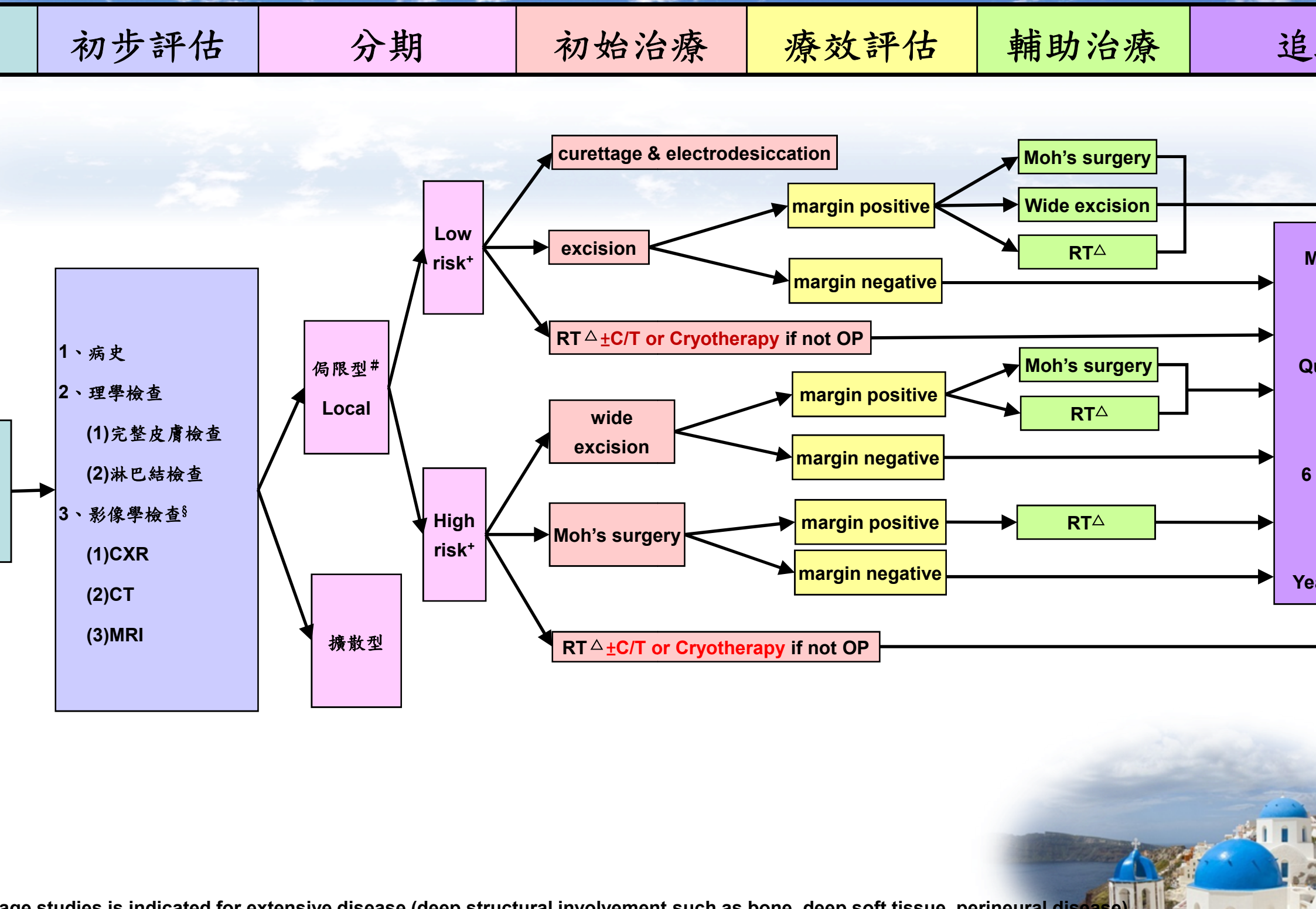
高雄榮民總醫院

皮膚癌(SCC、Keratoacanthoma)

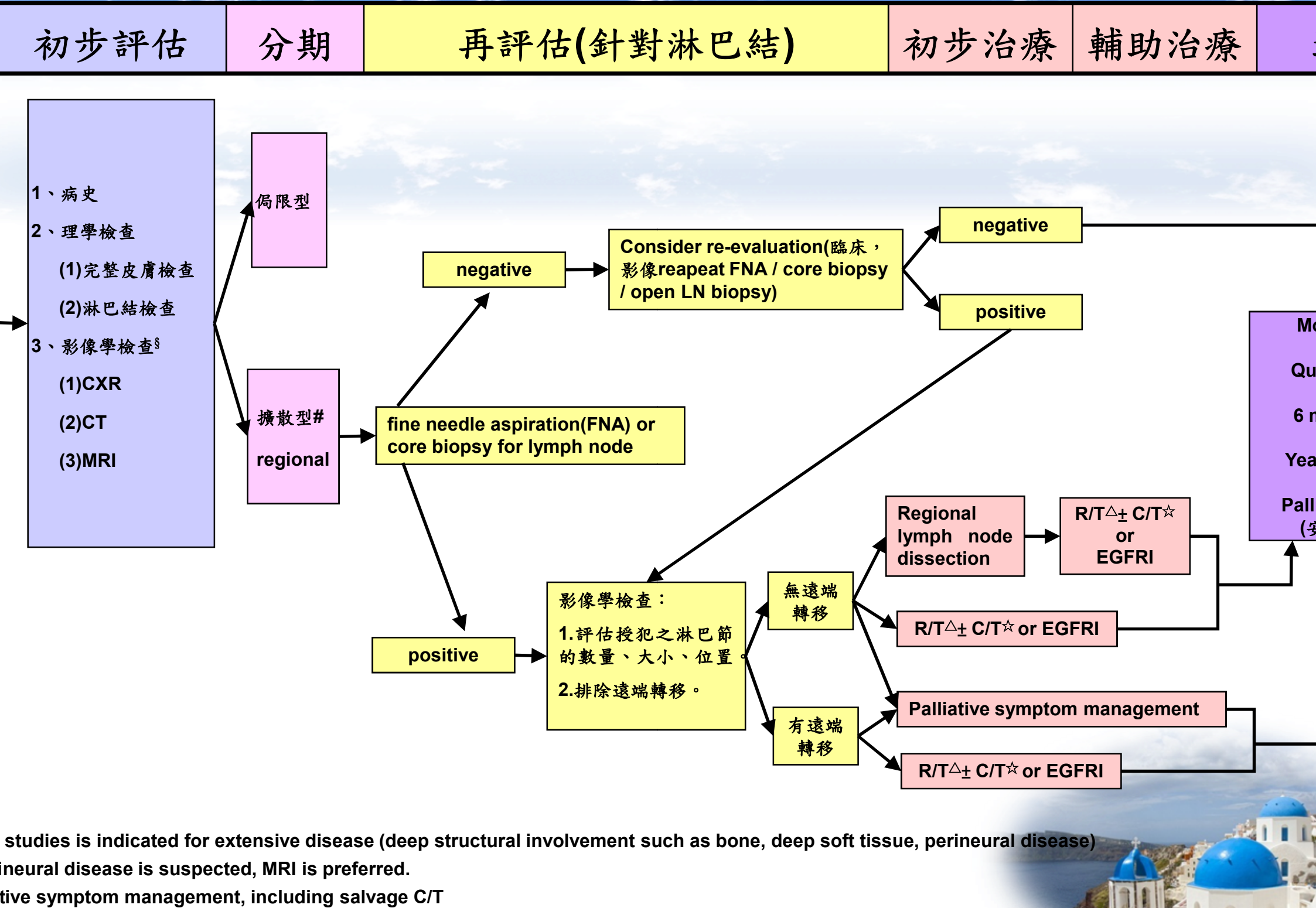
診療原則

SCC診療指引審視修訂會議討論日期

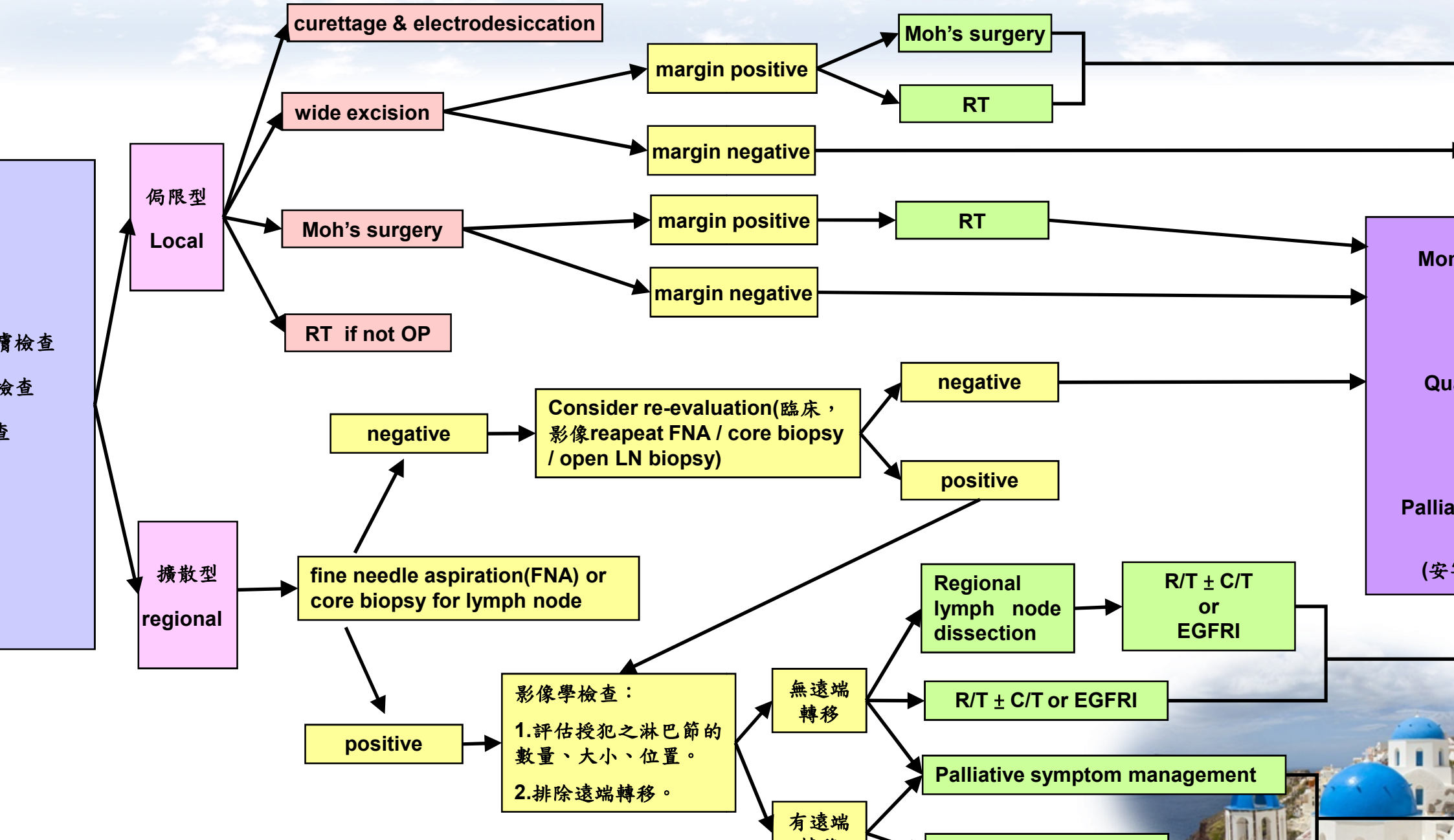
- 前次會議：2019/02/19
- 本共識經審視後與上一版之差異



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


初步評估
分期
再評估(針對淋巴結)
初步治療
輔助治療
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
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
有遠端轉移
Regional lymph node dissection
R/T△± C/T☆ or EGFRI
R/T△± C/T☆ or EGFRI
Palliative symptom management
R/T△± C/T☆ or EGFRI
studies is indicated for extensive disease (deep structural involvement such as bone, deep soft tissue, perineural disease)
ineural disease is suspected, MRI is preferred.
tive symptom management, including salvage C/T

復發


curettage & electrodesiccation
wide excision
margin positive
Moh's surgery
RT
margin negative
侷限型
Local
Moh's surgery
margin positive
RT
margin negative
RT if not OP
negative
Consider re-evaluation(臨床，影像reapeat FNA / core biopsy / open LN biopsy)
negative
positive
擴散型
regional
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
有遠端
Regional lymph node dissection
R/T ± C/T or EGFRI
R/T ± C/T or EGFRI
Palliative symptom management

癌症藥物停藥準則

據CTCAE (Common Terminology Criteria for Adverse Events, Version 4.

blished: May 28, 2009【v4.03: June 14, 2010】)，出現Grade 3 ~ Grade 4

verse event。

藥至adverse event回復至Grade 1或Baseline時可再次用藥，但有些患者必須

用藥劑量。

用BRAF inhibitor時可能產生cutaneous SCC。此現象雖被CTCAE列為Grad

xic effect, 但此現象不必停藥或調整劑量。

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

慮停止投藥並選擇其他治療方法)。

患要求 (Hospice care或其他因素)。

National Comprehensive Cancer Network®

NCCN Guidelines Version 2.2019
Squamous Cell Skin Cancer

NCCN Guidelines Index
Table of Contents
Discussion

RISK FACTORS FOR LOCAL RECURRENCE OR METASTASES

	Low Risk	High Risk
H&P		
Location/size[1]	Area L <20 mm Area M <10 mm[4]	Area L ≥20 mm 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 (See SCC-A)		
Degree of differentiation	Well or moderately differentiated	Poorly differentiated
Acantholytic (adenoid), adenosquamous (showing mucin production), desmoplastic, or metaplastic (carcinosarcomatous) subtypes	(-)	(+)
Depth[2,3]: Thickness or level of invasion	≤6 mm and no invasion beyond subcutaneous fat	>6 mm or invasion beyond subcutaneous fat
Perineural, lymphatic, or vascular 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 hands, nail units, pretibia, ankles, feet).

[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]Deep invasion is defined as invasion beyond the subcutaneous fat OR >6 mm (as measured from the granular layer of adjacent normal epidermis to the base of the tumor, consistent with AJCC 8th edition).
[4]Location independent of size may constitute high risk.
[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

PRINCIPLES OF RADIATION THERAPY FOR SQUAMOUS CELL SKIN CANCER

General Principles

- Protracted fractionation is associated with improved cosmetic results and should be utilized for poorly vascularized or cartilaginous areas.
- For extensive perineural invasion, clinically evident perineural involvement, or involvement of named nerves (particularly in the head and neck region): consider including the course of the local nerves proximally.
- 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.

General Treatment Information

	Examples of Dose Fractionation and Treatment Duration
Primary Tumor	
Definitive RT	
Tumor diameter <2 cm	60–64 Gy over 6 to 7 weeks 50–55 Gy over 3 to 4 weeks 40 Gy over 2 weeks 30 Gy in 5 fractions over 2 to 3 weeks
Tumor diameter ≥2 cm, T3/T4, or those with invasion of bone or deep tissue	60–70 Gy over 6 to 7 weeks 45–55 Gy over 3 to 4 weeks
Postoperative Adjuvant	60–64 Gy over 6 to 7 weeks 50 Gy over 4 weeks
Regional Disease	
• Lymph node regions, after lymph node dissection	
▸ Negative margins, no ECE	50–60 Gy over 5 to 6 weeks
▸ Positive margins or ECE	60–66 Gy over 6 to 7 weeks
• Lymph node regions, without lymph node dissection	
▸ Clinically negative, at risk	50 Gy over 5 weeks
▸ Clinically positive	60–70 Gy over 6 to 7 weeks
• Clinically at-risk nerves	50–60 Gy over 5 to 6 weeks

ECE = Extracapsular extension

三-1.

National Comprehensive Cancer Network®

NCCN Guidelines Version 2.2019
Squamous Cell Skin Cancer

NCCN Guidelines Index
Table of Contents
Discussion

American Joint Committee on Cancer (AJCC)
TNM Staging Classification for Cutaneous Squamous Cell Carcinoma of the Head and Neck (cSCC) (8th ed., 2017)

Table 1. **Definitions for T, N, M**

T	Primary Tumor
TX	Primary tumor cannot be assessed
Tis	Carcinoma *in situ*
T1	Tumor smaller than 2 cm in greatest dimension
T2	Tumor 2 cm or larger, but smaller than 4 cm in greatest dimension
T3	Tumor 4 cm or larger in maximum dimension or minor bone erosion or perineural invasion or deep invasion*
T4	Tumor with gross cortical bone/marrow, skull base invasion and/or skull base foramen invasion
T4a	Tumor with gross cortical bone/marrow invasion
T4b	Tumor with skull base invasion and/or skull base foramen involvement

*Deep invasion is defined as invasion beyond the subcutaneous fat or >6 mm (as measured from the granular layer of adjacent normal epidermis to the base of the tumor); perineural invasion for T3 classification is defined as tumor cells within the nerve sheath of a nerve lying deeper than the dermis or measuring 0.1 mm or larger in caliber, or presenting with clinical or radiographic involvement of named nerves without skull base invasion or transgression.

Clinical N (cN)

cN	Regional Lymph Nodes
NX	Regional lymph nodes cannot be assessed
N0	No regional lymph node metastasis
N1	Metastasis in a single ipsilateral lymph node, 3 cm or smaller in greatest dimension and ENE(−)
N2	Metastasis in a single ipsilateral node larger than 3 cm but not larger than 6 cm in greatest dimension and ENE(−); or metastases in multiple ipsilateral lymph nodes, none larger than 6 cm in greatest dimension and ENE(−); or in metastasis in bilateral or contralateral lymph nodes, none larger than 6 cm in greatest dimension and ENE(−)
N2a	Metastasis in a single ipsilateral node larger than 3 cm but not larger than 6 cm in greatest dimension and ENE(−)
N2b	Metastasis in multiple ipsilateral nodes, none larger than 6 cm in greatest dimension and ENE(−)
N2c	Metastasis in bilateral or contralateral lymph nodes, none larger than 6 cm in greatest dimension and ENE(−)
N3	Metastasis in a lymph node larger than 6 cm in greatest dimension and ENE(−); or metastasis in any node(s) and clinically overt ENE [ENE(+)]
N3a	Metastasis in a lymph node larger than 6 cm in greatest dimension and ENE(−)
N3b	Metastasis in any node(s) and ENE (+)

Note: A designation of "U" or "L" may be used for any N category to indicate metastasis above the lower border of the cricoid (U) or below the lower border of the cricoid (L). Similarly, clinical and pathological extranodal extension (ENE) should be recorded as ENE(−) or ENE(+).

三-2:

National Comprehensive Cancer Network®

NCCN Guidelines Version 2.2019
Squamous Cell Skin Cancer

NCCN Guidelines Index
Table of Contents
Discussion

American Joint Committee on Cancer (AJCC)
TNM Staging Classification for Cutaneous Squamous Cell Carcinoma of the Head and Neck (cSCC) (8th ed., 2017)

Pathological N (pN)

pN	Regional Lymph Nodes
NX	Regional lymph nodes cannot be assessed
N0	No regional lymph node metastasis
N1	Metastasis in a single ipsilateral lymph node, 3 cm or smaller in greatest dimension and ENE(−)
N2	Metastasis in a single ipsilateral lymph node, 3 cm or smaller in greatest dimension and ENE(+); or larger than 3 cm but not larger than 6 cm in greatest dimension and ENE(−); or metastases in multiple ipsilateral lymph nodes, none larger than 6 cm in greatest dimension and ENE(−); or in bilateral or contralateral lymph node(s), none larger than 6 cm in greatest dimension, ENE(−)
N2a	Metastasis in single ipsilateral node 3 cm or smaller in greatest dimension and ENE(+); or a single ipsilateral node larger than 3 cm but not larger than 6 cm in greatest dimension and ENE(−)
N2b	Metastasis in multiple ipsilateral nodes, none larger than 6 cm in greatest dimension and ENE(−)
N2c	Metastasis in bilateral or contralateral lymph node(s), none larger than 6 cm in greatest dimension and ENE(−)
N3	Metastasis in a lymph node larger than 6 cm in greatest dimension and ENE(−); or in a single ipsilateral node larger than 3 cm in greatest dimension and ENE(+); or multiple ipsilateral, contralateral, or bilateral nodes, any with ENE(+); or a single contralateral node of any size and ENE(+)
N3a	Metastasis in a lymph node larger than 6 cm in greatest dimension and ENE(−)
N3b	Metastasis in a single ipsilateral node larger than 3 cm in greatest dimension and ENE(+); or multiple ipsilateral, contralateral, or bilateral nodes, any with ENE(+); or a single contralateral node of any size and ENE(+)

Note: A designation of "U" or "L" may be used for any N category to indicate metastasis above the lower border of the cricoid (U) or below the lower border of the cricoid (L). Similarly, clinical and pathological extranodal extension (ENE) should be recorded as ENE(−) or ENE(+).

M	Distant Metastasis
M0	No distant metastasis
M1	Distant metastasis

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

Table 2. **AJCC Prognostic Stage Groups**

	T	N	M
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
	Any T	N3	M0
	T4	Any N	M0
	Any T	Any N	M1

四-1:chemotherapy regimen or metastasis

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**

四-2:chemotherapy regimen & EGFRI or metastasis

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 * Q**

uximab could be continued as long as the response or the stabilization persisted

四-2:chemotherapy regimen & EGFRI or metastasis

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

etuximab could be continued as long as the response or the stabilization persisted

四-3:EGFRI or metastasis

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**

etuximab could be continued as long as the response or the stabilization persisted

N Clinical Practice Guideline in Oncology, Basal and Squamous Cell Skin Cancers, Version 2.2019

Clin Dermatol. 2016 Oct;17(5):491-508. Cutaneous Squamous Cell Carcinoma: A Review of High-Risk and Metastatic Disease.

enhall WM, Ferlito A, Takes RP, et al. Cutaneous head and neck basal and squamous cell carcinomas with perineural invasion. Oral Onc

48:918-922.

dutt VV, Genden EM. Cutaneous squamous cell carcinoma of the head and neck. J Skin Cancer 2011;2011:502723.

e II study of cetuximab as first-line single-drug therapy in patients with unresectable squamous cell carcinoma of the skin. J Clin Oncol. 20

25):3419-26

G, Manz R, Koch C, Lorenz RR. Aggressive behavior of nonmelanotic skin cancers in solid organ transplant recipients. Transplantation

90:683-687.

mer LD, Engelhardt C, Morgan SS. Treatment of unresectable and metastatic cutaneous squamous cell carcinoma. Oncologist 2010;15:1

sch KD, Meisner C, Schonfisch B, et al. Analysis of risk factors determining prognosis of cutaneous squamous-cell carcinoma: a prospect

et Oncol 2008;9:713-720.

um-Based Chemotherapy plus Cetuximab in Head and Neck Cancer.N Engl J Med 2008;359:1116-27.Neville JA, Welch E, Leffell DJ.Mar

nmelanoma skin cancer in 2007. Nat Clin Pract Oncol 2007;4:462-469.

mous cell carcinoma developing on burn scar. Ann Plast Surg 2006;56:406-408.

AS, Schmults CD. Sentinel lymph node biopsy in cutaneous squamous cell carcinoma: a systematic review of the English literature. Der

2006;32:1309-1321.

ss MJ, Morgan GJ, Palme CE, Gebski V. Surgery and adjuvant radiotherapy in patients with cutaneous head and neck squamous cell car

static to lymph nodes: combined treatment should be considered best practice. Laryngoscope 2005;115:870-875.