# General Commissioning Statement

<table>
<thead>
<tr>
<th><strong>Condition or Treatment</strong></th>
<th><strong>Primary care management of Actinic Keratosis (AK)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Referral guidance</strong></td>
<td>Referral guidance only</td>
</tr>
<tr>
<td><strong>Commissioning statement</strong></td>
<td>When to refer?</td>
</tr>
<tr>
<td></td>
<td>• Diagnostic uncertainty (consider referral to an in-house colleague with a specialist interest in dermatology)</td>
</tr>
<tr>
<td></td>
<td>• 2 week referral:</td>
</tr>
<tr>
<td></td>
<td>o Lesion suspicious of an SCC</td>
</tr>
<tr>
<td></td>
<td>o Hyperkeratotic AK and unable to visualise the base</td>
</tr>
<tr>
<td></td>
<td>o Inspected base and concerned (remove crust with an emollient)</td>
</tr>
<tr>
<td></td>
<td>o AK on the lip more likely to be SCC</td>
</tr>
<tr>
<td></td>
<td>• Refer routinely patients with AK at higher risk of developing SCC e.g. immunocompromised/ post-transplant patients or younger patients with AK</td>
</tr>
</tbody>
</table>

## 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.

---

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 25cm²)**

- 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 (>25cm²)**

- 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
If lesions remain following treatment consider lesion specific treatment as outlined above.

- Refer patients if not responding to treatment for consideration of photodynamic therapy.

<table>
<thead>
<tr>
<th>Effective from</th>
<th>2/11/15</th>
</tr>
</thead>
</table>
| Summary of evidence / rationale | Above guideline based on  
| Date | October 15 |
| Review Date | October 16 |
| Contact for this policy | Dr Bruce Willoughby  
GP/Governing Member  
Brucewilloughby@nhs.net |