

高雄榮民總醫院

皮膚癌(SCC、Keratoacanthoma)

診療原則

修訂日期: 2025. 05. 20

SCC診療指引審視修訂會議討論日期

● 前次會議：2024/05/14

上一版	新版
NCCN Guidelines 2024年版	更換附件為:NCCN Guidelines 2025年版



鱗狀上皮細胞癌(SCC、Keratoacanthoma)

診斷

初步評估

分期

初始治療

療效評估

輔助治療

追蹤

Standard 4-6 mm clinical margin
High risk 應更寬

超過真皮要切除

curettage & electrodesiccation

excision

RT Δ \pm C/T or Cryotherapy if not OP

wide excision

Moh's surgery

RT Δ \pm C/T or Cryotherapy if not OP

Moh's surgery

Wide excision

RT Δ

Moh's surgery

RT Δ

RT Δ

Monthly*III

Quarterly*III

6 months*II

Yearly for life

- 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

局限型#
Local

擴散型

Low risk+

High risk+

margin positive

margin negative

margin positive

margin negative

margin positive

margin negative

臨床診斷之可疑病灶，經皮膚切片及病理組織學證實。

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

+ : 附件一

Δ : RT主要針對手術不適用之情形, 附件二

: T any, N0, M0, 附件三



皮膚癌
多專科團隊



STRATIFICATION TO DETERMINE TREATMENT OPTIONS AND FOLLOW-UP FOR LOCAL CSCC BASED ON RISK FACTORS FOR LOCAL RECURRENCE, METASTASES, OR DEATH FROM DISEASE

Risk Group ^a	Low Risk	High Risk	Very High Risk
Treatment options	SCC-3	SCC-4	SCC-4 and SCC-5
H&P			
Location/diameter (cm)	Trunk, extremities ≤2 cm	Trunk, extremities >2 cm – ≤4 cm	>4 cm (any location)
Clinical borders	Well-defined	Poorly-defined	頭頸/手足/pretibia/肛生殖區 = 高風險 (與大小無關)
Primary vs. recurrent	Primary	Recurrent	
Immunosuppression	(-)	(+)	
Site of prior RT or chronic inflammation	(-)	(+)	
Rapidly growing tumor	(-)	(+)	
Neurologic symptoms	(-)	(+)	
Pathology (SCC-A)			
Degree of differentiation	Well or moderately differentiated		Poor differentiated
Histologic subtype ^b	(-)	(+)	(+)
Depth ^{c,d} : Thickness or level of invasion	<2 mm thick and no invasion beyond subcutaneous fat	2–6 mm depth and no invasion beyond subcutaneous fat	>6 mm or invasion beyond subcutaneous fat
>6 mm 或出脂肪 = 極高風險			Tumor cells within the nerve sheath of a nerve lying deeper than the dermis or measuring ≥0.1 mm
Perineural involvement	(-)	(+)	
Lymphatic or vascular involvement	(-)	(-)	(+)

^a Risk category assignment should be based on the highest risk factor present. The high-risk group has elevated risk of local recurrence; the very-high-risk group has elevated risk of local recurrence and elevated risk of metastasis.

^b Acantholytic (adenoid), adenosquamous, metaplastic (carcinosarcomatous), or desmoplastic subtypes in any portion of the tumor.

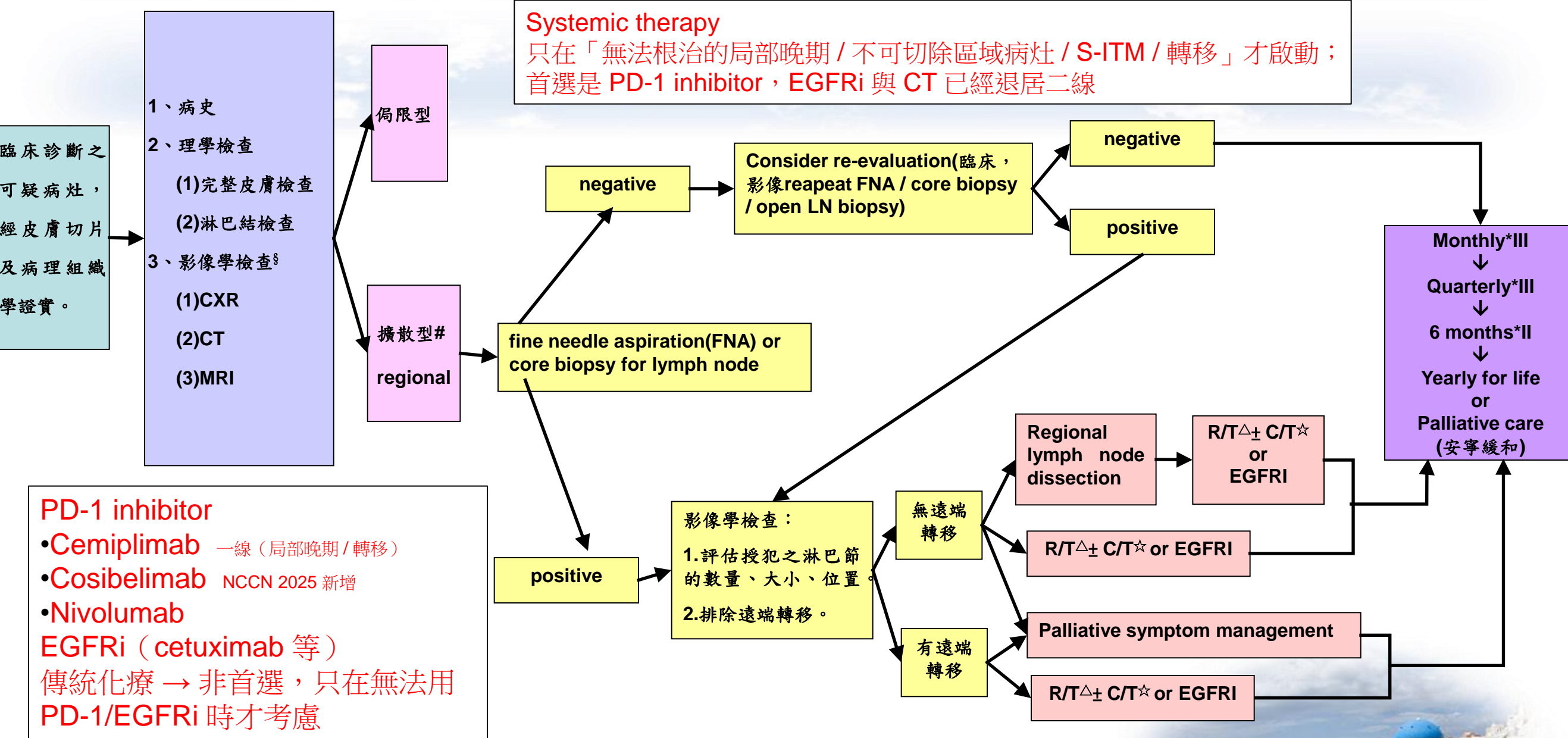
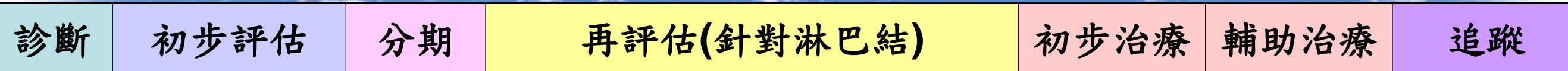
^c If clinical evaluation of incisional biopsy suggests that microstaging is inadequate, consider narrow margin excisional biopsy.

^d 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 the AJCC Cancer Staging Manual, 8th Edition).

^e Narrow excision margins due to anatomic and functional constraints are associated with increased recurrence rates with standard histologic processing. Complete margin assessment with Mohs/PDEMA is recommended. For tumors <6 mm in size, without other high-risk or very-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.

鱗狀上皮細胞癌(SCC、Keratoacanthoma)

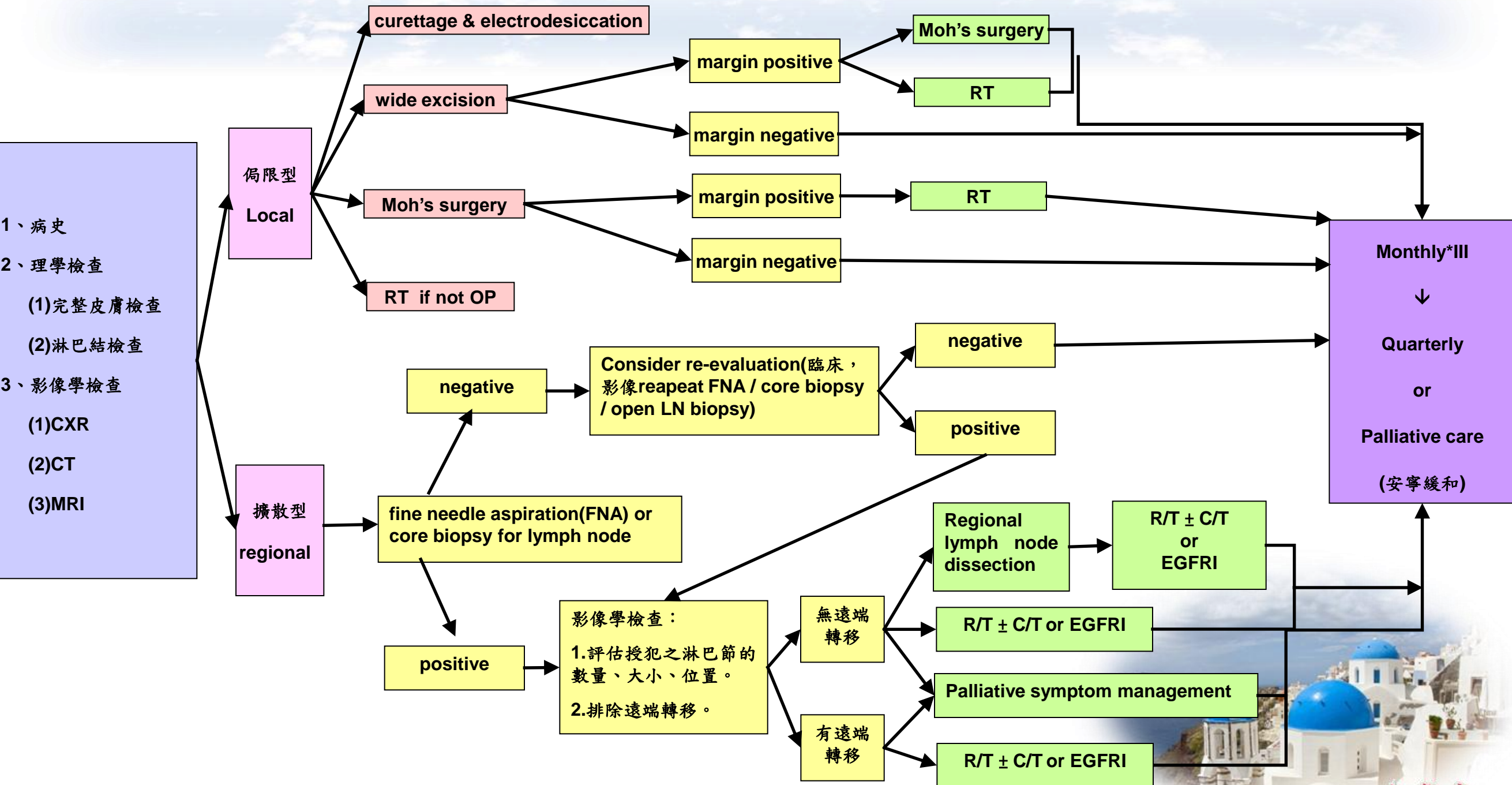


§ : Image studies is indicated for extensive disease (deep structural involvement such as bone, deep soft tissue, perineural disease) if perineural disease is suspected, MRI is preferred.
 ¶ : Palliative symptom management, including salvage C/T
 △ : RT主要針對手術不適用之情形, 附件二
 # : Palpable regional lymph node(s) or abnormal lymph nodes identified by image studies. (擴散型的“初始皮膚病灶”治療同局限型中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、Keratoacanthoma)

復發



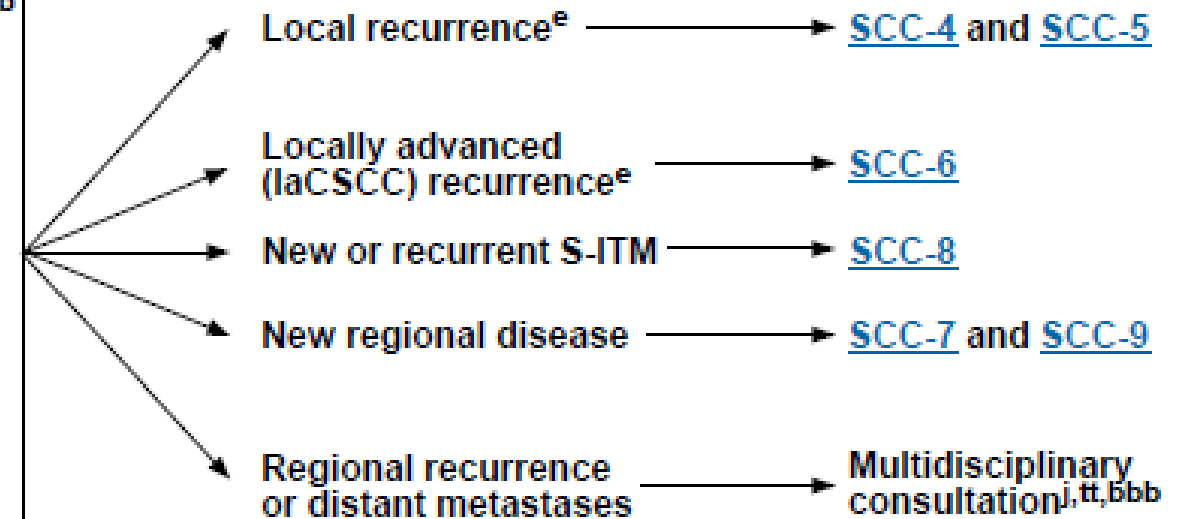
FOLLOW-UP

Local disease:

- H&P^{xx,yy,zz}
 - ▶ For patients who are low risk:
Every 3–12 mo for 2 y, then every 6–12 mo for 3 y, then annually for life^b
 - ▶ For patients who are high risk:
Every 3–6 mo for 2 y, then every 6–12 mo for 3 y, then annually for life^b
 - ▶ For patients who are very high risk:
Every 3–6 mo for 2 y, then every 6 mo for 3 y, then every 6–12 mo for life^b
- Consider imaging:
 - ▶ If clinical exam is insufficient for following disease
 - ▶ If there is appreciable risk of subclinical local or nodal recurrence^e
- Patient education
 - ▶ Sun protection
 - ▶ Self examination of skin

Regional/S-ITM disease:

- H&P^{xx,yy,zz}
 - ▶ Every 2–3 mo for 1 y,
then every 2–4 mo for 1 y,
then every 4–6 mo for 3 y,
then every 6–12 mo for life
- Consider imaging:
 - ▶ If clinical exam is insufficient for following disease
 - ▶ If there is appreciable risk of subclinical local or nodal recurrence^{e,aaa}
- Patient education
 - ▶ Sun protection
 - ▶ Self examination of skin
and lymph nodes



^{tt} Consider palliative RT/surgery for symptomatic sites. SBRT may also be considered in select patients.

^{xx} Including complete skin and regional lymph node exam.

^{yy} Frequency of follow-up should be adjusted based on risk.

^{zz} Follow-up with a dermatologist is strongly recommended if any of the following criteria are met: past or imminent solid organ, marrow, or stem cell transplant, one or more cutaneous melanomas in the past 5 years, or four or more non-melanoma skin cancers in the past 5 years.

^{aaa} Surveillance imaging of regional nodal basin and to evaluate for distant metastatic disease, ideally based on multidisciplinary board recommendation, or as clinically indicated.

^{bbb} Under highly selective circumstances, in the context of multidisciplinary consultation, resection of limited metastases can be considered.

Follow-up 建議改為分層：

低風險：q3–12mo x2y → q6–12mo x3y → 每年終身

高風險：q3–6mo x2y → q6–12mo x3y → 每年終身

極高風險：q3–6mo x2y → q6mo x3y → q6–12mo 終身

Regional / S-ITM：q2–3mo x1y → q2–4mo x1y → q4–6mo x3y → q6–12mo 終身

高危險病人（移植 / 黑色素瘤 <5y / ≥4 次 NMSC <5y）必須皮膚科追蹤。

鱗狀上皮細胞癌(SCC、Keratoacanthoma)

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

附件四-1:chemotherapy regimen or **metastasis**

化學治療處方

chemotherapy regimen

published C/T regimens	schedule
Cisplatin, 100 mg/m ² IV D1	Q 21-28 days x 4 cycles
5-FU, 1 g/m ² IV D1-3	Q 21-28 days x 4 cycles



鱗狀上皮細胞癌(SCC)_ regional disease

附件四-2:chemotherapy regimen & EGFRi or **metastasis**

化學治療處方

chemotherapy regimen & EGFRi

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

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



鱗狀上皮細胞癌(SCC)_ regional disease

附件四-3:EGFRI or metastasis

化學治療處方

EGFRI

published C/T regimens	schedule
•Cetuximab, 400 mg/m ² IV Week 1, then 250 mg/m ² QW	Till IV or unacceptable toxicity

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



Reference

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