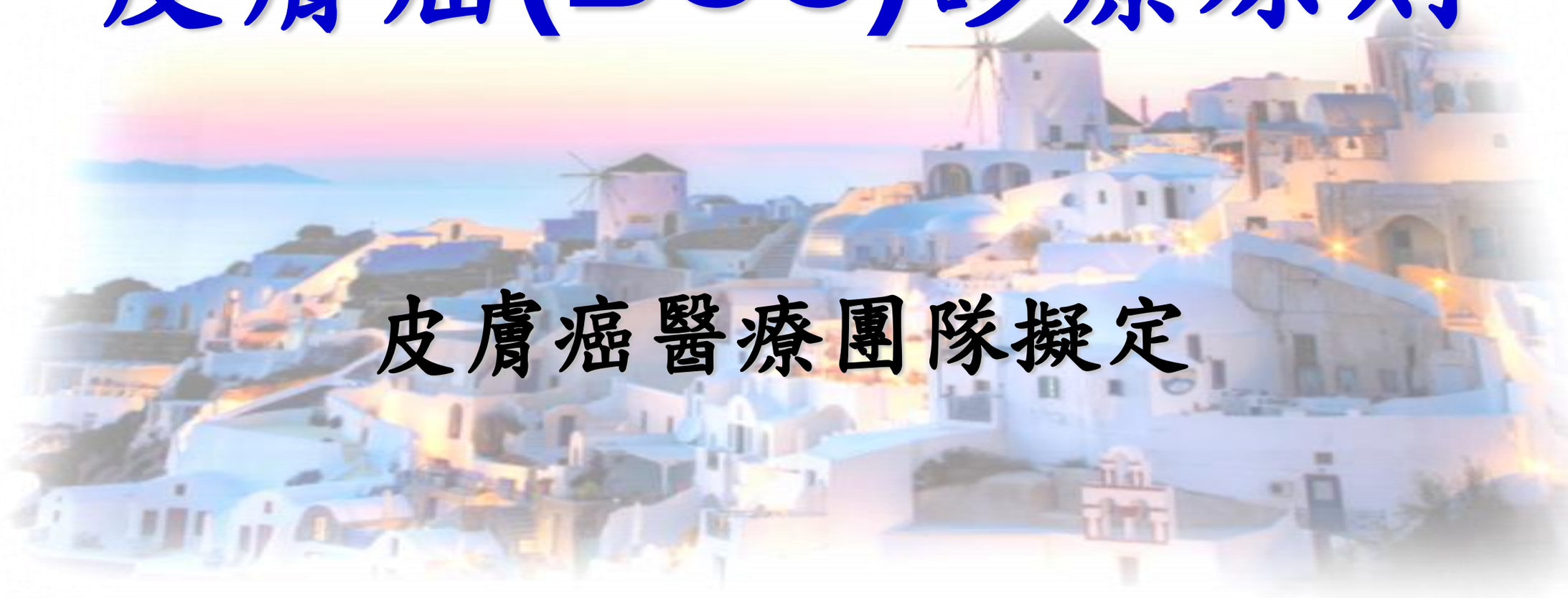
高雄榮民總醫院

皮膚癌(BCC)診療原則



皮膚癌醫療團隊擬定

Reference: NCCN Clinical Practice Guideline in OncologyTM ,Skin cancer, V.1.2015

基底細胞癌(BCC)

高雄榮民總醫院
臨床診療指引 2015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

臨床診斷之可疑病灶，經皮膚切片及病理組織學證實。

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#

Low risk☆
- curettage & electrodesiccation
- excision
  - margin positive
    - Moh's surgery
    - Wide excision
    - RT△
  - margin negative
- RT△ if not OP

High risk☆
- wide excision
  - margin positive
    - Moh's surgery
    - RT△
  - margin negative
- Moh's surgery
  - margin positive
    - RT△
  - margin negative
    - RT△ if large-nerve involvement
- RT△ if not OP

擴散型+
- Palliative symptom management
- clinical trial or Vismodegib

若仍有殘存病灶但已無法進行手術或放射線治療者，建議
Palliative symptom management
or clinical trial
or Vismodegib

Monthly*III
↓
Quarterly*III
↓
6 months*II
↓
Yearly for life
Or
Palliative care
(安寧緩和)

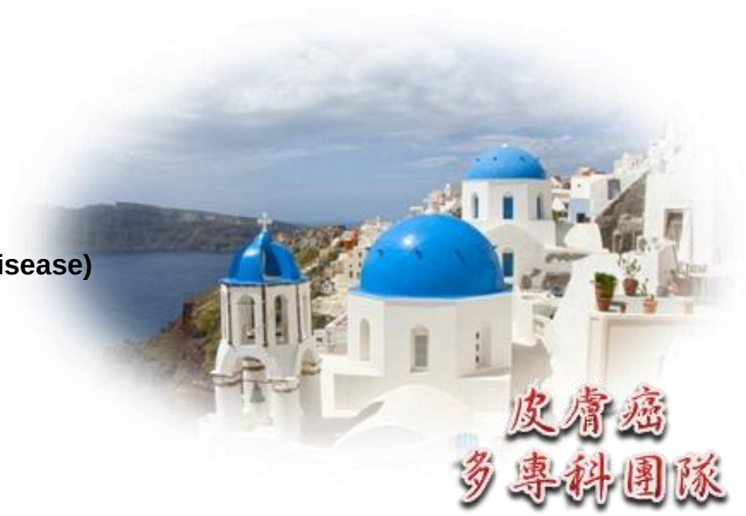
§： Image studies is indicated for extensive disease (deep structural involvement such as bone, deep soft tissue, perineural disease)

#： T any, N0, M0(附件三)

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

☆：附件一

△：附件二



基底細胞癌(BCC)

高雄榮民總醫院
臨床診療指引 2015第一版

復發

臨床診斷之可疑病灶，經皮膚切片及病理組織學證實。

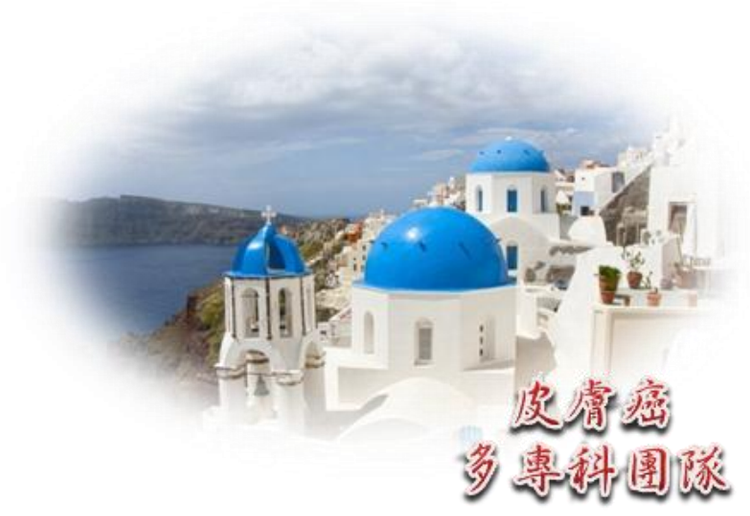
1、病史
2、理學檢查
(1)完整皮膚檢查
(2)淋巴結檢查
3、影像學檢查
(1)CXR
(2)CT
(3)MRI

侷限型
- wide excision
  - margin positive
    - Moh's surgery
    - RT
  - margin negative
- Moh's surgery
  - margin positive
    - RT
  - margin negative
    - RT if large-nerve involvement
- RT△ if not OP

擴散型
- Palliative symptom management
- clinical trial or Vismodegib

若仍有殘存病灶但已無法進行手術或放射線治療者，建議Palliative symptom management or clinical trial or Vismodegib

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



基底細胞癌(BCC)

高雄榮民總醫院
臨床診療指引　2015第一版

附件一：

National Comprehensive Cancer Network®

NCCN Guidelines Version 1.2015
Basal Cell Skin Cancer

NCCN Guidelines Index
Basal Cell TOC
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	Area M ≥10 mm
	Area H <6 mm[1]	Area H ≥6 mm[1]
Borders	Well defined	Poorly defined
Primary vs. Recurrent	Primary	Recurrent
Immunosuppression	(-)	(+)
Site of prior RT	(-)	(+)
Pathology		
Subtype	Nodular,[2] superficial	Aggressive growth pattern[3]
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 in certain clinical settings.
[2]Low risk histologic subtypes include nodular, superficial and other non-agressive growth patterns such as keratotic, infundibulocystic, and fibroepithelioma of Pinkus.
[3]Having morpheaform, basosquamous (metatypical), sclerosing, mixed infiltrative, or micronodular features in any portion of the tumor.

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.

基底細胞癌(BCC)

高雄榮民總醫院
臨床診療指引 2015第一版

附件二:

National Comprehensive Cancer Network®

NCCN Guidelines Version 1.2015
Basal Cell Skin Cancer

NCCN Guidelines Index
Basal Cell TOC
Discussion

PRINCIPLES OF RADIATION THERAPY FOR BASAL CELL SKIN CANCER

Dose and Field Size

Tumor Diameter	Margins	Examples of Electron Beam Dose and Fractionation
<2 cm	1–1.5 cm[1]	64 Gy in 32 fractions over 6–6.4 weeks[2] 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[1]	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)

[1]When using electron beam, wider field margins are necessary than with orthovoltage x-rays due to the wider beam penumbra. 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. 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 cancer patient 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 2015第一版

附件三-1:

NCCN 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 2015第一版

附件三-2:

NCCN National Comprehensive Cancer Network®

NCCN Guidelines Version 1.2014
Basal and Squamous Cell Skin Cancers

NCCN Guidelines Index
Basal and Squamous Cell TOC
Discussion

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 2.2014
2. Rubin AI, Chen EH, Ratner D. Basal-cell carcinoma. N Engl J Med 2005;353:2262-2269.
3. Basal cell carcinoma. Identification and treatment of the high-risk patient. Dermatol Surg 1996;22:255-261.
4. Lott DG, Manz R, Koch C, Lorenz RR. Aggressive behavior of nonmelanotic skin cancers in solid organ transplant recipients. Transplantation 2010;90:683-687.
5. Pack GT, Davis J. RADIATION CANCER OF THE SKIN. Radiology 1965;84:436-442.
6. 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.
7. Basosquamous carcinoma. J Am Acad Dermatol 2009;60:137-143.
8. Bath-Hextall F, Bong J, Perkins W, Williams H. Interventions for basal cell carcinoma of the skin: systematic review. BMJ 2004;329:705.
9. Neville JA, Welch E, Leffell DJ. Management of nonmelanoma skin cancer in 2007. Nat Clin Pract Oncol 2007;4:462-469.
10. 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.
11. Wolf DJ, Zitelli JA. Surgical margins for basal cell carcinoma. Arch Dermatol 1987;123:340-344.
12. 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.
13. 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.
14. 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.
15. 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.