

Multiprofessional Guidelines for the Management of the Patient with Primary Cutaneous Squamous Cell Carcinoma

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Primary cutaneous squamous cell carcinoma (SCC) is a malignant tumour arising from the keratinising cells of the epidermis or its appendages. It is locally invasive and may metastasise. These guidelines do not apply to SCC of the penis, vulva and anus, SCC in-situ (Bowen's disease), SCC arising from mucous membranes and keratoacanthoma.

Tumour characteristics associated with increased risk of metastasis includes:

Site High risk sites include lip & ear, non sun-exposed sites (e.g. perineum, sacrum, sole of foot), SCC in areas of radiation or thermal injury, chronic draining sinuses, chronic ulcers, chronic inflammation or Bowen's disease.

Diameter Tumours greater than 2cm in diameter are twice as likely to recur locally (15.2% vs. 7.4%), and three times as likely to metastasise (30.3% vs. 9.1%) as smaller tumours.

Depth Tumours > 4mm in depth or extending to the subcutaneous tissue are more likely to recur and metastasise compared with thinner tumours.

Histological differentiation Poorly differentiated tumours have double the local recurrence rate and triple the metastatic rate of better differentiated SCC. Tumours with perineural involvement are more likely to recur and to metastasise.

Host immunosuppression Tumours arising in patients who are immunosuppressed have a poorer prognosis.

Treatment options

Treatment involves complete removal or treatment of the primary tumour and awareness of the possibility of local 'in transit' metastases and lymphatic metastases to draining lymph nodes.

Attempted single complete surgical Excision A minimum 4mm margin around well-defined, low risk tumours < 2 cm in diameter is adequate in 95% of cases (*Strength of Recommendation A, Quality of Evidence II-iii*). High risk tumours require a wider margin (6mm or more) or Mohs' micrographic surgery.

Mohs' Micrographic Surgery results in 97% 5 year cure rates (*Strength of Recommendation B, Quality of Evidence II-iii*).

Curettage and Cautery of small (<1cm), well-differentiated, primary, slow growing SCCs on sun-exposed selected and treated by experienced physicians results in <5year follow up local recurrence rates of >2% (*Quality of Evidence II-iii*).

Cryosurgery of small histologically confirmed SCC may be an appropriate technique for selected cases in specialised centres.

Radiotherapy gives 5 year cure rates of 90% and excellent cosmetic results at specific sites.

Elective prophylactic lymph node dissection Elective lymph node dissection is not routinely practised and there is no evidence of benefit over morbidity (*Strength of Recommendation C, Quality of Evidence II-iii*).

Follow-up

Observation for recurrent disease by the specialist, GP or patient of high-risk SCC should be undertaken for up to 5 years (*Strength of Recommendation A, Quality of Evidence II-ii*).

Audit Points:

Complete v incomplete local excision

Local recurrence and metastasis rates

Reference:

Br J Dermatol 2002; 146: 18

Key to evidence and recommendation rating

Summary of recommendations

Local complete excision is the objective in primary SCC. Metastatic risk varies with tumour site, histology, size and host immunity. High risk SCC should be treated rapidly and with wider margins.

Production of this guideline summary was kindly sponsored by the British National Formulary