AK
Actinic Keratosis

Actinic (Solar) Keratosis – Primary Care Treatment Pathway

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What is an AK

An actinic keratosis is a common, UV induced, scaly or hyperkeratotic lesion which has a very small potential to become malignant. There is a high spontaneous regression rate and low rate of transformation to squamous cell cancer– **less than 1 in 1000 per annum, but with an average of 7 AKs the risk of one transforming in 10 years is 10%***

Important Information about Treatments

- Expect local skin reactions (e.g. crusting, inflammation, discomfort) with several of these treatments. These can be significant, especially if large areas are being treated. Patients should be advised to expect skin reactions as a positive response rather than unwanted, but if severe, have a break from treatment or stop
- Re-consider the diagnosis if no inflammatory reaction is produced when using any topical except Solaraze
- For large areas, treat sequentially by dividing areas into sections and addressing one section at a time. This minimizes unwanted effects but extends the overall treatment duration
- Clearance of lesions can be delayed several weeks beyond end of treatment. Be mindful that not all lesions may clear, and multiple/ frequent treatments may be required. The aim is controlling, not curing, disease. Recurrence is common
- Please refer to product SPCs for further information especially regarding pregnancy, lactation, or fertility advice. Efudix® ingestion is toxic to dogs!
- Local formularies and regional guidance may exist for individual products

Identify High Risk Patient

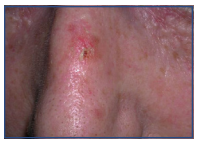
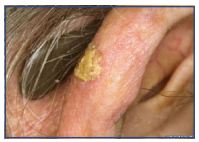
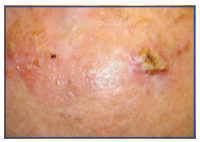
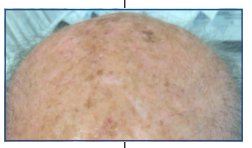
Those with extensive UV damage, immunosuppressed patients or the young (<age 40): consider referral to secondary care or accredited GPwER

Red Flag

Lesions that:

- Are rapidly growing
- Have a firm and fleshy base and/or are painful
- Have thick scale (grade III AK)

Refer on 2WW suspected skin cancer pathway

			Grade I	Grade II	Grade III	Field Change	
	Generic Name	Brand Name	Single or few lesions, better felt than seen 	Moderately thick lesions, easily felt & seen 	Thick hyperkeratotic lesions 	Small – up to 25cm²	Large 
Topical	3% Diclofenac with HA	Solaraze	✓✓	✓	✗	✓✓	✓✓
Topical	5% Fluorouracil (5-FU)	Efudix	✓✓	✓✓	✗	✓✓	Use sequentially
Topical	4% Fluorouracil (5-FU)	Tolak	✓✓	✓✓	✗	✓✓	
Topical	Tirbanibulin 10mg/g	Klisyri	✓✓	✓	✗	✓✓	
Topical	5% Imiquimod	Aldara	✓✓	✓✓	✗	✓	✗
Topical	0.5% 5-FU+10% Salicylic acid	Actikerall	✓	✓✓	✗	✓	✗
Topical	3.75% Imiquimod	Zyclara	✓	✓	✗	✓	✓✓
Other	Liquid Nitrogen		✓	✓	✗	✗	✗
Other	Curettage		✗	✓	✗	✗	✗

Legend ✓ relative recommendation ✓✓ Strong recommendation ✗ Not recommended in Primary Care

Please note these recommendations do not take into consideration the cost of treatment and are based on national and international consensus and guidelines, and the clinical expertise of the guideline contributors with the products

Reference: * De Berker D et al. British Journal of Dermatology 2007;156: 222-230

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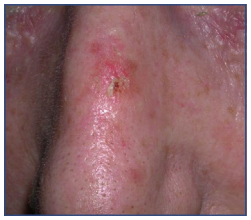
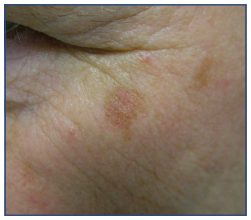
General Measures

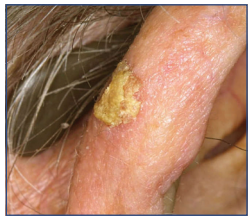
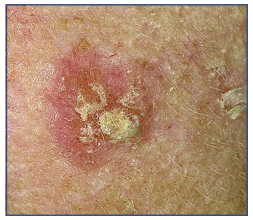
Applicable to all patients and may be all that is needed for management:

1. **AKs are a marker of UV damage: examine other areas of the skin**
2. Encourage prevention: sunscreen and protection
3. Reinforce lesion vigilance and ABCDE (EFG) checklist to patients
4. Use petrolatum ointment or emollients for post-treatment symptom control

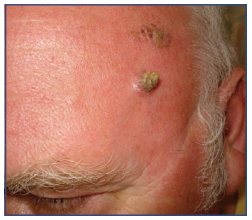
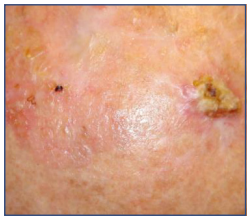
Clinical Grading (according to Olsen 1991)

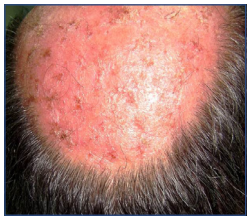
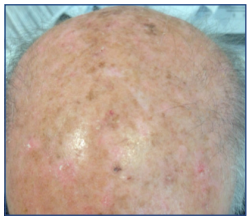
Grade I: Flat, pink macules without signs of hyperkeratosis often easier felt than seen. Scale and possible pigmentation may be present

Grade II: Moderately thick hyperkeratosis on background of erythema that are easily felt and seen

Grade III: Very thick hyperkeratosis. Main differential to exclude is SCC

Field damage: Large areas of multiple AKs on a background of erythema and sun damage

Suggested Treatment Regimes

Brand Name	Protocol	Notes
Solaraze	Twice daily for 60-90 days. Assess 4-6 weeks after treatment. Can be repeated but if no further improvement, choose an alternative	Because of the length of treatment needed, compliance may be an issue. Can cause inflammatory reactions
Efudix	Once daily for 4 weeks. Assess after 8 weeks after treatment. Can be repeated but no further response, choose an alternative	Early & vigorous inflammatory reaction is normal, typically peaking in the second week
Tolak	Once daily for 4 weeks. Assess after 8 weeks after treatment. Can be repeated but no further response, choose an alternative	Similar reactions to efudix. Vehicle base is refined peanut oil which to date is unlikely to cause anaphylaxis in peanut allergy (clinical discretion advised).
Actikerall	Once daily for 6-12 weeks. Assess at 8 weeks after treatment. If scaly patches remain, consider alternative treatments and/or referral	Apply with brush applicator & peel off existing coating before reapplication. An inflammatory response should occur
Aldara	Apply three times a week for 4 weeks. Assess after 8 weeks. Can be repeated but no further response, choose an alternative	Flu-like symptoms are occasionally reported. Expect an early and vigorous inflammatory reaction
Zyclara	Once daily for two weeks then off-treatment for 2 weeks, then repeat once daily for 2 weeks. Can be repeated but if no further improvement, choose an alternative	Flu-like symptoms are occasionally reported. Expect an early and vigorous inflammatory reaction
Klisyri	Once daily for 5 days. Assess 8 weeks later. Can be repeated but choose an alternative if improvements plateau	Short-lived localized inflammation, pain, flaking and pruritus can be expected