高 雄 榮 民 總 醫 院

皮膚癌(BCC)診療原則

2018年01月23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 2016版 診療指引

BCC診療指引審視修訂會議討論日期

- 上次會議：2017/03/21
- 本共識經審視後與上一版之差異

上一版:	新版:
一、使用NCCN 2017版 診療指引 二、修改治療方式 1.侷限型low risk 2.輔助治療	一、更新 NCCN 2018版 診療指引 二、修改治療方式 1.侷限型low risk增加± Cryotherapy 2.輔助治療增加± Cryotherapy

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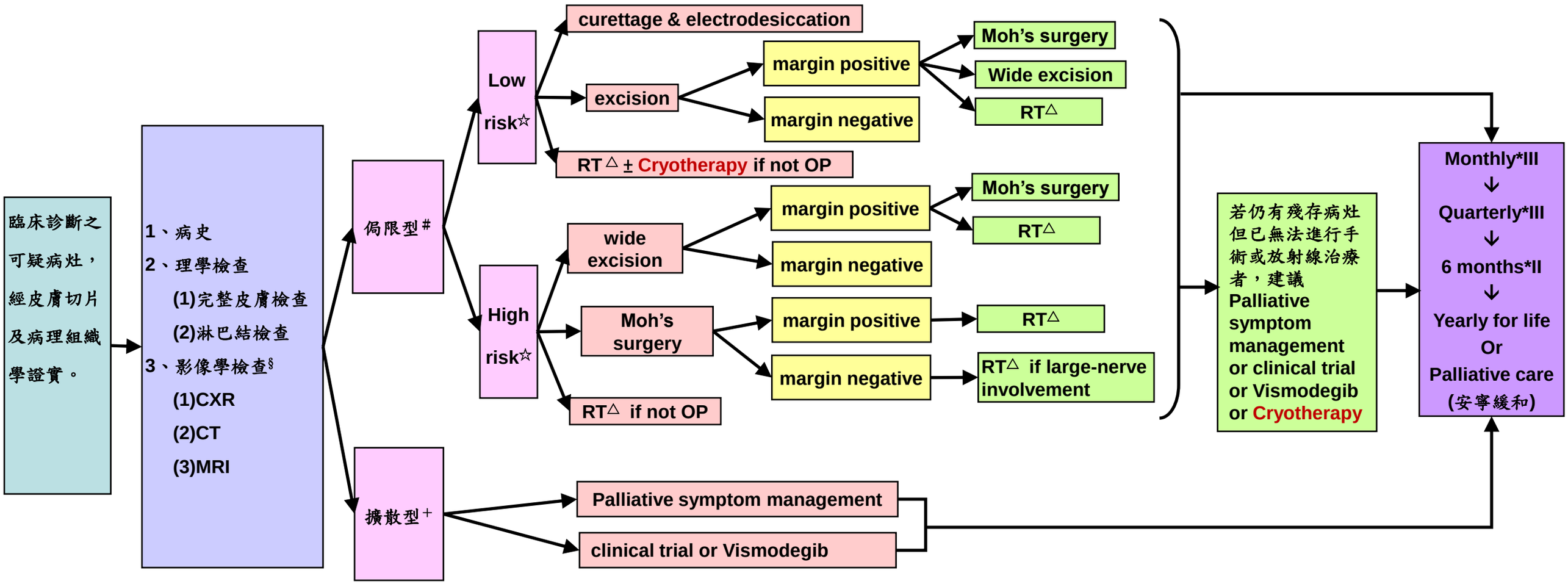
診斷	初步評估	分期	初始治療	療效評估	輔助治療	追蹤



§： 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)

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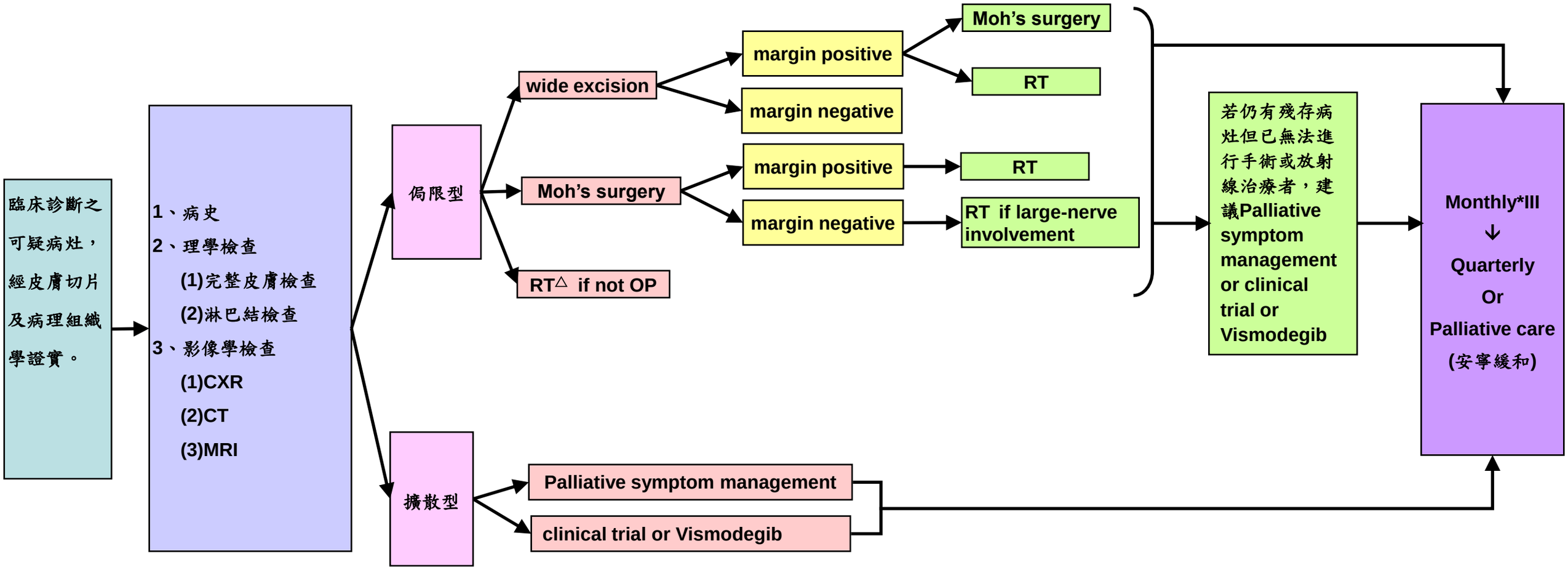
復發



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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。
- 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。

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附件一：

National Comprehensive Cancer Network®

NCCN Guidelines Version 1.2018
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, sclerosing, mixed infiltrative, or micronodular features in any portion of the tumor. In some cases basosquamous tumors may be prognostically similar to SCC; clinicopathologic correlation is recommended in these cases.

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.

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附件二:

PRINCIPLES OF RADIATION THERAPY FOR BASAL CELL SKIN CANCER

Dose and Field Size

Definitive RT	Examples of Electron Beam Dose and Fractionation
Tumor diameter <2 cm	60–64 Gy over 6–7 weeks 50–55 Gy over 3–4 weeks 40 Gy in 2 weeks 30 Gy in 5 fractions over 2–3 weeks
Tumor diameter ≥2 cm, T3/T4, or those with invasion of bone or deep tissue	60–70 Gy over 6–7 weeks 45–55 Gy over 3–4 weeks
Postoperative adjuvant	60–64 Gy over 6–7 weeks 50 Gy over 4 weeks

- Protracted fractionation is associated with improved cosmetic results and should be utilized for poorly vascularized or cartilaginous areas.
- Radiation therapy is contraindicated in genetic conditions predisposing to skin cancer (eg, basal cell nevus syndrome) and relatively contraindicated for patients with connective tissue diseases (eg, scleroderma).
- Given higher complication rates, re-irradiation should not be routinely utilized for recurrent disease within a prior radiation field.
- There are insufficient long-term efficacy and safety data to support the routine use of electronic surface brachytherapy.
- Radioisotope brachytherapy could be considered in highly selected cases.

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.

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臨床診療指引 2018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

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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

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