**Referral Support Service**

**Dermatology**

**D02**

**Actinic (Solar) Keratoses**

**Definition**

* Scaly, flat pink, red or brownish lesions, on any sun exposed skin from mid-life onwards.
* Typical areas affected are scalp in balding patients, upper pinna, temples, bridge of nose, anterior upper chest.
* Images - [**click here**](https://dermnetnz.org/topics/actinic-keratosis)
* Often multiple, with a dry adherent scale. They occasionally itch.
* Hyperkeratotic scale can form a cutaneous horn.
* The vast majority of actinic keratoses do not progress to squamous cell carcinoma

Evidence suggests that the annual incidence of transformation to SCC is less than <2%. This risk is higher in immuno-compromised patients.

* The majority of patients can be managed in primary care.
* There is a field change effect- so if sufficient UV exposure has occurred to trigger 1 actinic keratosis, adjacent skin will not be far behind, and more will likely occur over coming months and years.

**Exclude Red Flag Symptoms**

* Tender and /or indurated lesions are more likely to be SCCs or other significant pathology.
* Also if bleed spontaneously. Refer if ?SCC or concerns about malignant change

**Management**

* Click [Here](https://www.valeofyorkccg.nhs.uk/seecmsfile/?id=6983) for the 2024 Primary Care Treatment pathway.
* **Fluorouracil (Efudix®)** is the most cost effective treatment. Its application and use needs care and there are a number of leaflets within the treatment pathway that help to explain this to patients. Apply every night for four weeks. Wash hands thoroughly after application. Leave treated areas uncovered and wash the following morning. Patients should be advised to expect a relatively mild degree of redness and discomfort during the treatment period**.**
* **ONLY IF FLUOROURACIL OUT OF STOCK:**
* Imiquimod 3.5 or 5% is a much more expensive treatment for actinic keratoses, and can be used 3 x per week for 6 weeks. Like efudix, there is usually a degree of redness and discomfort, but this can also be severe on occasion, and/or imiquimod can rarely cause flu like symptoms. If the latter side effect happens, they should avoid the treatment in future.
* Actikerall is another alternative, containing salicylic acid as well as fluorouracil (aimed usually at viral warts), use as for efudix, once day for up to four weeks but can be more irritant.
* Tirbanibulin (klysiri) is a new treatment for actinic keratoses, this is currently a red drug for primary care once a day for 5 days. This is also considerably more expensive. Do not prescribe, unless directed by secondary care or through advice and guidance.
* AKs can regress spontaneously especially if sun exposure is reduced.
* Do a full body examination for other sun induced lesions.
* For all patients advise avoid sun exposure by wearing hats and clothing, use sunscreens (SPF 50+) applied from April to October and reapply frequently on sunnier days or when outside for longer periods. Reinforce this frequently.
* If patient follows this rigorously may need vitamin D measurement or supplementation
* Isolated well defined lesions:
* *Cryotherapy* – not on lower legs (thermal injury takes too long to heal); 10-20 second freeze, depending on thickness; can be useful for thicker or resistant lesions

Curettage of difficult lesions can also be carried out in primary care, preferably double curettage and cautery. This should be sent for histology in case SCC is missed.

**Refer or seek advice and guidance if:**

* Diagnostic doubt (actinic keratosis vs SCC)
* Failed more than 2 treatment modalities
* Immunosuppressed patients
* Consider not treating– many regress spontaneously
* cryotherapy – not on lower legs (thermal injury takes too long to heal); • 10-20 second freeze depending on thickness
  + Can be useful for thicker or resistant lesions.

**Referral Information**

* **Information to include in referral letter**
* Previous treatments tried and their effect.
* Photograph (desirable)
* Relevant past medical/ surgical history
* Current regular medication
* BMI/smoking status
* **Referral Criteria**
* Diagnostic doubt.
* Failure of 2 different treatments.
* Immuno-compromised patients

**Patient information leaflets**

* [York Hospital Foundation Trust's leaflet](https://www.valeofyorkccg.nhs.uk/seecmsfile/?id=4209) (a one page summarised leaflet)
* [Manufacturer Patient Information Leaflet](https://www.medicines.org.uk/emc/medicine/15898) (a more detailed leaflet)
* British Association of Dermatologists' leaflet

**References**

* [Primary Care Dermatology Society](https://www.pcds.org.uk/clinical-guidance/actinic-keratosis-syn-solar-keratosis)