

Intraarticular Steroid Phobia in Physicians: Is There a Basis?

Hekimlerde İntraartiküler Steroid Fobisi: Bir Temeli Var mı?

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ABSTRACT

Aim: Intra-articular corticosteroid (IACS) injections are a frequently used treatment method worldwide. Local steroid injections are frequently used not only for osteoarthritis but also for joint, soft tissue, or spinal pain. It is known that systemic administration of glucocorticoids can pose significant risks. There may be significant prejudice against steroids in society. This has been demonstrated in studies on topical steroids. The aim of this study is to investigate IACS phobia in physicians.

Method: The TOPICOP score, a validated score, is used to assess topical steroid phobia. In this study, a cross-sectional online survey using the TOPICOP score as a reference was administered to assess physicians' perceptions of IACS use.

Results: When comparing survey data, no significant differences were found in terms of age, gender, geographical regions, and institution, while belief scores were lower in surgical branches. Belief scores were highest in the group with 6-10 years of experience. Fear scores were lower in physicians who had previously undergone IACS and those who had performed IAS on their patients. Physicians who had personally experienced IACS-related complications reported significantly lower fear scores, while no significant differences in belief, fear, or attitude scores were observed between physicians who had observed complications in their patients after IAS and those who had not.

Conclusion: In our study, approximately half of the physicians (48.5%) agreed with the question "I am afraid of intra-articular steroids." Given that steroid phobia in physicians may influence patients' acceptance of IACS treatment, it is important to investigate the causes of intra-articular steroid phobia in physicians.

Keywords: Phobia, Corticosteroid, Steroid, Intraarticular

ÖZ

Amaç: Eklem içi kortikosteroid (İAS) enjeksiyonları, dünya çapında sıklıkla kullanılan bir tedavi yöntemidir. Lokal steroid enjeksiyonları, sadece osteoartrit değil, eklem, yumuşak doku veya omurga ağrılarının tedavisinde sıklıkla kullanılır. Glukokortikoidlerin sistemik olarak uygulandığında önemli riskler oluşturabileceği bilinmektedir. Toplumda steroidlere karşı ciddi önyargılar olabilir. Bu durum, topikal steroidler için yapılan çalışmalarda gösterilmiştir. Bu çalışmanın amacı hekimlerde İAS fobisini araştırmaktır.

Yöntem: Topikal steroid fobisini değerlendirmek için geçerli bir puan olan TOPICOP puanı kullanılmaktadır. Bu çalışmada İAS kullanımına ilişkin hekimlerin algılarını değerlendirmek amacıyla kesitsel olarak TOPICOP skoru referans alınarak oluşturulmuş bir anket çevrimiçi olarak uygulanmıştır.

Bulgular: Anket verileri karşılaştırıldığında yaş, cinsiyet, coğrafi bölge ve kurum açısından anlamlı fark saptanmazken, cerrahi branşlarda inanç skorları daha düşük saptanmıştır. Meslekte geçirilen süre 6-10 yıl olan grupta, inanç skorları en yüksek saptanmıştır. Daha önce kendisine İAS uygulanan ve hastasına İAS uygulayan hekimlerde korku skorları daha düşük saptanmıştır. İAS ile ilgili komplikasyonları bizzat deneyimleyen hekimler, anlamlı derecede daha düşük korku puanları bildirirken, İAS sonrasında hastalarında komplikasyon gözlemleyen ve gözlemlemeyen hekimler arasında inanç, korku veya tutum puanlarında anlamlı bir fark gözlenmemiştir.

Sonuç: Çalışmamızda hekimlerin yaklaşık yarısı (%48,5) 'eklem içi steroidlerden korkuyorum' sorusuna katıldığını bildirmiştir. Hekimlerdeki steroid fobisinin, hastaları İAS tedavisi konusunda etkileyebileceği düşünülürse; hekimlerde eklem içi steroid fobisinin nedenlerinin araştırılması önemlidir.

Anahtar Kelimeler: Fobi, Kortikosteroid, Steroid, İntraartiküler

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Introduction

Intra-articular corticosteroid (IACS) injections are a frequently used treatment worldwide, primarily for hip and knee osteoarthritis (OA) and are recommended in more than two-thirds of OA treatment protocols [1]. The incidence of osteoarthritis is rising due to increasing life expectancy, with an estimated incidence of 14% (the highest incidence is 24% in obese women). Pain from osteoarthritis can reduce quality of life [2]. The aim of knee OA treatment is to prevent damage to cartilage and other structures, reduce pain, eliminate existing joint movement limitations and reduce secondary functional impairment [3]. The first-line treatment for OA is pain control with an oral analgesic and a physical therapy program. When these treatments are not sufficient, intra-articular corticosteroid injections with local anesthetics can be used to reduce pain [4]. The American College of Rheumatology recommends IACS injections, while the Osteoarthritis Research Association recommends IACS injections only in patients with moderate to severe pain, in cases where, oral analgesic therapy is insufficient [5]. There is a need for treatments for OA that are both safe and effective. At present, there are no approved disease-modifying drug therapies and nonsurgical treatments are associated with small to moderate benefits and are a concern because of some side effects [6].

Local steroid injections are frequently used to treat joint, soft tissue or spine pain, not just osteoarthritis, but the systemic side effects associated with these injections have not been adequately defined. It is known that glucocorticoids can pose significant risks when administered systemically. However, there are no guidelines addressing systemic absorption, general systemic side effects or other side effects of locally injected glucocorticoids. Current data indicates that there is significant individual variation in the extent of systemic absorption and clinical effects of locally injected steroids. It is accepted that both intra-articular and epidural injections can cause systemic effects for weeks and can lead to complications such as Cushing's syndrome, loss of bone density, hyperglycemia and infection. The type of steroid used, its dose, the number of injections and the use of oral steroids together are

important points in predicting these risks. When intra-articular steroid injection is preferred, it is imperative to be aware of the possible systemic side effects and to inform the patient in this regard [7]. Corticosteroid injections are reported to be effective in many cases of osteoarthritis, but there are concerns about tendon damage and cartilage toxicity. Over the past 20 years, biologic injections such as platelet-rich plasma (PRP) and mesenchymal stem cells (MSCs) have gained further attention [8].

Although it is a widely used treatment in society, there can be serious prejudices against steroids and this can make treatment compliance difficult. This has been shown in studies conducted for topical steroids [9].

The prevalence of topical steroid phobia ranges from 21% to 83.7%. Studies using the TOPICOP score, a validated score for assessing steroid phobia, have found a mean score of 40.3 to 44 (0 being the least fearful, 100 being the most fearful). Most importantly, high topical steroid concerns can lead to excessive dietary restriction, use of harmful alternatives, and inadequate treatment, which can lead to flare-ups [10].

To the best of our knowledge, there exists no study in the literature evaluating patient or physician phobia regarding intra-articular steroids. Our aim in this study was to determine physicians' anxiety levels regarding intra-articular steroid administration and to contribute to the literature on this subject.

Methods

Study Design

A cross-sectional survey study was conducted to evaluate physicians' perceptions regarding the use of intra-articular steroids. The survey was administered online, allowing participating physicians to complete it at their convenience. No specific sampling method was used; instead, the survey form was shared via Google Drive to reach all accessible physicians from various specialties, and all voluntary respondents were included in the study. Physicians who declined to participate were excluded from the study. At the beginning of the survey, electronic informed consent was obtained

from all participants. The study received approval from the hospital ethics committee on January 12, 2025 (Approval No: 03-09).

Data Collection Form

The data collection form consisted of three sections. The first section included six questions regarding physicians' age, gender, specialty, city of practice, characteristics of their institutions, and professional experience. The second section comprised five questions addressing physicians' personal experiences with intra-articular corticosteroids and their experiences with these treatments in relation to their patients. The third section contained thirteen items designed to evaluate steroid-related phobia concerning joint injections. This section covered three domains: beliefs (6 items), fear (3 items) and attitudes (4 items). It was adapted from the TOPICOP scale, which was originally developed to assess topical steroid phobia. A validity and reliability study of the TOPICOP scale in Turkish has not yet been conducted; therefore, this study was planned as a preliminary investigation to support a future adaptation study. Responses were measured using a four-point Likert scale (score range 0–3; where 0 = strongly disagree, 1 = disagree, 2 = somewhat agree and 3 = strongly agree). Unlike the original version, an additional response option, "I do not understand this statement," was included for each item to assess item comprehensibility. A pilot study was conducted with ten physicians prior to the main study to evaluate the clarity of the items.

Statistical Analysis

Descriptive statistics were presented as mean, standard deviation, minimum and maximum for continuous variables, as well as frequency and percentage for categorical variables. Since the normality assumption was not met upon examination of the data distribution, non-parametric tests were employed. The Kruskal–Wallis test was used to analyze score differences across more than two independent groups, while the Mann–Whitney U test was applied for pairwise group comparisons. For dichotomous categorical variables, such as gender, distributions were also summarized using the median and interquartile range (IQR). All analyses were performed using

IBM SPSS Statistics version 26.0 (IBM Corp., Armonk, NY, USA). Statistical significance was set at $p < 0.05$.

Results

The demographic characteristics of the study group and the descriptive features of their corticosteroid experiences are presented in Table 1. A total of 165 physicians participated in the study, with a mean age of 41.14 ± 8.75 years (minimum: 27, maximum: 67). The sample included a wide spectrum of medical professionals representing various specialties across Türkiye, indicating broad professional diversity. Among all participants, 64.2% were female and 35.8% were male. Most physicians were employed in public institutions (70.9%), while 28.5% worked in private facilities. In terms of professional experience, 38.8% had 11–15 years of experience, and 32.7% had 16 years or more, showing that the majority were mid- to late- career physicians. Regarding corticosteroid exposure, 59.4% reported having previously used corticosteroid therapy, and 20.6% indicated that they had personally received an intra-articular corticosteroid (IACS) injection. In addition, 46.1% of participants had administered IACS injections to their patients, reflecting a substantial proportion of physicians familiar with this procedure in their clinical practice. 12.7% had encountered a complication in their patients, while 7.9% reported personally experiencing a complication (Table 1).

The proportion of those who stated that they personally experienced a complication was 7.9%. Among the participants' specialties, the most frequently reported fields were Physical Medicine and Rehabilitation (28.0%), Family Medicine (10.3%), Internal Medicine (8.5%), and Orthopedics (6.7%). When classified into medical (non-surgical) and surgical specialties, the majority of participants worked in medical specialties ($n=146$). In terms of practice locations, Antalya (21.5%), Izmir (13.3%) and Ankara (7.8%) were the most commonly represented cities. The remaining participants practiced in 40 other cities across the country. When categorized by region, participation was observed from the Mediterranean ($n=63$), Aegean ($n=35$), Marmara ($n=18$), Central Anatolia ($n=15$), Black Sea ($n=14$), Southeastern

Anatolia (n=12) and Eastern Anatolia (n=6), listed in order of frequency.

The descriptive findings regarding the use of intra-articular steroids are presented in Table 2. Participants' beliefs, fears and attitudes toward intra-articular corticosteroid use were examined under specific thematic categories. To assess participants' understanding of the questions, the questionnaire included the option "I do not understand this statement" for each item. This option was selected by only a small number of participants, with the rates typically ranging between 1.2% and 3.0%. Notably, for item 7 ("Although I do not have detailed knowledge about the side effects of intra-articular corticosteroids, I am still afraid of receiving them."), 5 participants (3.0%) chose the "I do not understand this statement".

The median scores of beliefs, fears and attitudes regarding intra-articular corticosteroid (IACS) injections according to sociodemographic and professional characteristics are presented in Table 3. No statistically significant differences were found in belief ($p=0.124$), fear ($p=0.045$), or attitude ($p=0.950$) scores between the age groups created based on the median age. Although fear scores appeared lower among older physicians, the difference did not reach statistical significance, suggesting that age may have a minimal influence on corticosteroid-related anxiety.

In comparisons based on gender, no significant differences were observed in belief, fear, or attitude scores ($p>0.05$ for all), indicating that physicians' perceptions toward intra-articular corticosteroids were not affected by gender.

When examined by specialty, belief scores were significantly lower among participants working in surgical branches compared to those in internal medicine ($p=0.005$). This may reflect the fact that physicians in surgical fields are more familiar with invasive interventions, leading to a less favorable perception of intra-articular corticosteroids as a conservative treatment option. No significant differences were found in fear or attitude scores ($p=0.445$ and $p=0.714$, respectively). In addition, specialties that commonly perform intra-articular corticosteroid injections—such as physical medicine and rehabilitation, orthopedics,

rheumatology, algology, geriatrics, and sports medicine were grouped as the "IACI performed" group, while all other specialties were classified as the "IACI not performed" group. Physicians belonging to the "IACI performed" group exhibited significantly lower fear scores ($p<0.001$), suggesting that direct procedural experience may reduce injection-related anxiety.

Although variations were observed in belief, fear and attitude scores across geographical regions, none of these differences were statistically significant ($p=0.058$, 0.312 and 0.367 , respectively).

No significant differences were found in any of the scores according to the type of institution (public vs. private) ($p=0.874$, 0.272 and 0.610), indicating similar perceptions regardless of workplace setting.

In terms of years of professional experience, a significant difference was found in belief scores, with the highest median score observed in the group with 6–10 years of experience ($p=0.009$). This may reflect a greater confidence in clinical decision-making during mid-career stages. However, no significant differences were found in fear or attitude scores ($p>0.05$).

Having previously received corticosteroid treatment or undergoing an intra-articular injection personally did not significantly affect belief or attitude scores ($p>0.05$). However, participants who had received IACS injections reported significantly lower fear scores ($p=0.002$).

Participants who had previously administered intra-articular injections to patients had significantly lower fear scores compared to those who had not ($p=0.001$). No significant differences were found in belief or attitude scores between these groups ($p=0.256$ and $p=0.123$, respectively). This finding reinforces the association between procedural familiarity and reduced fear.

Physicians who had personally experienced complications related to IACS reported significantly lower fear scores ($p=0.007$), possibly due to increased procedural confidence or desensitization following firsthand management of complications. No significant differences were

Table 1. Descriptive Statistics

		Median ± IQR
Age	41.14±8.75 (27-67)	37 ± 10
		N (%)
Gender	Female	106 (64.2%)
	Male	59 (35.8%)
Institution Type	Public	117 (70.9%)
	Private	47 (28.5%)
Years of Professional Experience	1-5 years	13 (7.9%)
	6-10 years	34 (20.6%)
	11-15 years	64 (38.8%)
	16 years and above	54 (32.7%)
Previous Use of Corticosteroid Treatment	Yes	98 (59.4%)
	No	67 (40.6%)
History of Receiving Intra Articular Steroid Injection Personally	Yes	34 (20.6%)
	No	131 (79.4%)
History of Administering Intra- Articular Steroid Injection to Patients	Yes	76 (46.1%)
	No	89 (53.9%)
Experience of Observing Complications in Patients	Yes	21 (12.7%)
	No	144 (87.3%)
Experience of Having Complications Personally	Yes	13 (7.9%)
	No	152 (92.1%)

Table 2. Descriptive Statistics of Items Related to Intra-Articular Corticosteroids Use (IASU)

		Strongly Disagree	Disagree	Somewhat Agree	Strongly Agree	Not understood
		N (%)	N (%)	N (%)	N (%)	N (%)
Belief Items	Intra-articular corticosteroids can be absorbed into the bloodstream.	9	40	77	37	2
		(5,5%)	(24,2%)	(46,7%)	(22,4%)	(1,2%)
	Intra-articular corticosteroids can cause infection.	5	40	72	46	2
		(3,0%)	(24,2%)	(43,6%)	(27,9%)	(1,2%)
	Intra-articular corticosteroids may lead to weight gain.	39	90	29	6	1
		(23,6%)	(54,5%)	(17,6%)	(3,6%)	(0,6%)
	Intra-articular corticosteroids can lead to skin damage.	13	59	73	19	1
		(7,9%)	(35,8%)	(44,2%)	(11,5%)	(0,6%)
Fear Items	Intra-articular corticosteroids will have a negative impact on my future health	27	81	44	12	1
		(16,4%)	(49,1%)	(26,7%)	(7,3%)	(0,6%)
	I believe that intra-articular corticosteroid injections can lead to addiction.	62	92	7	4	0
		(37,6%)	(55,8%)	(4,2%)	(2,4%)	(0,0%)
	I am afraid of receiving intra-articular corticosteroid injections.	24	61	53	27	0
		(14,5%)	(37,0%)	(32,1%)	(16,4%)	(0,0%)
	Although I do not have detailed knowledge about the side effects of intra-articular corticosteroids, I am still afraid of receiving them.	35	65	39	21	5
		(21,2%)	(39,4%)	(23,6%)	(12,7%)	(3,0%)
	I am afraid of receiving repeated intra-articular corticosteroid injections.	9	20	58	78	0
		(5,5%)	(12,1%)	(35,2%)	(47,3%)	(0,0%)

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Table 2. Descriptive Statistics of Items Related to Intra-Articular Corticosteroids Use (IASU). (Continue...)

		Strongly Disagree	Disagree	Somewhat Agree	Strongly Agree	Not understood
		N (%)	N (%)	N (%)	N (%)	N (%)
Attitude Items	I wait as long as possible before receiving intra-articular corticosteroid injections.	10 (6,1%)	53 (32,1%)	58 (35,2%)	42 (25,5%)	2 (1,2%)
	I prefer non-steroid intra-articular injections, even if they are more expensive.	18 (10,9%)	63 (38,2%)	41 (24,8%)	41 (24,8%)	2 (1,2%)
	I need reassurance regarding intra-articular corticosteroids	14 (8,5%)	48 (29,1%)	52 (31,5%)	51 (30,9%)	0 (0,0%)
	I prefer non-steroid treatments even if they are more painful.	22 (13,3%)	83 (50,3%)	34 (20,6%)	26 (15,8%)	0 (0,0%)

Table 3. Comparison of Median Belief, Fear and Attitude Scores by Participant Characteristics

		Belief score		Fear score		Attitude score	
		Median ± IQR	p	Median ± IQR	p	Median ± IQR	p
Age group	≤37 (n=82)	9±4	0.124	6±4	0.045	6±4	0.950
	≥38 (n=80)	8±4		4±3		6.5±3.7	
Gender	Male (n=57)	8±5	0.999	4±3	0.103	6±4	0.228
	Female (n=106)	8±3		5±4		6.5±4	
Specialty	Internal (n=146)	9±3	0.005	5±4	0.445	6±3	0.714
	Surgical (n=17)	6±2		4±3		6±3	
Clinical practice	IACI performed (n=79)	8±3	0.853	4±3	<0.001	6±5	0.427
	IACI not performed (n=86)	8±4		6±4		6±3.25	
Region	Mediterranean (n=63)	8±4	0.058	4.5±4	0.312	6±3	0.367
	Aegean (n=35)	8±4		4±4		6±4	
	Eastern A. (n=6)	8±6		2.5±2.5		4±3.5	
	Southern A. (n=12)	8±3		5±3		7±4	
	Central A. (n=15)	9±3		5±4		6±4	
	Blacksea (n=14)	10.5±5		6±5.25		7.5±5.5	
	Marmara (n=18)	7±4		5±3		8±4	

detected in belief or attitude scores ($p=0.351$ and $p=0.058$).

Finally, no statistically significant differences were observed in belief, fear, or attitude scores between physicians who had and had not observed complications in their patients following IACS ($p=0.214$, 0.963 , and 0.197 , respectively). This suggests that vicarious exposure to complications does not substantially alter physicians' perceptions toward intra-articular corticosteroid injections.

Discussion

Steroid phobia is common and can reduce patient compliance, limiting treatment effectiveness. There has been significant variability in the reporting and measurement of topical steroid phobia. Therefore,

the TOPICOP scale was developed to ensure standardization across different groups. While the TOPICOP scale was designed to assess steroid phobia in patients with atopic dermatitis, it has been used in other studies to assess steroid phobia in a larger and more diverse population. In this study, we aimed to assess intra-articular steroid phobia in physicians using a questionnaire developed using the TOPICOP score as a reference. To our knowledge, this is the first study to assess intra-articular steroid phobia in physicians [12].

The worldwide prevalence of topical steroid phobia ranges from 31 to 95.7% and does not differ with patient race/ethnicity or dermatological condition [13].

Studies on topical steroid phobia have shown

that parents of girls have higher levels of steroid phobia. A study of adults and children with various skin conditions found that female participants were more likely to experience steroid phobia [12]. However, our study found no significant difference in gender comparisons.

It is known that the prevalence of phobias peaks in middle age and older age [14]. However, according to our study, in the questionnaire assessing IACS phobia, scores regarding belief levels were found to be lower in the older physician group. When asked about years of professional experience, the highest scores were found between 6 and 10 years. This can be explained by the increase in professional experience over time and having more knowledge about possible complications. Supporting this information, fear scores were found to be lower in both physicians who applied IACS to themselves and to their patients. Furthermore, physicians who had personally experienced IACS-related complications reported significantly lower fear scores; interestingly, no statistically significant difference in IACS phobia scores was observed between physicians who reported complications after IACS in their patients and those who did not.

In one study, when asked whether they had any concerns about using steroid creams for treating their children, 20.5% of patient relatives and 54% of healthcare workers responded 'yes'. This suggests that individuals become more concerned about medication side effects as their level of education increases [9]. Since our study was conducted in a group with a high level of education, the level of IACS phobia may have been found to be relatively high.

A study conducted in the Netherlands examined corticophobia among professionals caring for children with atopic dermatitis (nurses, general practitioners, public health physicians, pediatricians) and found that public health nurses had the highest levels of corticophobia, while pediatricians and public health physicians had the lowest [15]. Using our adapted questionnaire, we assessed IACS corticophobia among different physicians and demonstrated statistically significant differences in belief scores between internal medicine and surgical specialties.

A study examining family physicians' knowledge of topical steroids showed that family physicians unintentionally frightened patients when prescribing topical steroids [16]. According to one study, the majority of information about steroids comes from doctors, followed by the internet and media. However, trust in doctors was reported to be the highest compared to other sources. While we cannot prevent the misrepresentation of steroids online, interventions to direct patients to online sources with accurate medical information may be beneficial [12]. Based on this data, it can be alleged that steroid phobia among physicians may also affect patients regarding intra-articular steroid treatment. According to the data from our study, nearly half of the physicians reported that they were afraid of intra-articular steroids (48.5%). Therefore, it is vital to investigate the causes of intra-articular steroid phobia in physicians.

A previous study reported that corticosteroid phobia is common among healthcare professionals, with significant differences in fear levels observed between different professional groups, such as pharmacists and physicians. Our study focused solely on physicians, so we were unable to perform inter-professional comparisons. However, the variations in fear levels related to differences in professional experience in our findings suggest a similar underlying mechanism [17]. Another study conducted among pharmacists indicated that factors like geographical location and work setting (rural vs. urban, public vs. private) could influence fear levels. In contrast, our study found no significant differences based on geographical region or type of institution. This discrepancy may be due to the more homogeneous nature of our sample [18]. Furthermore, one study showed that educational interventions conducted by clinical pharmacists can help reduce corticophobia, which aligns with our finding that "experience and prior practice" can lower fear levels. This implies that targeted training programs for physicians may effectively reduce their fear of IACS [19]. Additionally, a qualitative study exploring clinicians' perspectives on the use of IACS found a positive correlation between the frequency of administration and confidence levels. Consistent with this result, our study revealed that physicians who had actively administered IACS and managed complications reported lower fear scores, supporting the idea that

clinical experience enhances confidence. Another qualitative study identified “training,” “previous experience,” and “patient expectations” as key factors influencing physicians’ decision-making regarding IACS administration. Our results are consistent in line with these qualitative findings, particularly regarding the role of experience and prior practice in reducing fear [20].

While steroid phobia is perceived as a negative concept, the uninformed use of powerful steroids can lead to various side effects. Patient education should not only emphasize the safety of steroids but also aim to minimize the overuse of powerful steroids [12].

In the current study, we demonstrated that length of time in the profession and previous intra-articular steroid administration may influence IACS phobia in physicians. Those with 6 to 10 years of professional experience had the highest belief scores. ($p=0.009$) Fear scores were lower in participants who had previously used IACS and who had used it on their patients. ($p=0.002$, $p=0.001$)

To the best of our knowledge, there are currently no studies in the Turkish or international literature which specifically examine intra-articular corticosteroid phobia among physicians. Present study was thus designed as a preliminary investigation and a foundational step toward developing and validating a corticosteroid phobia scale for healthcare professionals in future research. Our findings aim to provide valuable insights into corticosteroid-related fears among physicians and may serve as a basis for further exploration and intervention in this under-researched area.

Limitations

Limitations of the study comprise the lack of formal sample size calculations and the fact that participant selection was based on physicians’ willingness to complete the survey. Additionally, the absence of a Turkish validity and reliability study for the questionnaire represents a methodological limitation. However, this preliminary investigation aims to provide a foundation for future adaptation and validation studies of the TOPICOP scale in Turkish.

Conclusion

In summary, we emphasize the need to assess the presence of corticophobia in physicians, determine its impact on patients and treatment adherence, as well as assess IACS phobia and its risk factors in order to implement additional educational programs, particularly for physicians at high risk of IACS phobia. Providing physicians with more detailed information about IACSS may overcome unnecessary fears, ultimately increasing treatment adherence and satisfaction and improving patient outcomes.

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