic transition. The deadline for submissions has passed, but we will still consider articles, including original research, although we cannot now promise publication in the theme issue. Our ambition is that this issue on South Asia will start to bring together health professionals in the region to discuss issues that are common to all. Our grander ambition is that this non-political collaboration may be the beginning of a sustained and combined effort to improve health care in the region and, perhaps, promote peace and unity in a part of the world crippled by religious, social, and nationalist divisions.

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1 The Human Development Center. *Human development in south Asia. The education challenge*. Oxford, Karachi: Oxford University Press, 1998.
2 Ranis G, Naseeem R. The tortoise and the hare: comparing development in east and south Asia. In: Haq K, ed. *The south Asian challenge*. Oxford, Karachi: Oxford University Press, 2002:242-80.
3 Black RE, Morris SE, Bryce J. Where and why are 10 million children dying every year? *Lancet* 2003;361:2226-34.
4 Gillespie S, ed. *Malnutrition in south Asia: a regional profile*. Kathmandu: UNICEF Regional Office for South Asia, 1997.
5 Sen G, Iyer A, George A. Class, gender and health equity: lessons from India. In Sen G, George A, Ostlin P, eds. *Engendering international health: the challenge of equity*. Cambridge: MIT Press, 2002:281-312.
6 Victora C, Wagstaff A, Schellenberg JA, Gwatkin D, Claeson M, Habicht J-P. Applying an equity lens to child health and mortality: more of the same is not enough. *Lancet* 2003;362:233-41.
7 Bhutta ZA. Children of war: the real victims of the Afghan conflict. *BMJ* 2002;324:349-52.
8 Bhutta ZA, Nundy S. Thinking the unthinkable. *BMJ* 2002;324:1405-6.
9 Anand S, Kanbur SMR. Public policy and basic needs provision: intervention and achievements in Sri Lanka. In Dreze J, Sen A, Hussain A, eds. *The political economy of hunger*. Oxford, New Delhi: Oxford University Press, 1999:298-331.
10 Yunus M. *Banker to the poor*. Dhaka: University Press Ltd, 1998.
11 Oxford Policy Management. Lady Health Worker Programme. *External evaluation of the national programme for family planning and primary health care. Final report*. Islamabad: Government of Pakistan, 2002.
12 Bang AT, Bang RA, Baitule SB, Reddy MH, Deshmukh MD. Effect of home-based neonatal care and management of sepsis on neonatal mortality: field trial in rural India. *Lancet* 1999;354:1955-61.

Topical corticosteroids in atopic dermatitis

Recent research reassures that they are safe and effective in the medium term

Topical corticosteroids have been the mainstay of treatment for atopic dermatitis over the past 40 years. Hydrocortisone was the first to be used; some 30 additional corticosteroid compounds have now been licensed for treatment of atopic dermatitis. The recent development of the topical immunomodulators, tacrolimus and pimecrolimus, has provided alternatives to topical corticosteroids, but these remain expensive and are not effective in every case.[1] Atopic dermatitis remains a therapeutic challenge, and topical corticosteroids continue to have an important role.

Topical applications containing corticosteroid compounds vary greatly in potency. In general the more potent ones are associated with the greater risk of adverse effects. When one of the more potent topical corticosteroids is applied for the first time by a patient with atopic dermatitis the benefit is likely to be rapid and striking, often resulting in clearance of the rash within a few days. The snag is that persistent application of a potent preparation will put the patient at risk of unwanted local effects on the skin. These effects vary from barely perceptible, fully reversible thinning, to irreversible telangiectasiae and striae distensae. Worse still, patients find that the initial benefit is generally rather rapidly lost because of tachyphylaxis—a trend for effectiveness to diminish progressively with continued use.[2] This phenomenon can result in an increased risk of adverse effects since it is tempting, when faced with declining effectiveness, to respond by increasing the potency of the topical corticosteroid.

Clinical trials of topical corticosteroids have focused almost exclusively on the effectiveness of short term treatment, over periods of four weeks or less.[3] In these studies, comparators have generally either been a placebo or other topical corticosteroids. Limited evidence indicates that twice daily application may be more effective, although trials of newer topical corticosteroids have generally concluded that once daily application is adequate.

The short term effectiveness and safety of topical corticosteroids in atopic dermatitis are not in doubt, but very few data are available to help us make informed decisions regarding their optimal use in the medium and longer term. Three randomised controlled trials have addressed this issue.[4–6]

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In the first of these trials, adults with atopic dermatitis who were initially cleared of lesions by two weeks of daily application of a potent topical corticosteroid, fluticasone 0.005% ointment, were recruited into a double blind, controlled, randomised study to investigate whether continuing application of the same preparation on just two successive days each week would maintain the benefit.[4] Patients applied the topical corticosteroid, or placebo, to previously healed and any new lesions. Those who continued using the topical corticosteroid showed only slight deterioration of the atopic dermatitis over the 16 week period of the study—significantly less than those who applied placebo, and their relapse rate was almost three times less. No evidence was found of a significant systemic effect from absorption of the topical corticosteroid, and no evidence of skin atrophy was shown by serial biopsies.

The second trial[5] was conducted over an 18 week period, during which children with atopic dermatitis either applied a potent corticosteroid preparation (0.1% betamethasone valerate) for three successive days followed by the base ointment alone for the following four days, or a weak preparation (1% hydrocortisone) for seven days. Treatment was applied in bursts of seven days only when required. Both groups showed clinically important improvements in severity of disease and quality of life compared with baseline, and no differences were shown in any outcome measure after 18 weeks. Skin thickness was measured at baseline and 18 weeks using ultrasound and showed some thinning in both groups but not clinically apparent in either.

The third trial is very similar in concept to the first of these studies.[6] The patient groups were much larger, and included adolescents as well as adults. Patients used either fluticasone 0.05% cream or 0.005% ointment (both classified as potent), or the equivalent base. Patients were then divided into two groups for a 16 week trial of maintenance therapy: both groups applied emollient daily, one group in addition applying the same topical corticosteroid, the other the base alone—twice weekly in each case. The results again showed that twice weekly application of a potent topical corticosteroid was clearly superior, with median time to relapse more than 16 weeks, compared with six weeks for emollient alone. Evidence of skin thinning was sought visually only and was not found in any of the patients.

For those involved in the care of patients with atopic dermatitis these are important studies as they show that topical corticosteroids can be used effectively in the medium term as well in as the short term. They are not as reassuring regarding adverse effects because the treatment periods are still too short for this purpose, nor do they tell us whether similar benefits would persist over longer periods. Nevertheless, they are certainly the most relevant clinical trials to date of topical corticosteroids in atopic dermatitis, because they evaluated ways of using topical corticosteroids that very closely resemble the ways that patients in the real world use them. These trials are not strictly comparable, but the two different types of trials provide valuable insights. The trial by Thomas et al[5] shows that, contrary to standard teaching, potent topical corticosteroids probably can be used safely as well as effectively in children. None of the studies addresses the issue of tachyphylaxis directly, but it is relevant that in studies by Van der Meer et al and Berth-Jones et al,[4 6] most patients applying a potent topical corticosteroid twice weekly had not relapsed by the end of nearly four months, implying that this intermittent pattern of use may help to prevent or delay the onset of clinically relevant tachyphylaxis.

During the past decade, great public concern has developed in relation to topical steroids, which in many individuals comes close to phobia.[7] This has meant that many, particularly the parents of children with atopic dermatitis, may refuse to contemplate the use of topical corticosteroids for their child's disease under any circumstances. These studies provide for the first time some reassurance that topical corticosteroids can in fact be used safely and effectively, if certain guidelines are followed.

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1 Williams H. New treatments for atopic dermatitis. *BMJ* 2002;324:1533-4.
2 Du Vivier A. Tachyphylaxis to topically applied steroids. *Arch Dermatol* 1976;112:1245-8.
3 Hoare C, Li Wan Po A, Williams H. Systematic reviews of treatments for atopic eczema. *Health Technol Assess* 2000;4:1-191.
4 Van Der Meer JB, Glazenburg EJ, Mulder PG, Eggink HF, Coenraads PJ. The management of moderate to severe atopic dermatitis in adults with fluticasone propionate. *Br J Dermatol* 1999;140:1114-21.
5 Thomas KS, Armstrong S, Avery A, Po AL, O'Neill C, Young S, et al. Randomised controlled trial of short bursts of a potent topical corticosteroid versus prolonged use of a mild preparation for children with mild or moderate atopic eczema. *BMJ* 2002;324:768-71.
6 Berth-Jones J, Damstra RJ, Golsch S, Livden JK, Van Hooteghem O, Allegra F, et al. Twice weekly fluticasone propionate added to emollient maintenance treatment to reduce risk of relapse in atopic dermatitis: randomised, double blind, parallel group study. *BMJ* 2003;326:1367.
7 Charman CR. Morris atopic dermatitis. Williams HC. Topical corticosteroid phobia in patients with atopic eczema. *Br J Dermatol* 2000;142:931-6.

The rise of trust doctors

Stop exploiting them and start rewarding their input

See special issue of *Career Focus* and *Papers* p 961

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Non standard grade doctors—more commonly called trust doctors—are a relatively new phenomenon in the United Kingdom. They have several different titles, but essentially they have arisen as a means by which hospital trusts can employ additional junior doctors, despite the Department of Health's ceiling on training grade numbers, which exists to prevent a bottleneck at specialist level. Trust doctors are employed by trusts (local hospitals) for service and are therefore not regulated by the royal colleges or the deaneries (departments of postgraduate medical education). There were few posts for trust doctors in the United Kingdom until the introduction of stricter regulations of hours for junior doctors. Trusts most