Actinic (Solar) Keratosis

PRIMARY CARE TREATMENT PATHWAY

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**Description**
An actinic keratosis is a common, sun induced, scaly or hyper-keratotic lesion which has a very small potential to become malignant. There is a high spontaneous regression rate and low rate of transformation – less than 1 in 1000 per annum, but with an average of 7.7 AKs the risk of one transforming in 10 years is 10%.

**Identify High Risk Patient**
Immunosuppressed patients, those with a past history of skin cancer and those with extensive evidence of sun damage; patients with previous history of phototherapy; very young patients or patients with xeroderma pigmentosum consider referral to secondary care or accredited GPsW Si. If not high risk then consider treatment as below.

**Grade I**
- Single or few lesions, better felt than seen

**Grade II**
- Moderately thick lesions (hyperkeratotic), easily felt and seen

**Grade III**
- Thick hyperkeratotic lesions

**Field Change**
- Lesions grouped in same area, with marked background damage

**Red Flag**
- Lesions that:
  - Are rapidly growing
  - Have a firm and fleshy base and/or are painful
  - Refer urgently as Priority Cancer
  - Referral to secondary care

**Generic Name**
- 5% Fluorouracil (5-FU)
- Imiquimod
- Diclofenac 3%
- 0.5% 5-FU+10% Salicylic acid
- Liquid Nitrogen
- Photodynamic Therapy
- Curettage

**Brand**
- Efudix
- Aldara
- Solaraze
- Actikarall
- Metvix
- Actikerall
- Not recommended in primary care

**Legend:**
- ✓ strong and ✓ relative recommendation
- X Not recommended in primary care

**General Measures**
Applicable to all patients and may be all that is needed for management:
1. AKs are a marker of sun damage: examine other areas of the skin
2. Encourage prevention: sunscreen and protection
3. Advise patients to report change
4. Consider use of emollients for symptom control

**PLEASE NOTE:**
1. All topical treatments cause inflammation which indicates their desired action against abnormal cells. If severe then the treatments should be stopped until the reaction subsides and then restarted, perhaps at a reduced frequency. Patients should be warned to expect this effect of the treatment rather than regarding it as an unwanted side effect.
2. Complete clearance of lesions can be delayed several weeks beyond completion of topical therapies.
3. None of the topical treatments apart from actikerall, have a license for non-facial sun exposed areas e.g backs of hands, but there is no clinical reason why they should not be used on these sites.

**Reference:**

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**Clinical Grading (according to Olsen 1991)**

**Grade I**
Flat, pink maculae without signs of hyperkeratosis and erythema often easier felt than seen. Flat erythematosus macules with or without scale and possible pigmentation

**Grade II**
Moderately thick hyperkeratosis on background of erythema that are easily felt and seen

**Grade III**
Very thick hyperkeratosis, or obvious AK, differential diagnosis cutaneous horn

**Field Damage**
Large areas of multiple AKs on a background of erythema and sun damage

Reference: