HERPC
Hull and East Riding Prescribing Committee

TREATMENT PATHWAY FOR ACTINIC (SOLAR) KERATOSIS

Description

Actinic keratosis is a common, sun induced, scaly 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%*
(* De Berker D et al. British Journal of Dermatology 2007;156: 222-230)

Identify High Risk Patients

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 GPwSI.
If not high risk then consider treatment as below

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

Description	1st line	2nd line	Further options (on referral)
Grade 1 - Single or few lesions, better felt than seen	Diclofenac 3% *(Solaraze)*	Ingenol mebutate *(Picato)*	Imiquimod 5-fluouracil
Grade 2 - Moderately thick lesions (hyperkeratotic), easily felt and seen	5-Fluouracil *(Efudix)*	Imiquimod *(Aldara)*	Liquid Nitrogen
Grade 3 - Thick hyperkeratotic lesions	Liquid Nitrogen		Surgical procedure
Field Change - Lesions grouped in same area, with marked background damage	Dilofenac 3% *(Solaraze)* OR 5-Fluouracil *(Efudix)*	Ingenol mebutate *(Picato)*	Imiquimod

- **Refer high risk, red flag patients or where 1st line, 2nd line treatments have failed or are not tolerated**

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. Not all of the topical treatments, 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.

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: sun screen and protection (not available on FP10)
3. Advise patients to report change
4. Consider use of emollients for symptom control

TREATMENT INFORMATION FOR TOPICAL PREPARATIONS

Drug name	Licensed indication	Dose directions	Duration of treatment
Ingenol mebutate 150 micrograms/g gel (3 x 0.47g single use tubes)	Cutaneous treatment of non-hyperkeratotic, non-hypertrophic actinic keratosis in adults **on face & scalp**	apply once daily *The content of one tube covers a treatment area of 25 cm^2 (e.g. 5 cm x 5 cm).*	3 days
Ingenol mebutate 500 micrograms/g gel (2 x 0.47g single use tubes)	Cutaneous treatment of non-hyperkeratotic, non-hypertrophic actinic keratosis in adults **on trunk and extremities**	apply once daily	2 days
Diclofenac 3% gel (50g, 100g)	Actinic keratosis in adults	apply thinly twice daily (Max 8g daily) *Normally 0.5 grams (the size of a pea) of the gel is used on a 5 cm x 5 cm lesion site.*	60 – 90 days
Fluouracil 5% cream (40g)	Topical treatment of superficial pre-malignant and malignant skin lesions; keratoses including actinic forms	Apply once or twice daily *(max area of skin treated 500 cm^2, 23 x 23cm)*	3-4 weeks
Imiquimod 5% cream (12 x 250mg sachet pack)	Includes clinically typical, nonhyperkeratotic, nonhypertrophic actinic keratoses (AKs) on the face or scalp	Apply three times a week at night *(max dose is one sachet)*	4 weeks. Assess after 4 week treatment-free interval. Course can be repeated once only.

For full details on licensed indication, dosage, administration, contraindications, cautions, drug interactions and adverse effects always check with BNF www.bnf.org.uk or SPC (www.medicines.org.uk).