NHS
Harrogate and Rural District
Clinical Commissioning Group

General Commissioning Statement

Condition or Treatment	**Primary care management of Actinic Keratosis (AK)**
Background	Phase I of the CCG's RSS project indicated that patients with Actinic Keratosis were often referred to secondary care without management options in primary care being exhausted.
Referral guidance	**Referral guidance only**

Commissioning statement	**When to refer?**
	• Diagnostic uncertainty (consider referral to an in-house colleague with a specialist interest in dermatology)
	• 2 week referral:
	  ○ Lesion suspicious of an SCC
	  ○ Hyperkeratotic AK and unable to visualise the base
	  ○ Inspected base and concerned (remove crust with an emollient)
	  ○ AK on the lip more likely to be SCC
	• Refer routinely patients with AK at higher risk of developing SCC e.g. immunocompromised/ post-transplant patients or younger patients with AK
	
	Red Flags suggestive of an SCC:
	Recent growth, discomfort, ulceration or bleeding
	
	General Advice to all patients with AK
	• **In the UK apply SPF30 daily as UV protection and wear a hat in the sun (protects against further development of AKs and skin cancer).**
	• **Apply daily emollients (some mild AKs will resolve with daily emollient alone)**
	• **Not all patients require treatment e.g. for those with a small number of thin lesions who have a short life-expectancy. However, should continue to use emollient.**
	• **All patients who are being monitored should be educated on red flags suggesting transformation to an SCC.**

Notes

1.This Statement will be reviewed in the light of new evidence, or guidance from NICE

Lesion specific treatment

- Risk of malignant transformation of an AK is less than 1 in 1000 per annum.[1]
- First line: Efudix (5FU) to be applied every night for 4 weeks.
  Warn re side effects: provide patients with a leaflet and show photos of what to expect.
  Recommended patient information links:

  Picato Patient Information Leaflet shows excellent photos of an inflamed face.

  Alan's Efudix Blog for patients who prefer online blog's to leaflets.

- Alternative to consider if compliance is an issue: cryotherapy (single freeze-thaw cycle of 10s). Warn patients re potential for scarring and hypopigmentation.
- For non-sinister hyperkeratotic AK: Actikerall (5FU + salicyclic acid) to be applied once a day for 6-12 weeks
- Isolated lesions failing to respond to the above treatment: curettage with histology being sent (to be done in general practice provided GP with minor surgery skills available).

Field change (defined as areas of skin with multiple AKs and associated background of erythema or telangiectasia)

- Higher risk of transformation to SCC so *should* be treated.
- Any treatment used should be applied to the whole area of field change rather than to individual lesions.

- **Smaller areas (up to 25cm^2)**
  - First line: Efudix (5FU) applied once daily for 4 weeks, then consider 1% hydrocortisone BD for 2-4 weeks to settle skin reaction. Follow up at 3 months. Provide leaflet and warn re side effects. Course of Efudix can be repeated 2 years after first application.
  - Second line: Aldara (5% imiquimod –comes in 12 sachets) applied 3 nights a week for 4 weeks followed up with 1% hydrocortisone BD for 2-4 weeks. Review at 3 months and can repeat course if needed.
  - If compliance a concern: Picato (prescribe site specific preparation – applied OD for 2 or 3 days depending on site). Side effect profile similar to Efudix and can be painful.

- **Larger areas (>25cm^2)**
  - First line: Efudix applied as above or
  - Second line: Solaraze (diclofenac) applied BD for 12 weeks. Evidence suggests solaraze less effective than effudix. Review following

	treatment. ○ If lesions remain following treatment consider lesion specific treatment as outlined above. • Refer patients if not responding to treatment for consideration of photodynamic therapy.
Effective from	2/11/15
Summary of evidence / rationale	Above guideline based on 1 Marks et al. Malignant transformation of solar keratosis to squamous cell carcinomas. Lancet 1988; i: 795-797. 2 Berker et al. Guidelines for the management of AK. British Journal of Dermatology 2007: 156; 222-230. 3 Bower et al. Actinic (solar) Keratosis –Primary Care Treatment Pathway. PCDS. April 2014
Date	October 15
Review Date	October 16
Contact for this policy	Dr Bruce Willoughby GP/Governing Member Brucewilloughby@nhs.net