高 雄 榮 民 總 醫 院

皮膚癌(BCC)診療原則

2017年03月21日 第一版

皮膚癌醫療團隊擬定

注意事項：這個診療原則主要作為醫師和其他保健專家診療癌症病人參考之用。假如你是一個癌症病人，直接引用這個診療原則並不恰當，只有你的醫師才能決定給你最恰當的治療。

修訂指引

- 本共識依下列參考資料修改版本
  - NCCN 2017版 診療指引

BCC診療指引審視修訂會議討論日期

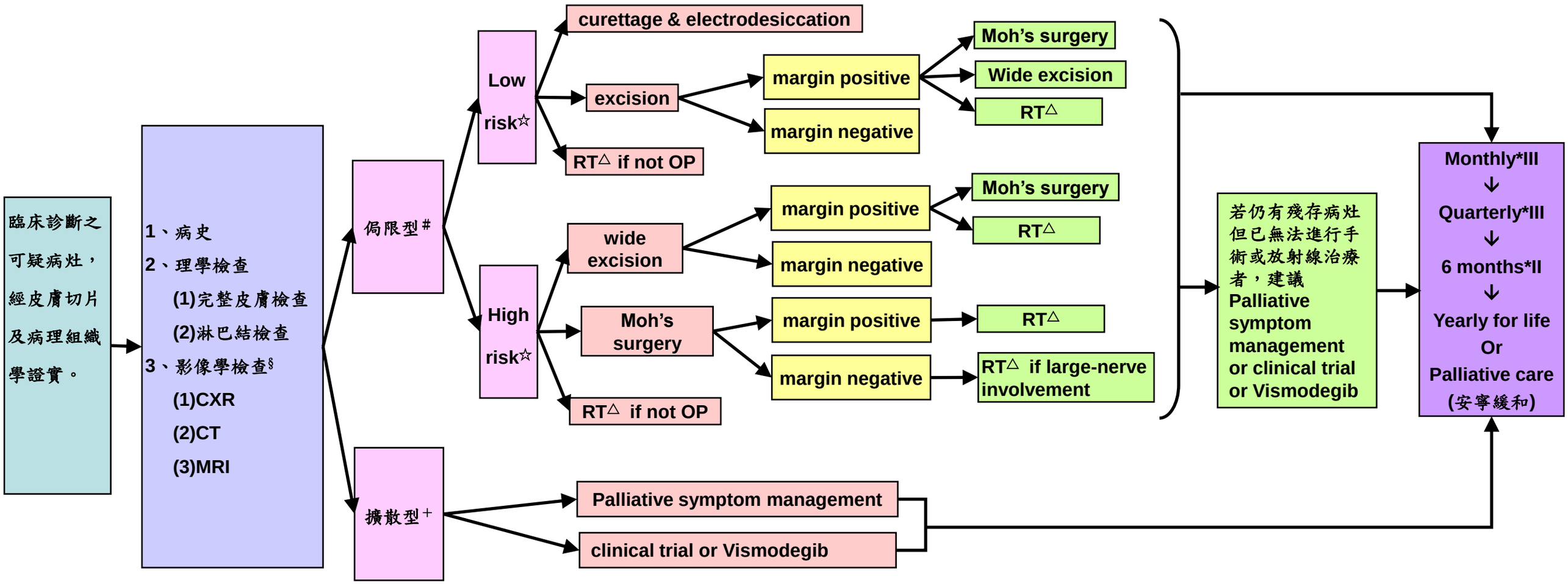
- 上次會議：2016/03/08
- 本共識經審視後與上一版之差異

上一版:	新版:
使用NCCN 2016版 診療指引	更新 NCCN 2017版 診療指引

基底細胞癌(BCC)

高雄榮民總醫院
臨床診療指引 2017第一版

診斷	初步評估	分期	初始治療	療效評估	輔助治療	追蹤



§： Image studies is indicated for extensive disease (deep structural involvement such as bone, deep soft tissue, perineural disease)

＋： regional or distal metastatic disease(初始皮膚病灶治療同侷限型)

☆：附件一

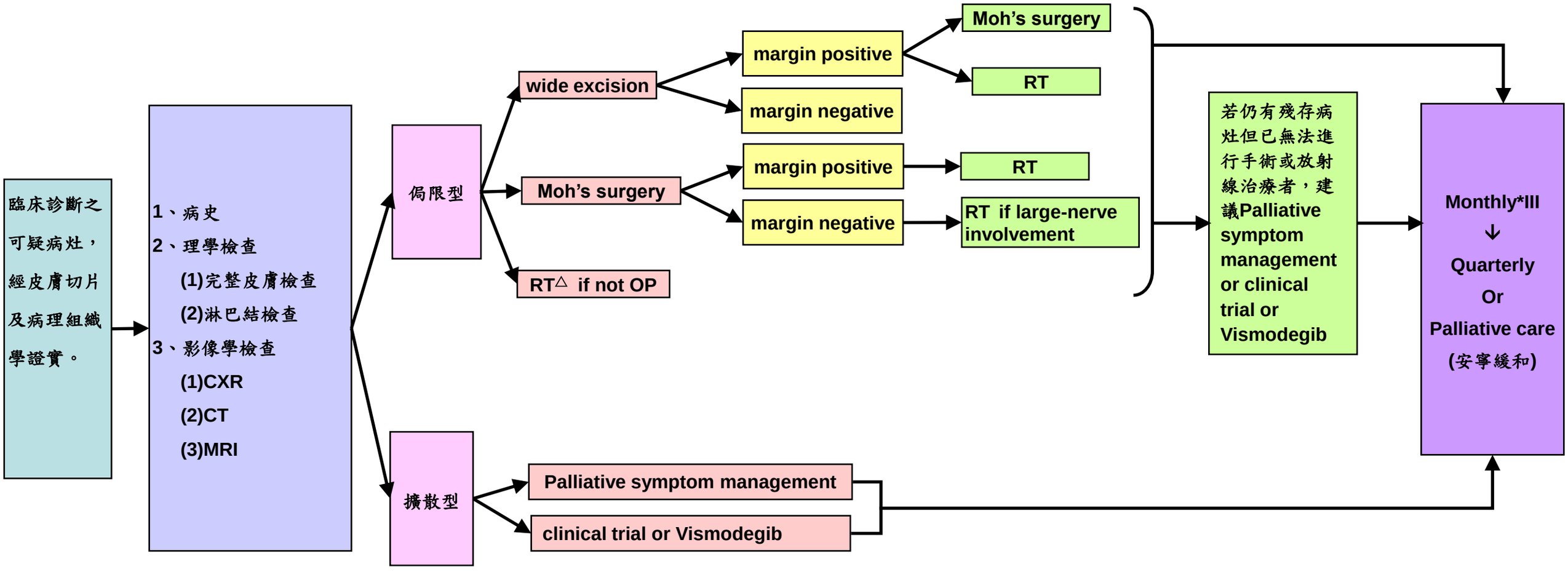
△：附件二

＃： T any, N0, M0(附件三)

基底細胞癌(BCC)

高雄榮民總醫院
臨床診療指引　2017第一版

復發



基底細胞癌(BCC)

高雄榮民總醫院
臨床診療指引　2017第一版

癌症藥物停藥準則

- 根據CTCAE (Common Terminology Criteria for Adverse Events, Version 4.0 Published: May 28, 2009 【v4.03: June 14, 2010】)，出現Grade 3 ~ Grade 4 adverse event。
- 停藥至adverse event回復至Grade 1或Baseline時可再次用藥，但有些患者必須調整用藥劑量。
- 使用BRAF inhibitor時可能產生cutaneous SCC。此現象雖被CTCAE列為Grade 3 toxic effect, 但此現象不必停藥或調整劑量
- 特定藥物治療下疾病仍持續進展，根據追蹤及評估顯示疾病對此特定藥物治療無效(考慮停止投藥並選擇其他治療方法)。
- 病患要求 (Hospice care或其他因素)
- 病患死亡

基底細胞癌(BCC)

高雄榮民總醫院
臨床診療指引　2017第一版

附件一：

National Comprehensive Cancer Network®

NCCN Guidelines Version 1.2017
Basal Cell Skin Cancer

NCCN Guidelines Index
Table of Contents
Discussion

RISK FACTORS FOR RECURRENCE

H&P	Low Risk	High Risk
Location/size	Area L <20 mm	Area L ≥20 mm
	Area M <10 mm[1]	Area M ≥10 mm
		Area H[3]
Borders	Well defined	Poorly defined
Primary vs. Recurrent	Primary	Recurrent
Immunosuppression	(-)	(+)
Site of prior RT	(-)	(+)
Pathology		
Subtype	Nodular, superficial[2]	Aggressive growth pattern[4]
Perineural involvement	(-)	(+)

Area H = "mask areas" of face (central face, eyelids, eyebrows, periorbital, nose, lips [cutaneous and vermilion], chin, mandible, preauricular and postauricular skin/sulci, temple, ear), genitalia, hands, and feet.
Area M = cheeks, forehead, scalp, neck, and pretibia.
Area L = trunk and extremities (excluding pretibia, hands, feet, nail units, and ankles).

[1]Location independent of size may constitute high risk.
[2]Low-risk histologic subtypes include nodular, superficial, and other non-agressive growth patterns such as keratotic, infundibulocystic, and fibroepithelioma of Pinkus.
[3]Area H constitutes high risk based on location, independent of size. Narrow excision margins due to anatomic and functional constraints are associated with increased recurrence rates with standard histologic processing. Complete margin assessment such as with Mohs micrographic surgery is recommended for optimal tumor clearance and maximal tissue conservation. For tumors <6 mm in size, without other high-risk features, other treatment modalities may be considered if at least 4-mm clinically tumor-free margins can be obtained without significant anatomic or functional distortions.
[4]Having morpheaform, basosquamous (metatypical), sclerosing, mixed infiltrative, or micronodular features in any portion of the tumor. In some cases basosquamous (metatypical) tumors may be prognostically similar to SCC. Clinicopathologic consultation is recommended.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

基底細胞癌(BCC)

高雄榮民總醫院
臨床診療指引 2017第一版

附件二:

PRINCIPLES OF RADIATION THERAPY FOR BASAL CELL SKIN CANCER

Dose and Field Size

Tumor Diameter	Margins[1]	Examples of Electron Beam Dose and Fractionation[2]
<2 cm	1–1.5 cm	64 Gy in 32 fractions over 6–6.4 weeks 55 Gy in 20 fractions over 4 weeks 50 Gy in 15 fractions over 3 weeks 35 Gy in 5 fractions over 5 days
≥2 cm	1.5–2 cm	66 Gy in 33 fractions over 6–6.6 weeks 55 Gy in 20 fractions over 4 weeks
Postoperative adjuvant		50 Gy in 20 fractions over 4 weeks 60 Gy in 30 fractions over 6 weeks

- **Protracted fractionation is associated with improved cosmetic results.**
- **Radiation therapy is contraindicated in genetic conditions predisposing to skin cancer (eg, basal cell nevus syndrome, xeroderma pigmentosum) and connective tissue diseases (eg, scleroderma).**
- **There is insufficient long-term efficacy and safety data to support the routine use of electronic surface brachytherapy.**

[1]When using electron beam, wider field margins are necessary than with orthovoltage x-rays due to the wider beam penumbra. Narrower field margins can be used with electron beam adjacent to critical structures (eg, the orbit) if lead skin collimation is used. Bolus is necessary when using electron beam to achieve adequate surface dose. An electron beam energy should be chosen that achieves adequate surface dose and encompasses the deep margin of the tumor by at least the distal 90% line. Appropriate medical physics support is essential.

[2]Electron beam doses are specified at 90% of the maximal depth dose (Dmax). Orthovoltage x-ray doses are specified at Dmax (skin surface) to account for the relative biologic difference between the two modalities of radiation.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

基底細胞癌(BCC)

高雄榮民總醫院
臨床診療指引 2017第一版

附件三-1:

National Comprehensive Cancer Network®

NCCN Guidelines Version 1.2014
Basal and Squamous Cell Skin Cancers

NCCN Guidelines Index
Basal and Squamous Cell TOC
Discussion

Staging

Table 1

American Joint Committee on Cancer (AJCC)

TNM Staging Classification for Cutaneous Squamous Cell Carcinoma (cSCC) and Other Cutaneous Carcinomas

(7th ed., 2010)

Primary Tumor (T)*

TX Primary tumor cannot be assessed
T0 No evidence of primary tumor
Tis Carcinoma in situ
T1 Tumor 2 cm or less in greatest dimension with less than two high-risk features**
T2 Tumor greater than 2 cm in greatest dimension
or
Tumor any size with two or more high-risk feature
T3 Tumor with invasion of maxilla, mandible, orbit, or temporal bone
T4 Tumor with invasion of skeleton (axial or appendicular) or perineural invasion of skull base

*Excludes cSCC of the eyelid

** High-risk features for the primary tumor (T) staging

Depth/invasion	> 2 mm thickness
	Clark level ≥ IV
	Perineural invasion
Anatomic location	Primary site ear
	Primary site non-hair-bearing lip
Differentiation	Poorly differentiated or undifferentiated

Regional Lymph Nodes (N)

NX Regional lymph nodes cannot be assessed
N0 No regional lymph node metastases
N1 Metastasis in a single ipsilateral lymph node, 3 cm or less in greatest dimension
N2 Metastasis in a single ipsilateral lymph node, more than 3 cm but not more than 6 cm in greatest dimension; or in multiple ipsilateral lymph nodes, none more than 6 cm in greatest dimension; or in bilateral or contralateral lymph nodes, none more than 6 cm in greatest dimension
N2a Metastasis in a single ipsilateral lymph node, more than 3 cm but not more than 6 cm in greatest dimension
N2b Metastasis in multiple ipsilateral lymph nodes, none more than 6 cm in greatest dimension
N2c Metastasis in bilateral or contralateral lymph nodes, none more than 6 cm in greatest dimension
N3 Metastasis in a lymph node, more than 6 cm in greatest dimension

Distant Metastasis (M)

M0 No distant metastases
M1 Distant metastases

Continue

基底細胞癌(BCC)

高雄榮民總醫院
臨床診療指引　2016第一版

附件三-2:

Table 1 Continued

American Joint Committee on Cancer (AJCC)

TNM Staging Classification for Cutaneous Squamous Cell Carcinoma (cSCC) and Other Cutaneous Carcinomas (7th ed., 2010)

Anatomic Stage/Prognostic Groups

Stage 0	Tis	N0	M0
Stage I	T1	N0	M0
Stage II	T2	N0	M0
Stage III	T3	N0	M0
	T1	N1	M0
	T2	N1	M0
	T3	N1	M0
Stage IV	T1	N2	M0
	T2	N2	M0
	T3	N2	M0
	T Any	N3	M0
	T4	N Any	M0
	T Any	N Any	M1

Histologic Grade (G)

GX	Grade cannot be assessed
G1	Well differentiated
G2	Moderately differentiated
G3	Poorly differentiated
G4	Undifferentiated

Reference

1. NCCN Clinical Practice Guideline in Oncology, Basal and Squamous Cell Skin Cancers, Version 2.2017.
2. G Ital Dermatol Venereol. 2016 Feb;151(1):77-86. Epub 2014 Jun 30. Treatments of advanced basal cell carcinoma: a review of the literature.
3. Sekulic A, Migden MR, Basset-Seguin N, et al. Long-term safety and efficacy of vismodegib in patients with advanced basal cell carcinoma (aBCC): 18-month update of the pivotal ERIVANCE BCC study. ASCO Meeting Abstracts 2013;31:9037.
4. Mendenhall WM, Ferlito A, Takes RP, et al. Cutaneous head and neck basal and squamous cell carcinomas with perineural invasion. Oral Oncol 2012;48:918-922.
5. Sekulic A, Migden MR, Oro AE, et al. Efficacy and safety of vismodegib in advanced basal-cell carcinoma. N Engl J Med 2012;366:2171-2179.
6. Lott DG, Manz R, Koch C, Lorenz RR. Aggressive behavior of nonmelanotic skin cancers in solid organ transplant recipients. Transplantation 2010;90:683-687.
7. Basosquamous carcinoma. J Am Acad Dermatol 2009;60:137-143.
8. Mendenhall WM, Amdur RJ, Hinerman RW, et al. Radiotherapy for cutaneous squamous and basal cell carcinomas of the head and neck. Laryngoscope 2009;119:1994-1999.
9. Mosterd K, Krekels GA, Nieman FH, et al. Surgical excision versus Mohs' micrographic surgery for primary and recurrent basal-cell carcinoma of the face: a prospective randomised controlled trial with 5-years' follow-up. Lancet Oncol 2008;9:1149-1156.
10. Neville JA, Welch E, Leffell DJ. Management of nonmelanoma skin cancer in 2007. Nat Clin Pract Oncol 2007;4:462-469.
11. Rodriguez-Vigil T, Vazquez-Lopez F, Perez-Oliva N. Recurrence rates of primary basal cell carcinoma in facial risk areas treated with curettage and electrodesiccation. J Am Acad Dermatol 2007;56:91-95.
12. Rubin AI, Chen EH, Ratner D. Basal-cell carcinoma. N Engl J Med 2005;353:2262-2269.
13. Bath-Hextall F, Bong J, Perkins W, Williams H. Interventions for basal cell carcinoma of the skin: systematic review. BMJ 2004;329:705.