高 雄 榮 民 總 醫 院

皮膚癌(SCC)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

SCC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:
1.使用NCCN 2016版 診療指引 2.修改Chemotherapy regimen處方用藥	1.更新 NCCN 2017版 診療指引 2.修改Chemotherapy regimen處方用藥 ◆ 刪除Bleomycin藥物

鱗狀上皮細胞癌(SCC)

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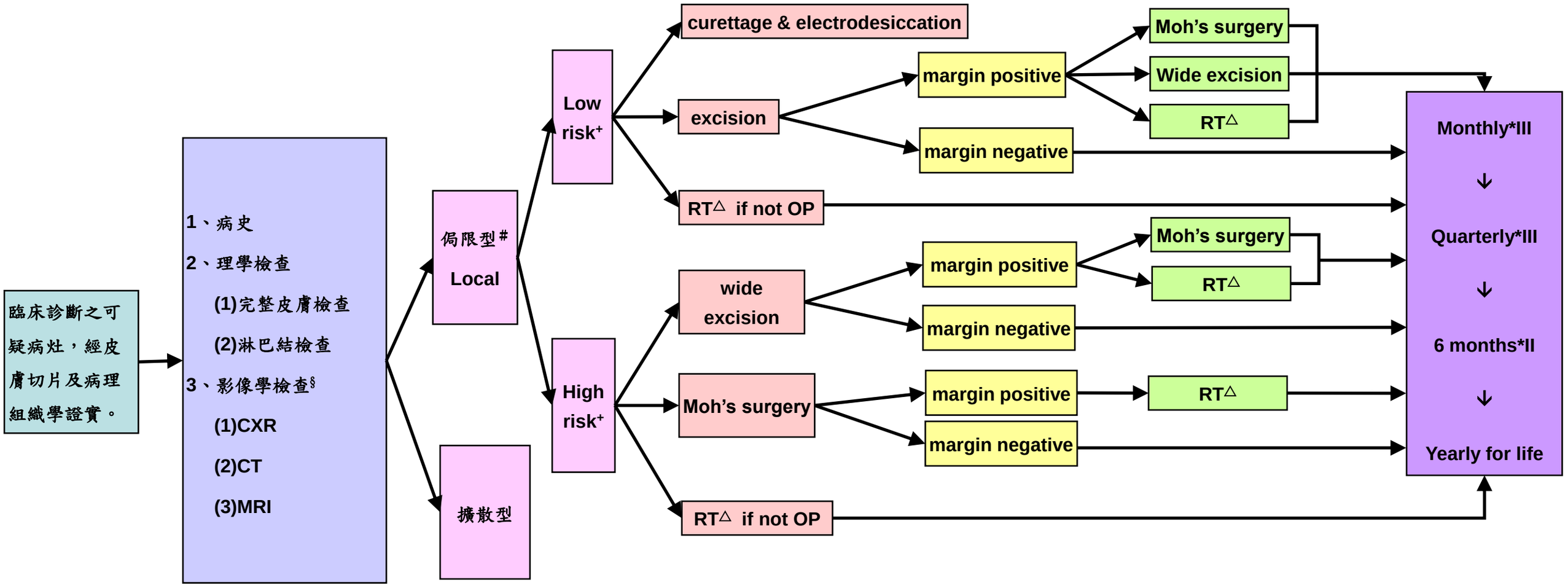
臨床診療指引 2017第一版

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)

＋：附件一

△： RT主要針對手術不適用之情形, 附件二

＃： T any, N0, M0, 附件三

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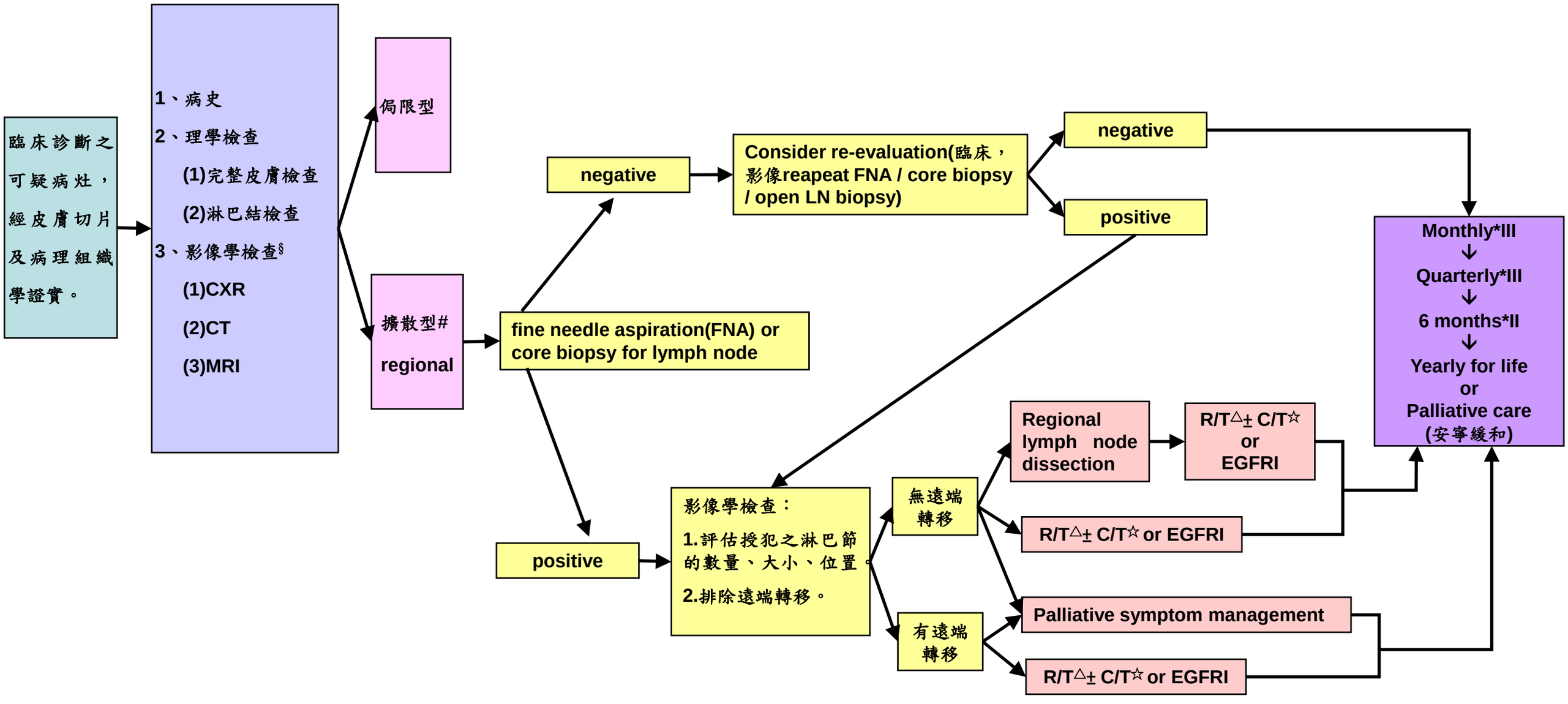
診斷	初步評估	分期	再評估(針對淋巴結)	初步治療	輔助治療	追蹤



§：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.

¥： Palliative symptom management, including salvage C/T

△： RT主要針對手術不是用之情形, 附件二

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

☆ ： chemotherapy regimen & EGFRI, 附件四

鱗狀上皮細胞癌(SCC)

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復發

1、病史
2、理學檢查
(1)完整皮膚檢查
(2)淋巴結檢查
3、影像學檢查
(1)CXR
(2)CT
(3)MRI

侷限型 Local

- curettage & electrodesiccation
- wide excision
  - margin positive
    - Moh's surgery
    - RT
  - margin negative
- Moh's surgery
  - margin positive
    - RT
  - margin negative
- RT if not OP

擴散型 regional

- negative
  - Consider re-evaluation(臨床，影像reapeat FNA / core biopsy / open LN biopsy)
    - negative
    - positive
- fine needle aspiration(FNA) or core biopsy for lymph node
- positive
  - 影像學檢查：
    1.評估授犯之淋巴節的數量、大小、位置。
    2.排除遠端轉移。
    - 無遠端轉移
      - Regional lymph node dissection
        - R/T ± C/T or EGFRI
      - R/T ± C/T or EGFRI
      - Palliative symptom management
    - 有遠端轉移
      - Palliative symptom management
      - R/T ± C/T or EGFRI

Monthly*III
↓
Quarterly
or
Palliative care
(安寧緩和)

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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。
- 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

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附件一：

National Comprehensive Cancer Network®

NCCN Guidelines Version 1.2017
Squamous Cell Skin Cancer

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Discussion

RISK FACTORS FOR LOCAL RECURRENCE OR METASTASES

H&P	Low Risk	High Risk
Location/size[1]	Area L <20 mm	Area L ≥20 mm
	Area M <10 mm[4]	Area M ≥10 mm
		Area H[5]
Borders	Well-defined	Poorly defined
Primary vs. recurrent	Primary	Recurrent
Immunosuppression	(-)	(+)
Site of prior RT or chronic inflammatory process	(-)	(+)
Rapidly growing tumor	(-)	(+)
Neurologic symptoms	(-)	(+)
Pathology		
Degree of differentiation	Well or moderately differentiated	Poorly differentiated
Adenoid (acantholytic), adenosquamous (showing mucin production), desmoplastic, or metaplastic (carcinosarcomatous) subtypes	(-)	(+)
Depth[2,3]: Thickness or Clark level	<2 mm or I, II, III	≥2 mm or IV, V
Perineural, lymphatic, or vascular involvement	(-)	(+)

[1]Must include peripheral rim of erythema.
[2]If clinical evaluation of incisional biopsy suggests that microstaging is inadequate, consider narrow margin excisional biopsy.
[3]A modified Breslow measurement should exclude parakeratosis or scale crust, and should be made from base of ulcer if present.
[4]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).

[5]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.

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.

鱗狀上皮細胞癌(SCC)_ regional disease

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附件二:

National Comprehensive Cancer Network®

NCCN Guidelines Version 1.2017
Squamous Cell Skin Cancer

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PRINCIPLES OF RADIATION THERAPY FOR SQUAMOUS CELL SKIN CANCER

Primary Tumor		Dose Time Fractionation Schedule
Tumor Diameter	Margins[1]	Examples of Dose Fractionation and Treatment Duration[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
Regional Disease: All doses at 2 Gy per fraction using shrinking field technique		
• 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).
- There are 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. If intensity-modulated radiation therapy is used to treat primary tumors, appropriate focus must be directed at assuring that there is adequate surface dose.

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附件三-1:

National Comprehensive Cancer Network®

NCCN Guidelines Version 1.2017 Staging Squamous Cell Skin Cancer

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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

Continue

鱗狀上皮細胞癌(SCC)_ regional disease

附件三-2:

National Comprehensive Cancer Network®

NCCN Guidelines Version 1.2017 Staging 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

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

附件四-1:chemotherapy regimen

化學治療處方

chemotherapy regimen	
published C/T regimens	schedule
Cisplatin, 100 mg/m2 IV D1	Q 21-28 days x 4 cycles
5-FU, 1 g/m2 IV D1–3	Q 21-28 days x 4 cycles
~~Bleomycin, bolus 16 mg IV D1 + 25 mg/m2 IV D1–3~~	~~Q 21-28 days x 4 cycles~~

附件四-2:chemotherapy regimen & EGFRI

化學治療處方

chemotherapy regimen & EGFRI	
published C/T regimens	**schedule**
Cisplatin 100 mg/m2 IV D1	**Q 21 days * 6 cycles**
5-FU 1 g/m2 IV D1-4	**Q 21 days * 6 cycles**
*** Cetuximab 400 mg/m2 ; 250 mg/m2 IV**	**400 mg/m2 * Week 1； then 250 mg/m2 * QW**

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

附件四-2:chemotherapy regimen & EGFRI

化學治療處方

chemotherapy regimen & EGFRI	
published C/T regimens	**schedule**
Cisplatin 100 mg/m2 IV D1	**Q 21 days * 6 cycles**
5-FU 1 g/m2 IV D1-4	**Q 21 days * 6 cycles**
*** Cetuximab, 400 mg/m2 IV Week 1, then 250 mg/m2 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/m2 IV Week 1, then 250 mg/m2 QW**	**Till IV or unacceptable toxicity**

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

Reference

1. NCCN Clinical Practice Guideline in Oncology, Basal and Squamous Cell Skin Cancers, Version 2.2017
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