

# 高雄榮民總醫院

## 皮膚癌(SCC)診療原則

2016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 2016版 診療指引

# SCC診療指引審視修訂會議討論日期

- 上次會議：2015/09/29
- 本共識經審視後與上一版之差異

上一版：

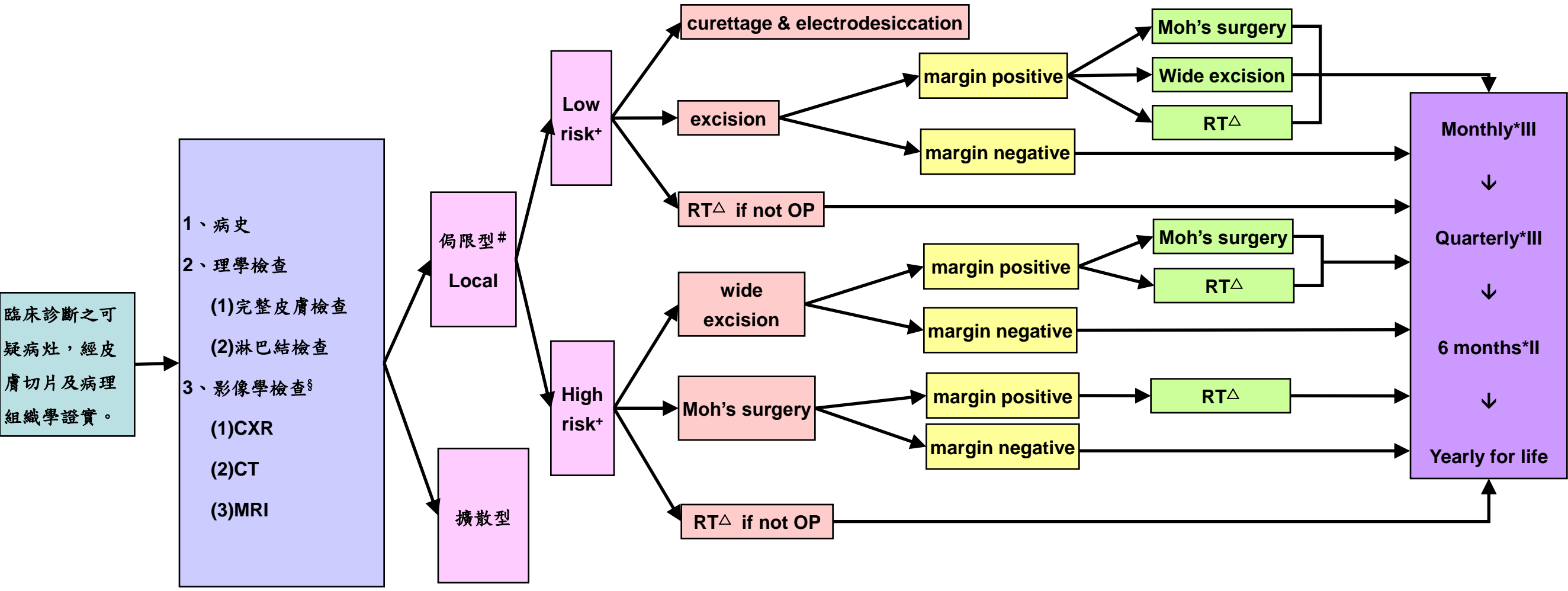
使用NCCN 2015版 診療指引

新版：

更新 NCCN 2016版 診療指引

# 鱗狀上皮細胞癌(SCC)

診斷	初步評估	分期	初始治療	療效評估	輔助治療	追蹤
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§ : Image studies is indicated for extensive disease (deep structural involvement such as bone, deep soft tissue, perineural disease)

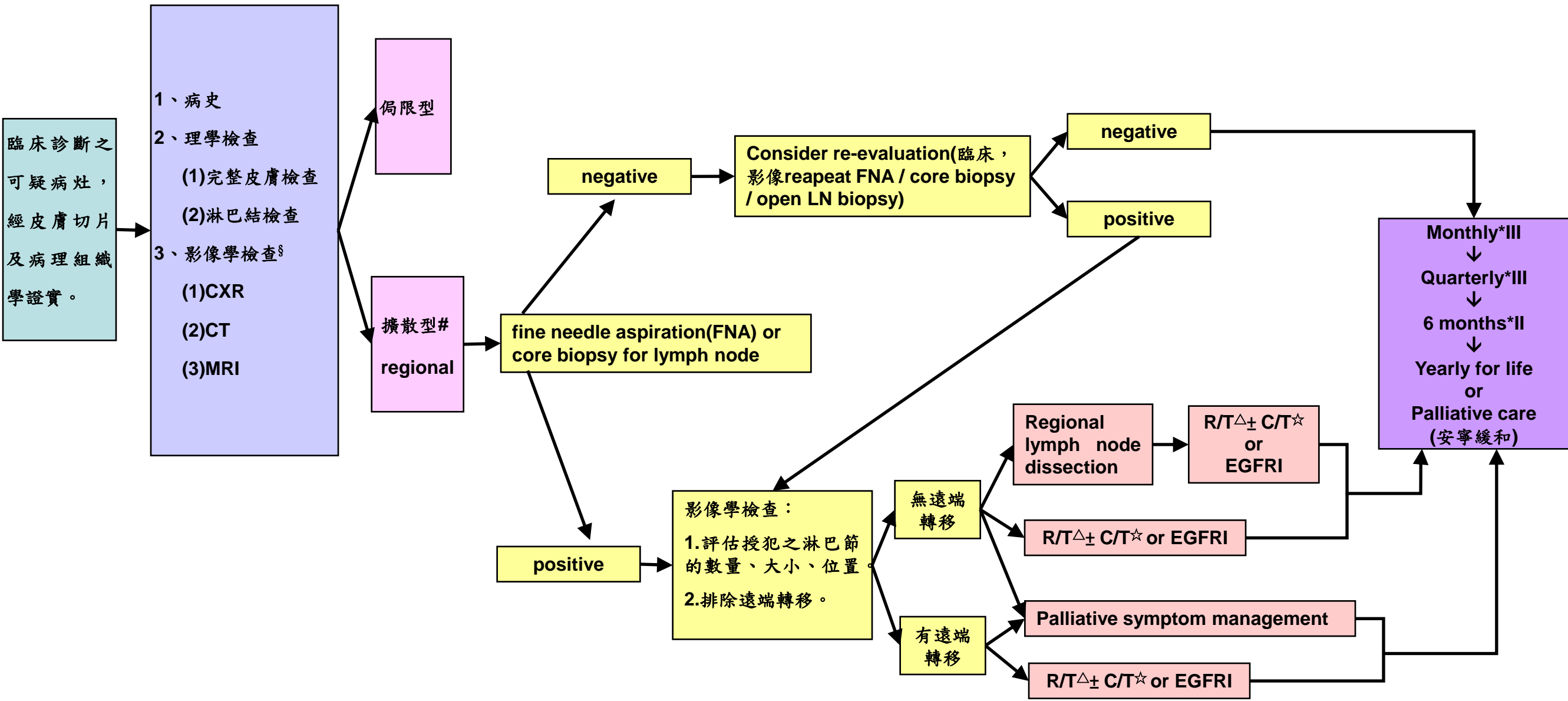
# : T any, N0, M0

△ : RT主要針對手術不適用之情形, 附件二

+ : 附件一

# 鱗狀上皮細胞癌(SCC)

診斷	初步評估	分期	再評估(針對淋巴結)	初步治療	輔助治療	追蹤
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§ : Image studies is indicated for extensive disease (deep structural involvement such as bone, deep soft tissue, perineural disease) if perineural disease is suspected, MRI is preferred.

# : Palpable regional lymph node(s) or abnormal lymph nodes identified by image studies. (擴散型的“初始皮膚病灶”治療同局限型中high risk)  
T any, N1, M0 or M1 (附件三)

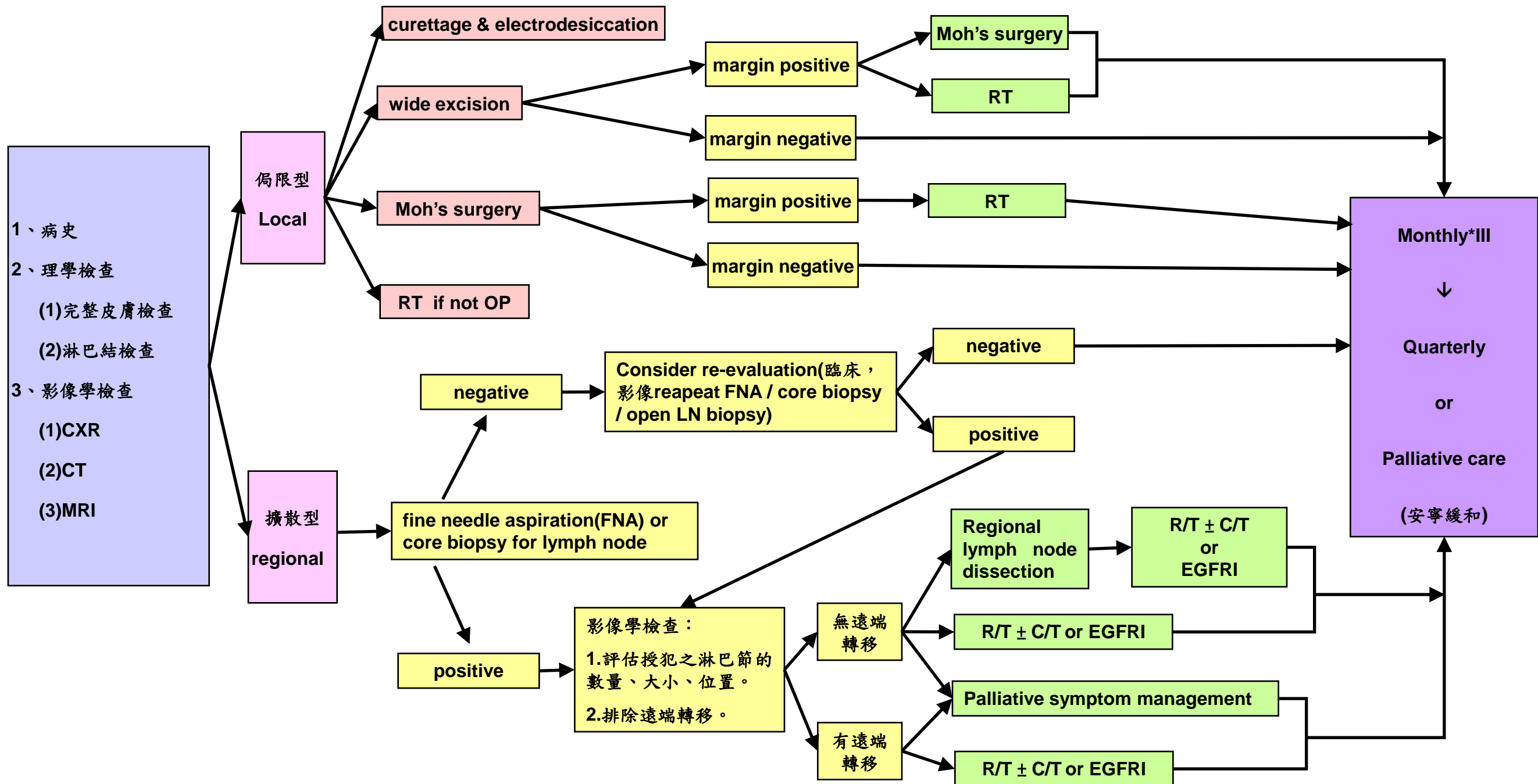
≡ : Palliative symptom management, including salvage C/T

△ : RT主要針對手術不是用之情形, 附件二

☆ : chemotherapy regimen & EGFRi, 附件四

# 鱗狀上皮細胞癌(SCC)

## 復發



# 鱗狀上皮細胞癌(SCC)

## 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

# 鱗狀上皮細胞癌(SCC)\_ regional disease

附件一：



## NCCN Guidelines Version 1.2016 Squamous Cell Skin Cancer

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[Squamous Cell TOC](#)  
[Discussion](#)

### RISK FACTORS FOR LOCAL RECURRENCE OR METASTASES

<u>H&amp;P</u>	<u>Low Risk</u>	<u>High Risk</u>
<b>Location/size<sup>1</sup></b>	Area L <20 mm Area M <10 mm <sup>4</sup> Area H <6 mm <sup>4</sup>	Area L ≥20 mm Area M ≥10 mm Area H ≥6 mm
<b>Borders</b>	Well-defined	Poorly defined
<b>Primary vs. recurrent</b>	Primary	Recurrent
<b>Immunosuppression</b>	(-)	(+)
<b>Site of prior RT or chronic inflammatory process</b>	(-)	(+)
<b>Rapidly growing tumor</b>	(-)	(+)
<b>Neurologic symptoms</b>	(-)	(+)
<u><b>Pathology</b></u>		
<b>Degree of differentiation</b>	Well or moderately differentiated	Poorly differentiated
<b>Adenoid (acantholytic), adenosquamous (showing mucin production), desmoplastic or basosquamous (metatypical) subtypes</b>	(-)	(+)
<b>Depth<sup>2,3</sup>: Thickness or Clark level</b>	<2 mm or I, II, III	≥2 mm or IV, V
<b>Perineural, lymphatic, or vascular involvement</b>	(-)	(+)

<sup>1</sup>Must include peripheral rim of erythema.

<sup>2</sup>If clinical evaluation of incisional biopsy suggests that microstaging is inadequate, consider narrow margin excisional biopsy.

<sup>3</sup>A modified Breslow measurement should exclude parakeratosis or scale crust, and should be made from base of ulcer if present.

<sup>4</sup>Location independent of size may constitute high risk.

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).

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



# 鱗狀上皮細胞癌(SCC)\_ regional disease

附件二:



## NCCN Guidelines Version 1.2016 Squamous Cell Skin Cancer

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### PRINCIPLES OF RADIATION THERAPY FOR SQUAMOUS CELL SKIN CANCER

<u>Primary Tumor</u> <sup>1</sup>	<u>Dose Time Fractionation Schedule</u>
<u>Tumor Diameter</u>	<u>Examples of Dose Fractionation and Treatment Duration</u>
<2 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	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
<b><u>Regional Disease:</u> All doses at 2 Gy per fraction using shrinking field technique</b>	
• After lymph node dissection	
▶ Head and neck; with ECE:	60–66 Gy over 6–6.6 weeks
▶ Head and neck; without ECE:	56 Gy over 5.6 weeks
▶ Axilla, groin; with ECE:	60 Gy over 6 weeks
▶ Axilla, groin; without ECE:	54 Gy over 5.4 weeks
• No lymph node dissection	
▶ Clinically (-) but at risk for subclinical disease:	50 Gy over 5 weeks
▶ Clinically evident adenopathy: head and neck:	66–70 Gy over 6.6–7 weeks
▶ Clinically evident adenopathy: axilla, groin:	66 Gy over 6.6 weeks

ECE= Extracapsular extension

- 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).

<sup>1</sup>Field margins for <2 cm primary tumors should be 1-1.5 cm; for tumors >2 cm, field margins should be 1.5-2 cm. Tighter 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 which achieves adequate surface dose and encompasses the deep margin of the tumor by at least the distal 90% line. 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. If intensity modulated radiation therapy is used to treat primary tumors, appropriate focus must be directed at assuring that there is adequate surface dose. Appropriate medical physics support is essential.

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

# 鱗狀上皮細胞癌(SCC)\_ regional disease

附件三-1:

## Staging

**Table 1**  
American Joint Committee on Cancer (AJCC)  
**TNM Staging Classification for Cutaneous Squamous Cell Carcinoma (cSCC)**  
(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

Used with the permission of the American Joint Committee on Cancer (AJCC), Chicago, Illinois. The original and primary source for this information is the AJCC Cancer Staging Manual, Seventh Edition (2010) published by Springer Science+Business Media, LLC (SBM). (For complete information and data supporting the staging tables, visit [www.springer.com](http://www.springer.com).) Any citation or quotation of this material must be credited to the AJCC as its primary source. The inclusion of this information herein does not authorize any reuse or further distribution without the expressed, written permission of Springer SBM, on behalf of the AJCC.

# 鱗狀上皮細胞癌(SCC)\_ regional disease

附件三-2:



## NCCN Guidelines Version 1.2016 Squamous Cell Skin Cancer

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**Table 1 Continued**

**American Joint Committee on Cancer (AJCC)  
TNM Staging Classification for Cutaneous Squamous Cell  
Carcinoma (cSCC)  
(7th ed., 2010)**

**Anatomic Stage/Prognostic Groups**

<b>Stage 0</b>	Tis	N0	M0
<b>Stage I</b>	T1	N0	M0
<b>Stage II</b>	T2	N0	M0
<b>Stage III</b>	T3	N0	M0
	T1	N1	M0
	T2	N1	M0
<b>Stage IV</b>	T3	N1	M0
	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)**

<b>GX</b>	Grade cannot be assessed
<b>G1</b>	Well differentiated
<b>G2</b>	Moderately differentiated
<b>G3</b>	Poorly differentiated
<b>G4</b>	Undifferentiated

Used with the permission of the American Joint Committee on Cancer (AJCC), Chicago, Illinois. The original and primary source for this information is the AJCC Cancer Staging Manual, Seventh Edition (2010) published by Springer Science+Business Media, LLC (SBM). (For complete information and data supporting the staging tables, visit [www.springer.com](http://www.springer.com).) Any citation or quotation of this material must be credited to the AJCC as its primary source. The inclusion of this information herein does not authorize any reuse or further distribution without the expressed, written permission of Springer SBM, on behalf of the AJCC.

## 附件四-1:chemotherapy regimen

### 化學治療處方

#### chemotherapy regimen

published C/T regimens	schedule
Cisplatin, 100 mg/m <sup>2</sup> IV D1	Q 21-28 days x 4 cycles
5-FU, 1 g/m <sup>2</sup> IV D1-3	Q 21-28 days x 4 cycles
Bleomycin, bolus 16 mg IV D1 + 25 mg/m <sup>2</sup> IV D1-3	Q 21-28 days x 4 cycles

## 附件四-2:chemotherapy regimen & EGFR

### 化學治療處方

### chemotherapy regimen & EGFR

published C/T regimens	schedule
Cisplatin 100 mg/m <sup>2</sup> IV D1	Q 21 days * 6 cycles
5-FU 1 g/m <sup>2</sup> IV D1-4	Q 21 days * 6 cycles
* Cetuximab 400 mg/m <sup>2</sup> ; 250 mg/m <sup>2</sup> IV	400 mg/m <sup>2</sup> * Week 1 ; then 250 mg/m <sup>2</sup> * QW

\* Cetuximab could be continued as long as the response or the stabilization persisted

## 附件四-2:chemotherapy regimen & EGFR

### 化學治療處方

#### chemotherapy regimen & EGFR

published C/T regimens	schedule
Cisplatin 100 mg/m <sup>2</sup> IV D1	Q 21 days * 6 cycles
5-FU 1 g/m <sup>2</sup> IV D1-4	Q 21 days * 6 cycles
* Cetuximab, 400 mg/m <sup>2</sup> IV Week 1, then 250 mg/m <sup>2</sup> QW	Till IV or unacceptable toxicity

\* Cetuximab could be continued as long as the response or the stabilization persisted

## 附件四-3:EGFRI

### 化學治療處方

### EGFRI

**published C/T regimens**

**schedule**

\* **Cetuximab, 400 mg/m<sup>2</sup> IV Week 1, then 250 mg/m<sup>2</sup> QW**

**Till IV or unacceptable toxicity**

\* Cetuximab could be continued as long as the response or the stabilization persisted

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