Discussion: To the best of our knowledge, this is the first reported case of adult iatrogenic CS secondary to topical Triamcinolone in the absence of any drug-drug interaction. Purser et al reported Triamcinolone induced CS in an HIV patient taking Ritonavir, a cytochrome P450 inhibitor that increases the amount of active steroid. Our patient had increased absorption due to the application of the cream to a large BSA and to open wounds. The two main factors that determine the development of iatrogenic CS are the potency of the glucocorticoids and the duration of exposure. The pathophysiology of wound healing in CS has been well studied and reported, therefore, the objective of this report is to understand how a relatively benign topical medication can have detrimental systemic effects.

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Steroid Hormones and Receptors

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Triamcinolone Cream-Induced Cushing Syndrome

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Introduction: Iatrogenic Cushing syndrome (CS) is typically due to systemic corticosteroids. Less frequently, it can be caused by inhaled, ocular, intra-articular, and topical glucocorticoids.

There are multiple reported cases of pediatric CS due to topical corticosteroids, this is partly due to this patient's population thinner dermis which allows for higher absorption. In adults, there are few reported cases of iatrogenic CS secondary to Clobetasol, one of the highest potency topical steroids available. We present a unique case of severe Iatrogenic CS secondary to topical Triamcinolone in a patient with no medications that could interfere with glucocorticoid metabolism.

Case: A 30-year-old-female with Type 2 Diabetes Mellitus and psoriatic arthritis was admitted with generalized psoriatic lesions affecting 70% of her body surface area (BSA) and non-healing open wounds affecting two thirds of her upper legs. The leg wounds had failed to improve after seven washouts and three skin grafts in the course of four months. Additionally, she reported recent weight gain and a new diagnosis of hypertension. Pertinent physical exam findings included moon facies, dorsocervical fat pad, acanthosis nigricans, and open wounds in 67% of bilateral upper legs. Subsequently, her cortisol was found to be 1.2 mg/dL (6.2-19.4 mg/dL) with an ACTH level of 1.2 pg/mL (7.2-63.3 pg/mL). ACTH stimulation test confirmed adrenal insufficiency.

The only medication she was prescribed for psoriasis at the time of admission was 0.1% Triamcinolone cream. She had been applying the steroid to over 50% of her BSA, including open wounds, for the past four months. Upon admission, Triamcinolone was discontinued, and she was started on cyclosporine and a TNF inhibitor for psoriasis management as well as oral hydrocortisone for adrenal insufficiency. Three months later, during her last office visit, her facial rounding and plethora, dorsocervical fat pad and hypertension had moderately improved.