ACTINIC KERATOSIS

Actinic keratosis (AK) becomes more prevalent with advanced age. Over one million new cases are reported annually. This lesion is the principal precursor of squamous-cell carcinoma (SCC) of the skin (6-10%), and 60% of all SCC develop from AK. Some authors consider it as a type of carcinoma in situ. AK occurs more frequently in Caucasians with long exposure to ultraviolet radiation (UVB, 290-320 nm); UVB produce mutations in the p53 tumor suppressor gene. T he cumulative risk depends on the number of lesions and the length of time they persist.

Actinic keratoses predominantly affect sun-exposed skin, i.e. face, bald scalp, and the dorsal aspect of hands and forearms. These lesions are chronic, small, scaly lesions, 2 to 6 mm in diameter, sometimes pink or brown hyperkeratotic plaques, and surrounded by atrophic skin, telangiectasia (broken blood vessels) and lentigines (brown marks). Usually they persist and may evolve to SCC. The diagnosis is easily made, but dermoscopy can improve clinical accuracy.

It is impractical to treat each individual lesion. Current options include cryosurgery; curettage and electrodessication; 0.5 to 5 %, topical 5-fluoruracil (5-FU) cream, applied once to twice daily for three to eight weeks; or 5% imiquimod cream applied daily or every other day for six to eight weeks, in one or several cycles. Chemical exfoliation with Jessner solution or 30% trichloracetic acid, as well as dermabrasion and laser resurfacing are also useful. Intralesional interferon alfa 2b has a good biologic activity and topical 5-aminolevulinic acid based photodynamic therapy has been established recently also as an effective treatment. In organ-transplant recipients, acitretin or isotretinoin are a good option.

Heriberto Vázquez, MD
J. Ruiz-Esmenjaud, MD
Roberto Arenas, MD
Acapulco, Mexico