

Actinic (Solar) Keratosis, Squamous Cell Carcinoma, and Basal Cell Carcinoma Referral Guideline

(Drake et al, Guidelines of care for actinic keratoses. JAAD 1995; 32:95-98.)

Indications for Specialty Care Referral

- Large or numerous actinic keratoses resistant to available therapy.
- Suspicious lesions that are unable to be biopsied by pcm.
- Biopsy-proven BCC or SCC whose treatment is outside the scope of practice of the primary care provider.
- Referral must note the location, size and suspected diagnosis. If a previous biopsy has noted a malignant lesion, please indicate on referral.

Criteria for Return to Primary Care

Actinic keratoses have resolved and/or a suitable treatment plan has been established

Diagnosis/Definition

- **AK** (ICD-9: 702.0): Rough, scaled, pink macules or thin papules often more easily perceived by palpation than visual inspection, found on chronically sun-damaged surfaces of the face, scalp, ears, hands and forearms that may be associated with sensations of pruritus, burning, or hyperesthesia.
- **SCC** (ICD-9 depends on location; 173.X): Similar to AK, usually thicker or larger.
- **BCC** (ICD-9 depends on location; 173.X): May be similar to AK when of superficial multifocal type; nodular BCC is common and is a telangiectatic or pearly papule or nodule that may have surface erosion.

Initial Diagnosis and Management

- Persons with fair skin, especially those who sunburn easily and tan poorly, as well as those with occupations or hobbies resulting in excessive and long-term sun exposure are at increased risk.
- AK can generally be diagnosed clinically, but biopsy may be indicated to verify diagnosis or exclude non-melanoma skin cancer i.e. BCC, SCC, if refractory to conventional therapy.
- Actinic Keratoses have the potential (from 1-10%) to develop into SCC and should therefore be treated when observed.

Treatment options include

- Cryotherapy – freezing with liquid nitrogen causes blistering and shedding of the damaged skin.
 - Curettage – curettage is the removal of a lesion by scraping it with a sharp instrument.
 - Topical 5-Fluorouracil - most useful when there are many keratoses, especially on the face. The cream is applied once or twice daily for 2-4 weeks. See [Effudex Handout](#)

- Topical Retinoids – may be effective if used twice daily for the treatment of some actinic keratoses.
- Imiquimod Cream – applied twice weekly for 16 weeks.
- Excisional Biopsy – definitive treatment and useful when lesions are suspicious for squamous cell carcinomas.
- Chemical Peels – alternative way to treat patients with extensive, actinically-damaged skin. Available on a limited basis at BACH.
- Photodynamic Therapy – a new technique in which a photosensitizer is applied to the affected area prior to exposing it to a strong source of visible light. This is now available at BACH.
- Laser Surgery – this modality is most appropriate for the treatment of extensive actinic keratosis of the lips (actinic cheilitis). This is currently not available at BACH.

Ongoing Management and Objectives

- Long-term patient follow-up may be necessary because of the real possibility of development of new actinic keratoses or non-melanoma skin cancer.
- Frequency of follow-up is dependent on the individual clinical situation (i.e., every 4 - 12 months).
- Prevention and education are vital to patient care. Monthly self-examination is recommended. Sun avoidance, protective clothing, and sunscreen protection may prevent future actinic skin damage.