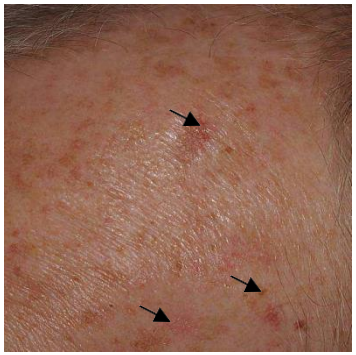
Oxford University Hospitals NHS Foundation Trust

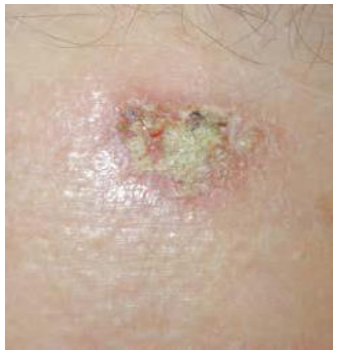
Oxfordshire Solar Keratosis Primary Care Treatment Pathway

(Adapted from the Primary Care Dermatology Society Treatment Pathway)

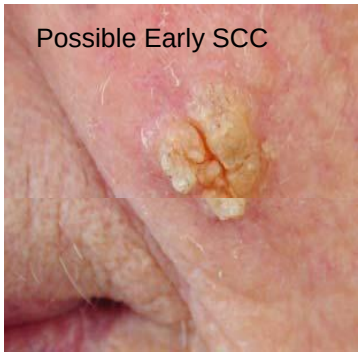
Oxfordshire Clinical Commissioning Group

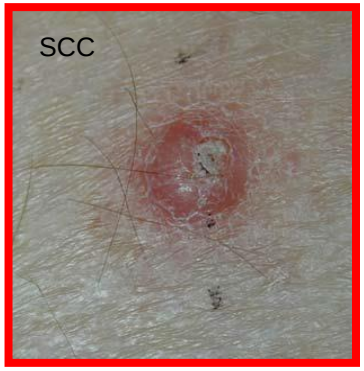


Early solar keratosis needs no treatment



Single solar keratosis consider cryotherapy





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

Impalpable or barely palpable

Sun avoidance advice including sunscreen.
Skin cancer info sheets

Palpable but not indurated

Does the patient want treatment?

No

Yes

Multiple or Single?

Multiple lesions

Is lesion hyperkeratotic?

No

Is cryotherapy available?

No

Yes

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

Urgent 2-week referral

Offer topical treatment-

1st line - 5-Fluorouracil cream (Efudix®) 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 – imiquimod 5% cream (Aldara ®) To be used if Efudix® are not tolerated or if there is field change (refer to specialist if needed). Apply to lesions 3 times a week at night (wash off after 8 hours) for 4 weeks; assess response after a 4 week treatment –free interval; repeat 4 week course if lesions persist; maximum 2 courses. *Patient Information sheet available here*

Single Lesion

Cryotherapy with liquid nitrogen 1x15sec freeze thaw cycle. Histofreeze® Not recommended as no evidence.

Hyperkeratotic Lesion

Actikerall®
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 (DermnetNZ, with photographs of reactions) available here

Review 4-weeks after stopping treatment. If no response, review diagnosis +/- 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 p rimary 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*): has been removed from the advice due to concerns that SCCs may be induced by ingenol mebutate

Aldara® (*5% Imiquimod*): For the topical treatment of face and scalp AK with field change up to an area of 100cm^2 . 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.