



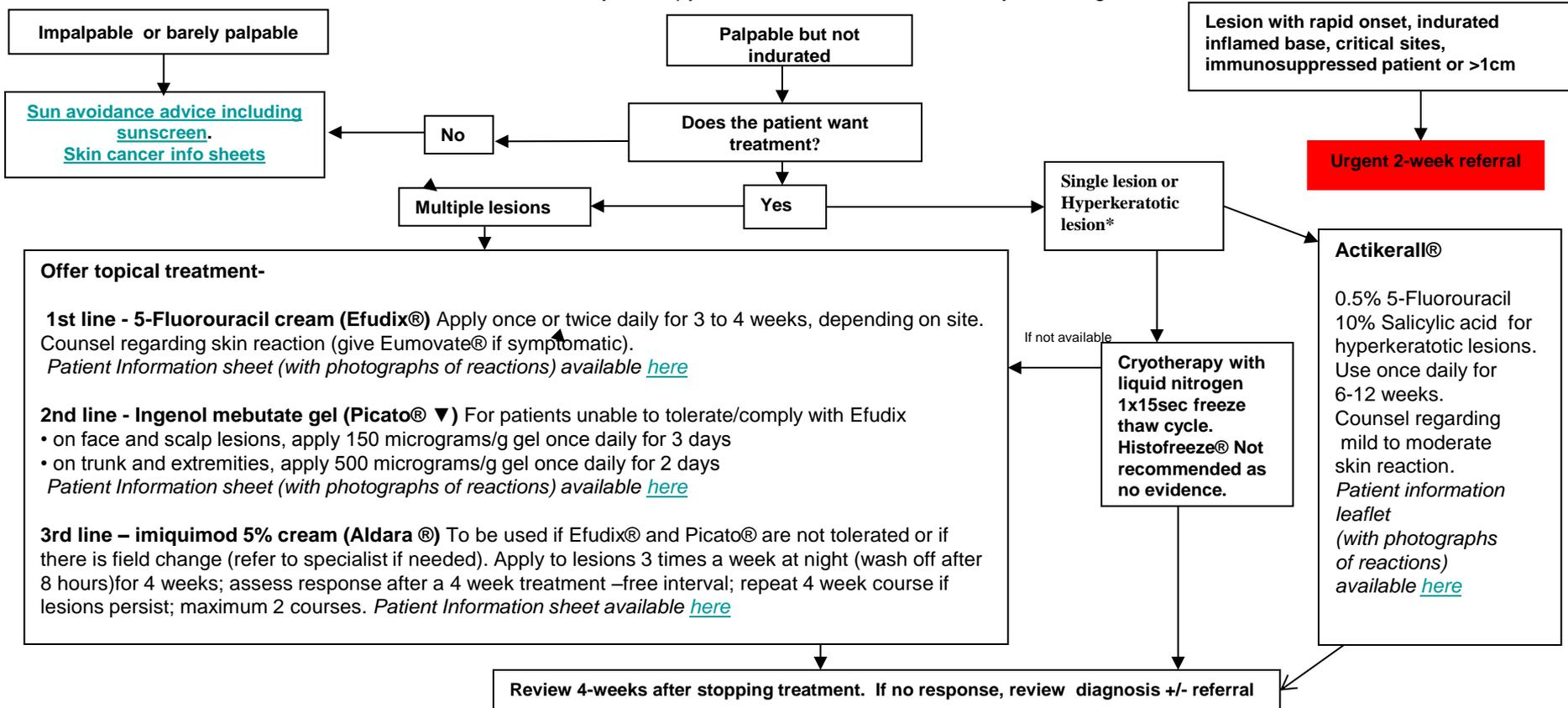
Early solar keratosis needs no treatment



Single solar keratosis consider cryotherapy



Crusted, indurated and inflamed lesion could turn out to be early SCC-urgent 2-week 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%

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.

Efudix® (5-Fluorouracil)

once or twice daily for 3 to 4 weeks, depending on site. Counsel regarding skin reaction (give Eumovate® if symptomatic). Give patient Information sheet (with photographs of reaction [Efudix PIL](#))

Actikerall® (0.5% 5-Fluorouracil. 10% Salicylic acid): Due to the unavailability of cryotherapy in primary care as well as the inefficacy of Efudix® on hyperkeratotic actinic keratoses, Aktikerall® provides an alternative treatment option with better results when used on thicker lesions in primary care and will save on secondary care referrals. Use once daily for 6-12 weeks. Counsel regarding mild to moderate skin reaction.

[Actikerall PIL](#)

Picato® (Ingenol mebutate): Is a 2-3 day topical treatment for AK with background field change for an area of 25cm² 0.015% gel should be used on scalp and face lesions in a 25cm² area for 3 consecutive days. 0.05% gel should be used for 2 consecutive days on the body. Counsel on moderate skin reaction.

[Picato 150mcg/g face & scalp Picato 500mcg/g body PIL](#)

Aldara® (5% Imiquimod): For the topical treatment of face and scalp AK with field change up to an area of 100cm². Treatment regime is a single application three times a week at night for 4 weeks followed by a 4 week rest period and then a further four weeks active treatment if lesions persist with a maximum of 2 course.

[Aldara PIL](#)

Bibliography

Actinic Keratosis Primary Care Treatment Pathway published by Primary Care Dermatology Society [PCDS AK guidelines](#) (available from <http://www.pcds.org.uk> or NHS Evidence - National Library of Guidelines)

[Guidelines for the management of actinic keratoses.](#) British Journal of Dermatology 2007 156, pp222–230 (Available from www.bad.org)

[NICE Guidance on Cancer Services. Improving outcomes for People with Skin Tumours including Melanoma. February 2006.](#)

[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.](#)

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