

## WEB EXCLUSIVES

# A Skin Cancer Conundrum: Are AKs Overtreated?

BY CURTIS PESMEN

*Answers to the treatment debate for actinic keratosis, a precancerous growth on the skin.*

It's not every day you hear cancer doctors cautioning each other to "back off." But it happened at the 2008 annual meeting of the American Academy of Dermatology (AAD), where skin cancer doctors and dermatologic surgeons debated about possible overtreatment of nonmelanoma skin cancer.

In particular, they aired arguments over the "best" treatment of AKs, or actinic keratoses (also called solar keratoses), which develop after years of sun (over)exposure. These lesions appear one-at-a-time or in groups as rough, scaly, reddish or brown patches of sun-damaged skin that can, though rarely, turn into squamous cell carcinoma. What then: Surgery? Liquid nitrogen (cryotherapy)? Chemo-topical or other lotions? Combo treatments? Or even watchful waiting? All this, for something that's not even cancer (yet)?

Still, over this there's little debate: More than one million people will get skin cancer this year, projects the AAD. Of those, up to 80 percent will be basal cell carcinoma (or BCC, which doesn't metastasize) and 16 percent or so will be squamous cell carcinoma (SCC), which can metastasize. (Another 4 percent will be melanoma, the most dangerous form of skin cancer, which can spread even when the lesion is small.)

People who have many AKs have about a 10 percent risk of developing SCC over their lifetime, which also means 90 percent of this subpopulation won't suffer this cancer. Cancer patients and others on immunosuppressive drugs or treatments face much higher risk of developing AK-related or dangerous skin cancers. A cure is highly likely for basal cell and squamous cell cancers if detected and treated early, according to the American Cancer Society. For SCCs that metastasize, the five-year survival rate is less than 50 percent.

As patients get to know the family of treatments from which to choose for AKs and nonmelanoma skin cancers, the initial urge to "cut it out" may not be the most prudent course, dermatologists say.

"AKs can be overtreated in my opinion," says Christopher Lum, MD, a dermatopathologist at the John A. Burns School of Medicine at the University of Hawaii, "because these lesions can tend to be multi-focal—or part of a 'field.'" When multiple sites on the skin are involved or affected, Dr. Lum explains,

surgically (or cryosurgically) removing many at a time might inflict unnecessary pain and scarring.

In recent years, dermatologists have increased use of topical treatments, including an older drug, 5-FU (fluorouracil), dispensed as a kind of chemo-in-a-tube. In 2004, the cream Aldara (imiquimod) gained approval from the Food and Drug Administration for treating some AKs as well as superficial BCC.

Still, because topical creams take weeks to work and carry side effects such as redness, pain, swelling, and scabbing, those who develop numerous AKs may opt for surgery or cryosurgery, while remaining aggressive and alert.

“Skin cancer is like a weed,” says Michael Hadley, MD, assistant professor and specialist in dermatological surgery at University of Utah-Huntsman Cancer Institute in Salt Lake City. “It’s easy to pull off the top, but it’s essential to get all the roots in order to stave off potential recurrence,” which is not to say liquid treatments for AKs aren’t effective; just to point out a biological truth.

As for aggressive surgical treatment, “In order to get a clear margin, you can be ‘chasing’ for a long time,” adds Dr. Lum. “There are other, perhaps better ways to achieve the [desired] reduction effect.” A further choice for patients with AK is light therapy, or photodynamic therapy, which combines a somewhat new, two-step treatment. First, the doctor applies ALA, or aminolevulinic acid (different drugs may be used); next, after an “incubation” period, the doctor aims pulses of photodynamic (blue) light at the field via an applicator that stimulates the drug. Photodynamic therapy appears most effective for small nonmelanoma cancers or precancerous areas.

“Some actinic keratoses can resolve on their own, but they should be monitored every four months or so,” says Shawn Allen, MD, a Boulder, Colorado, dermatologist and Mohs-trained skin cancer surgeon. (Mohs surgery involves a specially trained dermatologist or surgeon removing thin slices of the cancerous area, one by one, and examining each slice under a microscope until no tumor cells remain.) “And cancer patients or others who are immuno-compromised should know that those who tend to develop a lot of AKs, or who develop squamous cells, can be facing a more threatening situation.”

Dermatologists attending the AAD meeting believe that while every patient has a right to decide how and when to treat precancers of the skin, they expressed concerns about how long some patients might opt to wait to treat.

It’s a new, but increasingly common dilemma in oncology: What’s the best course of action for so-called stage 0 disease? From superficial skin lesions to gynecological dysplasia, the jury is still out. But the treatment options keep coming.