

Optimal treatment of actinic keratosis

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Dear editor

We read with interest the review by Uhlenhake on treatments for actinic keratosis (AK).¹ The author presents a summary of the various AK treatment options used to reduce the risk of progression to invasive squamous cell carcinoma. The article includes a table (Table 1) comparing advantages and side effects of these options.

Patient-administered topical treatments are an important strategy for treating confluent AKs and areas of sun-damaged skin that may contain subclinical AKs. Rates of complete and partial clearance are similar across the topical agents (fluorouracil, imiquimod, diclofenac, and ingenol mebutate). It is noteworthy that the uniquely brief regimen for ingenol mebutate, 2 to 3 days, produced clearance rates similar to those with the other agents, which have treatment regimens of several weeks.¹

All of the topical agents are associated with common side effects that include localized erythema, flaking, scaling, and crusting; however, dyspigmentation and scarring occur infrequently. Ingenol mebutate gel is a new topical treatment for AK. Occurrence of dyspigmentation and scarring are rare as there was minimal change in pigmentation and minimal scarring in all groups of the Phase III studies.² Neither dyspigmentation nor scarring are reported among adverse reactions in the Picato package insert.³ Localized changes in pigmentation and scarring have been reported with fluorouracil and imiquimod.⁴⁻⁶

Localized skin reactions persist during treatment.³⁻⁶ In my experience, some patients are unable to tolerate prolonged inflammatory skin reactions and may discontinue treatment early, thus failing to achieve the anticipated rates of clearance. The short treatment regimen of ingenol mebutate provides a valuable option for such patients.

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Disclosure

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