RISK STRATIFICATION & MANAGEMENT OF SCC DIAGNOSED CLINICALLY OR HISTOLOGICALLY INCLUDING AJCC/UICC8

[Any skin site including cutaneous not vermillion of lip. Not penis, vulva, anus or other mucosal sites.]

Bristol skin cancer SCC management v3.6
Author: [redacted] Bristol 2019. Review: 2022

*Clinical excision margins may be reduced for very small tumours (i.e.<5mm diameter) or anatomical constraints or Mohs surgery may be required.
**Histological resection margin. Values chosen are concordant with RCPath & COSD core dataset.

TUMOUR RISK

NOT EYELID: pT4 Gross bone or foramen invasion
EYELID: pT4 Invading eye, orbit or face
Any N or M or suspected

→ Stage 3 or 4 Already locally advanced or metastatic
→ MDT DISCUSSION & STAGING IMAGING
→ SSMDT DISCUSSION
→ Face-to-face results discussion within 2 weeks and consider prophylaxis***
→ Further treatment or palliation
→ Individualised FU

pT3 RISK FACTORS
EYELID: Tumour diameter >20mm

NOT EYELID: Tumour diameter >40mm
Large calibre PNI (≥ 0.1mm or named, or deeper than dermis, or tumour within nerve)
Over 6mm thickness
Over Clark's level 5 (beyond s/c fat)
Minor bony erosion

OTHER RISK FACTORS
Vascular/lymphatic invasion
Recurrent tumour

pT2 RISK FACTORS
NOT EYELID: pT2 Stage 2- Clinical diameter >20mm and ≤ 40mm
EYELID: pT2 Stage 2- Clinical diameter >10mm and ≤ 20mm

OTHER RISK FACTORS
Poorly differentiated
Over 4mm thickness
Clark's level 5 (into s/c fat)
Small calibre PNI
Desmoplastic, acantholytic, spindle

HIGHER RISK ANATOMICAL SITES
Lip
Ear
Temple
Non-sun-exposed site
From chronic wound/ulcer/inflammation
From atypical Bowen's

Total risk factors

- ANY 1 RISK FACTOR pT3 - Stage 3 → Stage 1, 2 or 3 Very high risk
  - Aim to excise with at least 6mm clinical margins or radiotherapy*
  - **Margins over 5mm
    - Yes → MDT VERY HIGH RISK PROTOCOL
    - No → MDT DISCUSSION
  - Face-to-face results discussion within 2 weeks and consider prophylaxis***
  - ±further treatment
  - Group education session
  - FU Year 1: 3 monthly Year 2: 4 monthly Year 3+: 4 monthly if needed and consider prophylaxis*
- OR ANY 4 or more pT1/pT2/pT3 / pT1/pT2 → Stage 1 or 2 High risk
  - Aim to excise with at least 6mm clinical margins or radiotherapy*
  - **Margins over 5mm
    - Yes → MDT HIGH RISK PROTOCOL
    - No → MDT DISCUSSION
  - Patient need (e.g. complex case, young, anxious) Atypical presentation Or further treatment to be offered
    - Yes any → Face-to-face results discussion within 2 weeks → ±further treatment
    - No → Results letter → Group education session
  - FU Year 1: 4 monthly Year 2: 4 monthly if needed
- ANY 2 or 3 pT1/pT2 → Stage 1 or 2 Moderately high risk ~7% LR/NM 0.5% DSD
  - Aim to excise with 6mm clinical margins or radiotherapy*
  - **Margins at least 1mm
    - Yes → MDT LOW RISK PROTOCOL
    - No → MDT DISCUSSION
- ANY 1 pT1/pT2 → Stage 1 Low risk ~1% LR/NM 0% DSD
  - Aim to excise with 4mm clinical margins or radiotherapy*
  - **Margins at least 1mm or curettage and electrodessication at least 2 cycles
    - Yes → MDT LOW RISK PROTOCOL
    - No → MDT DISCUSSION
  - Patient need (e.g. complex case, young, anxious) Atypical presentation Or further treatment to be offered
    - Yes any → Results letter Then face-to-face results discussion within 4 weeks → ±further treatment
    - No → Results letter → Group education session (Unless attended within 2 years)
  - Other conditions to be followed up
    - No → Discharge with advice
    - Yes → Continue FU
- NONE pT1

PATIENT RISK

- Declined or missed recommended further treatment, or can't be offered → Yes → High or Very high risk
- Immunosuppressed e.g. transplant, CLL, other active cancer/chemotherapy, HIV, immunosuppressant treatment → Yes → High or Very high risk → Aim for wider histological clearance margins than dictated by tumour alone i.e. At least 2mm or at least 5mm (depending on degree of immunosuppression)
- Skin SCC prone syndrome → Yes → High risk
- Frequent SCC but immunocompetent → Yes → High risk

POOR HEALTH OR MENTAL INCAPACITY
WHO performance status 3 or more
Life expectancy less than 3yrs
Frailty
Severe Dementia
Lack of capacity

→ Yes → Invite carer/Health & welfare attorney/family/significant other/ advocate (and consider 'best interests' meeting)
→ Individualised FU to be decided by Consultant considering rest of protocol
→ If appropriate
→ Group education session Carer can attend with or instead of patient

- Under regular FU already and on prophylaxis or recently considered
  - Yes → FU 3-4 monthly ongoing (Or at least 2 years) and consider prophylaxis*
  - No → Face-to-face results discussion within 2 weeks and consider prophylaxis*** → Group education session → FU 3-4 monthly ongoing (Or at least 2 years) and consider prophylaxis*

ASSESSMENT & TREATMENT

FIRST ASSESSMENT
If tumour found/suspected: check regional lymph nodes and offer full skin examination

PRIMARY TREATMENT OPTIONS
LOW risk: excise+4mm clinical margin
HIGH risk: excise+6mm clinical margin
Biopsy then radiotherapy

MDT TARGET HISTOLOGICAL MARGINS
LOW risk: accept 1mm
HIGH risk: accept 2mm
VERY HIGH risk: accept 5mm

CLINICAL STAGING
Stage 1= pT1 = no pT2 or pT3 risk factors
Stage 2= pT2
Stage 3= pT3 or N1
Stage 4= pT4 or N2/3 or met

MDT

PATHOLOGY
All cases with high risk pathology features are reviewed pre-MDT to screen for errors that may affect management e.g:
Resection margins closer than stated/wrongly interpreted, High risk factors missed, Diagnosis changed
Review slides in meeting for all margins <1mm

MDT DISCUSSION
1. Further treatment of any SCC with <1mm/ involved margin, or biopsies of high risk SCC:
±Standard excision
±Mohs excision
±Radiotherapy
2. Pre-op planning e.g. facial H-zone, large tumour.
3. Staging/planning imaging e.g. for deep/fixed or recurrent tumour, or prior to major surgery
i.e. CT ±MR tumour site + CT regional LN ±thorax
4. Follow-up

MDT MEETING WITH OR WITHOUT DISCUSSION
All cases listed on MDT list
Arranged in distinct sections
Clinically staged
Record of protocol outcome
Entered on cancer register

MDT OUTCOME & RESULTS

MDT OUTCOMES AND FOLLOW-UP
FU will be arranged automatically after MDT according to protocol. Plan & any actions are clearly stated in MDT outcomes.
Consultant to review MDT outcome, tailor to patient if needed, advise CNS if any changes to plan, and inform patient by letter or call in all cases not coming for urgent 1:1 FU
Any appointments stated in the outcomes will be made by the admin team at the request of the MDT coordinator.
All other actions will have a named responsible person allocated in outcomes.
FU starts from date of completed treatment

INDIVIDUALISED FOLLOW-UP
2nd or subsequent years of FU may be useful for patients at high risk of recurrence who cannot check themselves effectively. Or consider requesting primary care FU. Also some patients may not benefit from early detection at all e.g. WHOPS 3+.

INFORMING PATIENT & GP OF PLAN
In face to face appointment within 2 weeks
Or letter or call from Doctor or Nurse as stated in outcomes
Expected pathway clearly documented in letter to GP & patient

FOLLOW UP

FACE-TO-FACE 1:1 FU
Tailored discussion offering estimated prognosis if desired by patient
Offering further treatment if recommended by MDT
Full skin examination
Regional lymph node examination

ADVICE/GROUP EDUCATION
Checking scar
Checking own regional lymph nodes
Self-monitoring for new lesions
Sun protection balance
Vitamin D
Veterans compensation

RISK OF ANOTHER NMSC WITHIN 3YRS
After first SCC: SCC 18%; BCC 44%
After first BCC: BCC 44%; SCC 6%
Stern. Arch Dermatol 2000

***PROPHYLAXIS**
Change of immunosuppressant or dose reduction
Acitretin 10-20mg od (check LFT & lipids)
Nicotinamide 500mg bd (care in renal failure, or with COCP; avoid with carbamazepine)

EVIDENCE

RISK ESTIMATION
Risks quoted are approximate averages estimated for 10 year local recurrence (LR) or nodal metastasis (NM) or 10 year disease specific death (DSD)
Based on: Schmults et al JAMA Derm 2019, Karia et al JCO 2014, Schmults et al JAMA Derm 2013, UICC/AJCC8, and 2019 UHB/NBT recurrent SCC audit
Recurrent tumours: Risk estimate based on opinion only.

OTHER RELATED RESOURCES
UHB MDT standard operating procedure (SOP)
NICE guidance
BAD guidance
SWAG regional skin cancer guidance (including neck lump protocol)
SWAG Mohs surgery guidance
UHB group CNS FU session SOP
Group session education presentation