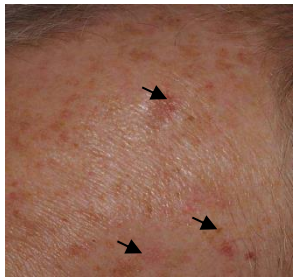
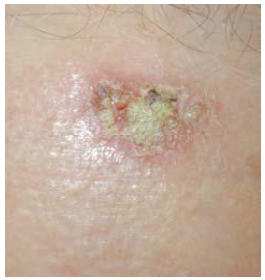
Nottinghamshire Actinic (Solar) Keratosis Primary Care Treatment Pathway

(Adapted from the Primary Care Dermatology Society Treatment Pathway)

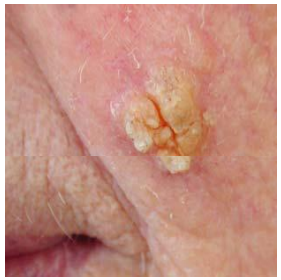
NHS Nottinghamshire Area Prescribing Committee



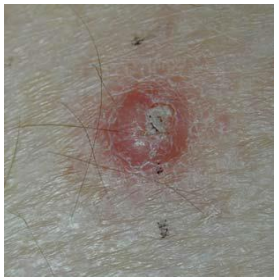
Early solar keratosis needs no treatment



Single solar keratosis consider cryotherapy



Crusted, indurated and inflamed lesion could turn out to be early squamous cell carcinoma (SCC) - urgent 2-week referral



Lesion(s) Impalpable or barely palpable

Sun avoidance advice including sunscreen e.g. here. Skin cancer info sheets e.g. here

Lesion(s) palpable but not indurated

Does the patient want treatment?

No

Yes

Multiple lesions

Hyperkeratotic lesion(s)

Single lesion

Lesion with rapid onset, indurated inflamed base, critical sites, immunosuppressed patient or >1cm

Urgent 2-week referral

Offer topical treatment-

1st line - 5-Fluorouracil 5% cream (Efudix®)

(Amber 3 – GP can initiate in line with this guideline)

Apply once or twice daily for 3 to 4 weeks, depending on site. Counsel regarding skin reaction (give Eumovate® if symptomatic).

Patient Information sheet (with photographs of reactions) available here

2nd line - Ingenol mebutate gel (Picato® ▼)

(Amber 3 – GP can initiate in line with this guideline)

For patients unable to tolerate/comply with Efudix

- on face and scalp lesions, apply 150 micrograms/g gel once daily for 3 days
- on trunk and extremities, apply 500 micrograms/g gel once daily for 2 days

Patient Information Sheet (with photographs of reactions) available here

3rd line – imiquimod 3.75% cream (Zyclara ®)

(Amber 3 – GP can initiate in line with this guideline)

To be used if Efudix® and Picato® are not tolerated or used earlier if the lesions cover a large area or if there is field change (refer to specialist if needed).

Apply up to 2 sachets (250mg per sachet) once daily before bedtime to the affected treatment field (full face or balding scalp) for two treatment cycles of 2 weeks each separated by a 2-week no-treatment cycle.

Patient Information Sheet available here

Review 4-weeks after stopping treatment. If no response, review diagnosis +/- referral

If not available

Cryotherapy with liquid nitrogen

1x15sec freeze thaw cycle.

Histofreezer® NOT recommended as no evidence.

OR

Actikerall®

(Amber 3 – GP can initiate in line with this guideline)

0.5% 5-Fluorouracil. 10% Salicylic acid for hyperkeratotic lesions. Use once daily for 6-12 weeks. Counsel regarding mild to moderate skin reaction.

Patient information leaflet (with photographs of reactions) available here

Review 4-weeks after stopping treatment. If no response, review diagnosis and consider Cryotherapy +/- referral

Actinic/Solar Keratosis Epidemiology

Chronic or repeated sun exposure is a major association >80% appear on the face, head or back of the hands, especially, but not exclusively, in those with fair skin. Caucasians previously living in hot climates or working outside are at highest risk. Prevention is better than cure (see national skin cancer prevention & sunscreen advice)

Prevalence in UK (Merseyside) age>40

	all	Age>70
males	15.4%	34.1%
females	5.9%	18.1%

Diagnosis

Red or white lesions with a gritty or sandpaper like texture on palpation but no induration at the base of the lesion, meaning there is epidermal thickening or dermal infiltration, both manifested as a thick red base.

Skin cancer risk

Actinic keratoses (AK) are a risk factor for skin cancer as they are very closely linked to sun exposure. Therefore patients with actinic keratoses should be educated in the signs of common skin cancers and asked to present if any new/ different lesions develop.

Less than 1 in 1000 actinic keratoses will transform into squamous cell carcinoma (SCC) in any one year therefore, treatment is dependent on patient preference, symptoms and the need to clear the sun damaged area in order to be able to see if any more sinister lesions such as basal cell carcinoma (BCC) or SCC are developing.

Progression of very early AK lesions and AK recurrence are reduced by daily use of an appropriate sunscreen (SPF factor 15+ or higher, available on prescription, annotate “ACBS”) if clinically indicated i.e. recurrent or multiple AK lesions.

The treatment guideline can be followed again if new lesions develop.

Solaraze® gel (diclofenac)

Solaraze gel is not included in the pathway due to cryotherapy, Efudix ® and Actikerall ® being more effective to the vast majority of clinical circumstances and having lower relapse rates.

Bibliography

- Actinic Keratosis Primary Care Treatment Pathway published by Primary Care Dermatology Society (available from http://www.pcds.org.uk or NHS Evidence - National Library of Guidelines)
- Guidelines for the management of actinic keratoses. D. de Berker, J.M. McGregor and B.R. Hughes - on behalf of the British Association of Dermatologists Therapy Guidelines and Audit Subcommittee British Journal of Dermatology 2007 156, pp222–230 (Available from www.bad.org.uk)
- NICE Guidance on Cancer Services. Improving outcomes for People with Skin Tumours including Melanoma. February 2006. (available from www.nice.org.uk)
- Stockfleth E et al. Low-dose 5-fluorouracil in combination with salicylic acid as a new lesion directed option to treat topically actinic keratoses-histological and clinical study results. Br J Dermatol. 2011 Nov;165(5):1101-8.
- Other references: BNF & product SPCs

Authors

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