Measure Title: FOLLOW-UP AFTER DIAGNOSIS OF ACTINIC KERATOSIS

Disease State: Cancer

Strength of Recommendation: C

Clinical Intent: To ensure that all eligible members diagnosed with actinic keratosis receive follow up care by a dermatologist.

Physician Specialties: Refer to PQSR 2007 Specialty Matrix

Clinical Rationale

Disease Burden
- From 1990 to 1999, actinic keratosis was diagnosed in more than 47 million ambulatory care visits, and occurred in 14% of patients visiting dermatologists.[1]
- Estimates indicate that 60% of predisposed people older than 40 years of age have at least one actinic keratosis.[2]

Reason for Indicated Intervention or Treatment
- Actinic keratoses share genetic tumor markers and identical p53 gene mutations with squamous cell carcinomas involving the dermis.[3]
- Studies have shown that 28-60% of squamous cell carcinomas arose from a lesion clinically diagnosed as an actinic keratosis in the past year.[4, 5]
- Furthermore, two retrospective studies of 165 and 1011 patients and one prospective study of 208 patients found that 72-94% of squamous cell carcinomas were either in close proximity, contiguous to, or within the confines of actinic keratoses.[5-7]
- Several studies have reported that dermatologists correctly diagnose significantly more skin lesions, including melanoma and basal cell carcinoma (two types of skin cancer), than do non-dermatologists. Early diagnosis and treatment are crucial when a patient has AKs. Left untreated, AKs have the potential to progress to squamous cell carcinoma, a type of skin cancer that can be deadly. Dermatologists’ training also makes them more comfortable in determining whether or not an AK lesion should be biopsied.[8, 9]

Evidence supporting Intervention or Treatment
- One prospective study of 1689 people with actinic keratoses showed that the risk of malignant transformation of an actinic keratosis to squamous cell carcinoma within 1 year was less than 1/1000.[4] However, another study indicated that the risk was 10.2% after 10 years.[10]
- To date, studies have not examined the relationship between follow-up examinations for patients with actinic keratosis and improved or earlier diagnosis of cutaneous squamous cell carcinoma.
- In addition, no evidence exists about the frequency of follow-up examinations in patients with actinic keratosis.

Clinical Recommendations
• The 1995 American Academy of Dermatology’s ‘Guidelines of care for actinic keratosis’ states that long-term follow-up in patients with actinic keratoses may be necessary due to the possible development of new actinic keratoses or actinically related skin cancer. However, no specific recommendations were offered for the frequency and duration of follow-up, which should be based on the individual clinical situation.[2]

• In 2006, the National Comprehensive Cancer Network (NCCN) issued Clinical Practice Guidelines in Oncology. The guidelines indicate that in regard to identification and management of high-risk patients for the treatment of precancers, ‘Actinic keratosis should be treated aggressively at first development.[11]

Source
Health Benchmarks, Inc.

Denominator
Continuously enrolled members who had a diagnosis of actinic keratosis during the year prior to the measurement year.

Relevant Billing Codes:
ICD-9 CM Dx codes: 702.0x

Exclusion
Members who had a diagnosis of actinic keratosis during the one year period starting two years prior to the measurement year.

Relevant Billing Codes:
ICD-9 CM Dx codes: 702.0x

Numerator
Members who had a follow-up visit with a dermatologist from 1 month to 1 year after the index diagnosis of actinic keratosis.

Relevant Billing Codes:
Dermatology Specialty Code: 007

Interpretation of Score
High score implies better performance

Physician Attribution
Score all physicians (in the selected specialties) who saw the member 0 - 1 year after the index date of actinic keratosis, inclusive of the index date.

References


1 **Indicator Classification** (Adapted from Health Plan Employer Data Information Set (HEDIS®) technical specifications)

**Diagnosis**
- Measures applicable to patients receiving diagnostic workups for a symptom or condition that delineate appropriate laboratory or radiological testing to be performed (e.g. evaluation of thyroid nodule; pregnancy test in patients with vaginal bleeding or abdominal pain)

**Effectiveness of Care**

**Prevention**
- Measures applicable to asymptomatic individuals that are designed to prevent the onset of the targeted condition (e.g. immunizations).

**Screening**
- Measures applicable to asymptomatic patients who have risk factors or pre-clinical disease, but in whom the condition has not become clinically apparent (e.g. pap smears; screening for elevated blood pressure).

**Disease Management**
- Measures applicable to individuals diagnosed with a condition that are part of the treatment or management of the condition (e.g. cholesterol reduction in patients with diabetes; radiation therapy following breast conserving surgery; appropriate follow-up after acute event).

**Medication Monitoring**
- Measures applicable to patients taking medications with narrow therapeutic windows and / or potential preventable significant side effects or adverse reactions (e.g. thyroid stimulating hormone (TSH) testing after levothyroxine dose change; hepatic enzyme monitoring for patients using antifungal pharmacotherapy)

**Medication Adherence**
- Measures applicable to patients taking medications for chronic conditions that are designed to assess patient adherence to medication (e.g. adherence to lipid lowering medication).

**Utilization**
- Measures applicable to patients receiving treatment for a symptom or condition that advocate appropriate utilization of laboratory and pharmaceutical resources (e.g. conservative use of imaging for low back pain; inappropriate use of antibiotics for viral upper respiratory infection).
Strength of Recommendation Based on a Body of Evidence

Is this a key recommendation for clinicians regarding diagnosis or treatment that merits a label?  

Yes

Is the recommendation based on patient-oriented evidence (i.e., an improvement in morbidity, mortality, symptoms, quality of life, or costs)?  

No

Strength of Recommendation = C

Yes

Is the recommendation based on opinion, bench research, a consensus guideline, usual practice, clinical experience, or a case series study?  

No

Is the recommendation based on one of the following?  
- Cochrane Review with a clear recommendation  
- USPSTF Grade A recommendation  
- Clinical Evidence rating of beneficial  
- Consistent findings from at least two good-quality randomized controlled trials or a systematic review/meta-analysis of same  
- Validated clinical decision rule in a relevant population  
- Consistent findings from at least two good-quality diagnostic cohort studies or systematic review/meta-analysis of same  

Yes

Strength of Recommendation = A

No

Strength of Recommendation = B

FIGURE 2. Algorithm for determining the strength of a recommendation based on a body of evidence (applies to clinical recommendations regarding diagnosis, treatment, prevention, or screening). While this algorithm provides a general guideline, authors and editors may adjust the strength of recommendation based on the benefits, harms, and costs of the intervention being recommended. (USPSTF = U.S. Preventive Services Task Force)