

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: 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

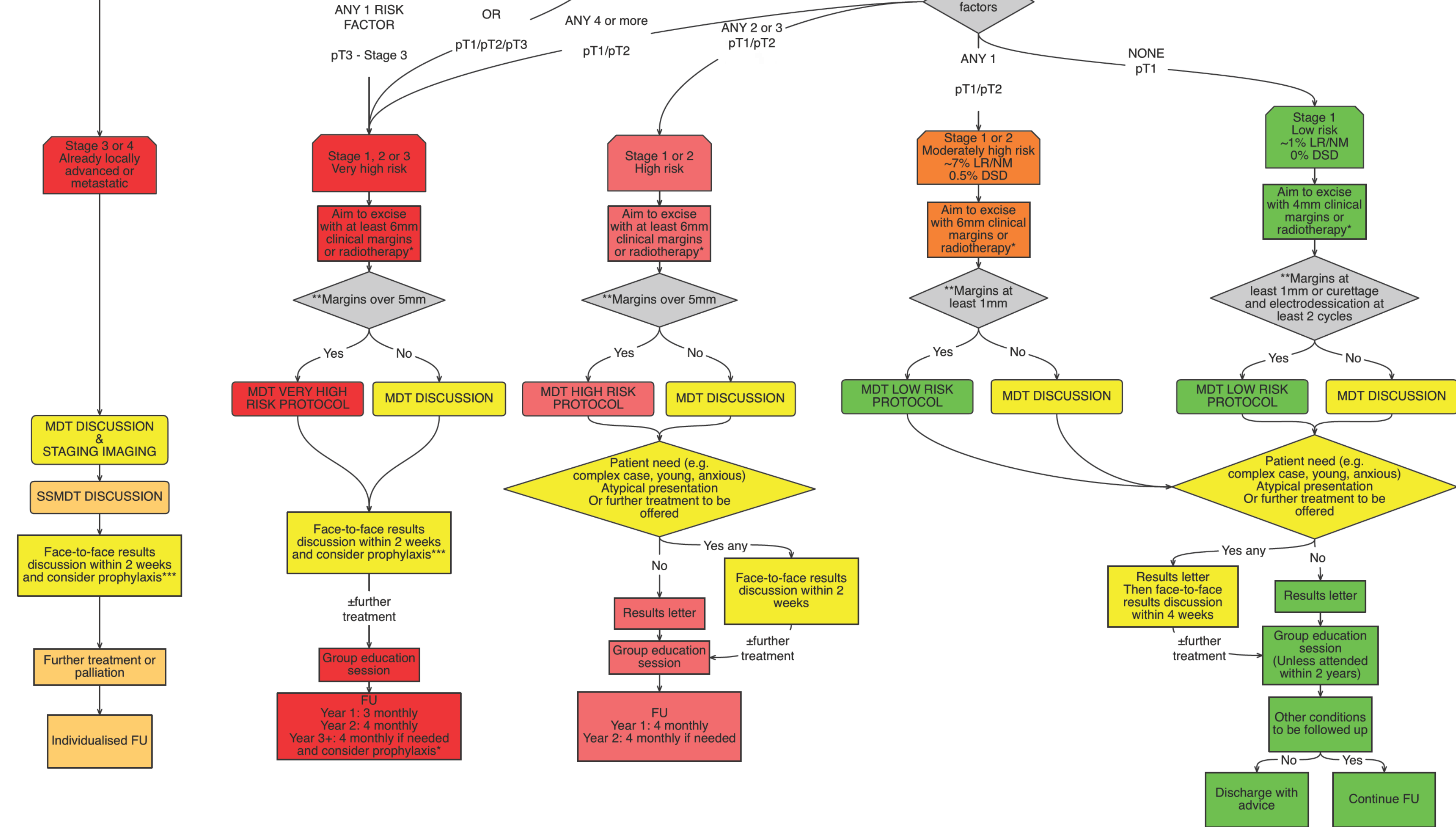
NOT EYELID: pT4 Gross bone or foramen invasion
EYELID: pT4 Invading eye, orbit or face
Any N or M or suspected

pT3 RISK FACTORS
EYELID: Tumour diameter >20mm
NOT EYELID: Tumour diameter >40mm
Large calibre PNI (≥ 0.1 mm 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

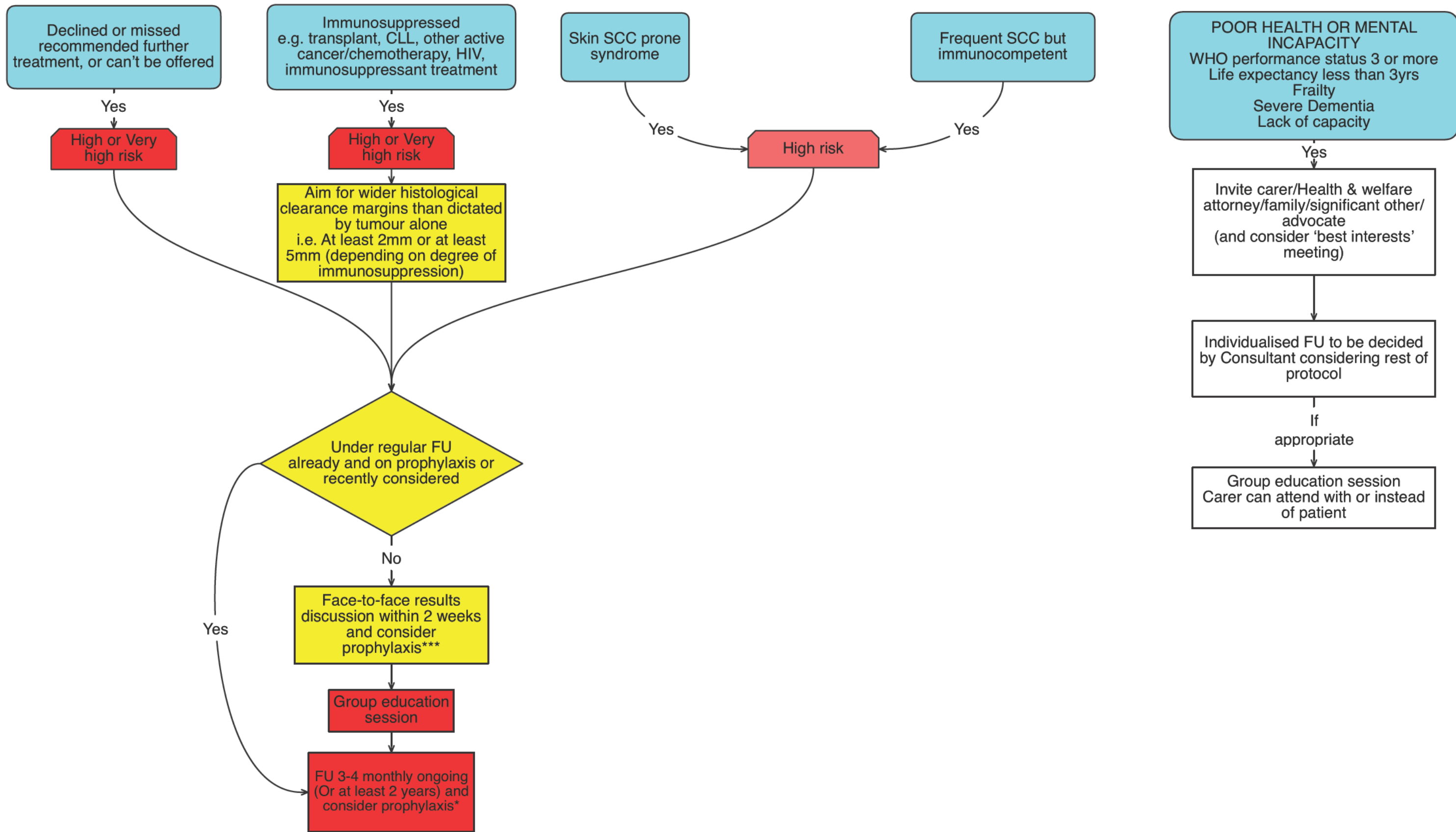
OTHER RISK FACTORS
Vascular/lymphatic invasion
Recurrent tumour

pT2 RISK FACTORS
NOT EYELID: pT2 Stage 2: Clinical diameter >20mm and ≤ 40 mm
EYELID: pT2 Stage 2: Clinical diameter >10mm and ≤ 20 mm
OTHER RISK FACTORS
Poorly differentiated
Over 4mm thickness
Clark's level 5 (into s/c fat)
Small calibre PNI
Desmoplastic, acantholytic, spindle

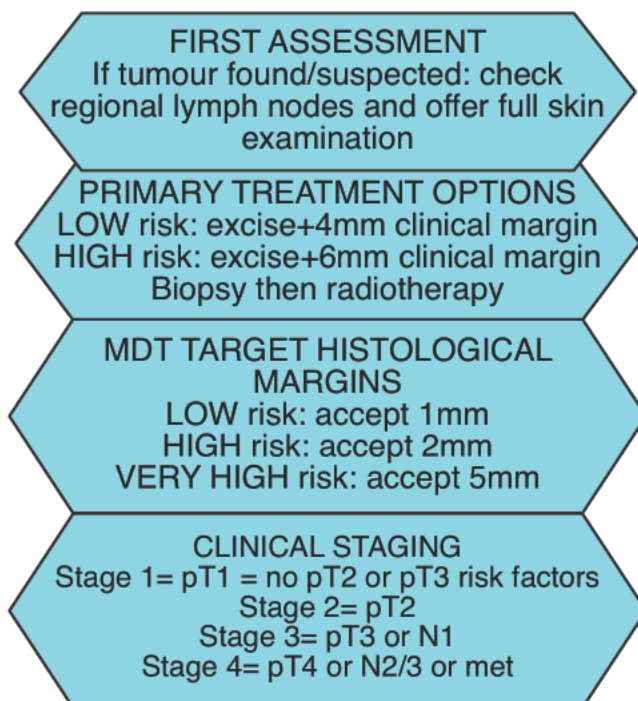
HIGHER RISK ANATOMICAL SITES
Lip
Ear
Temple
Non-sun-exposed site
From chronic wound/ulcer/inflammation
From atypical Bowen's



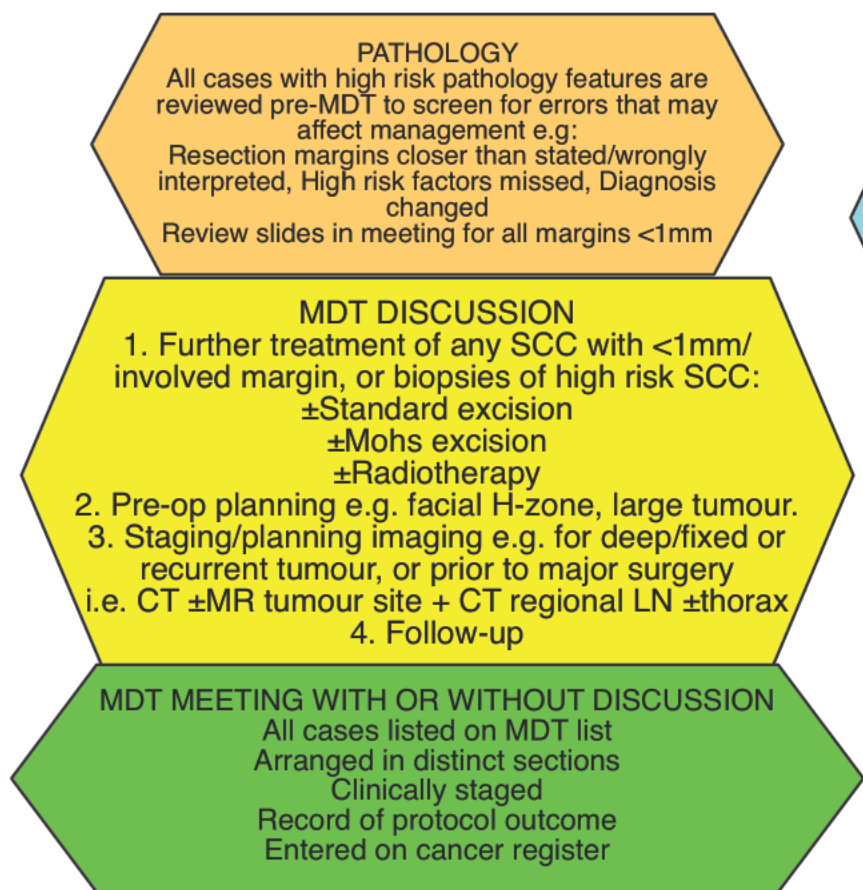
PATIENT RISK



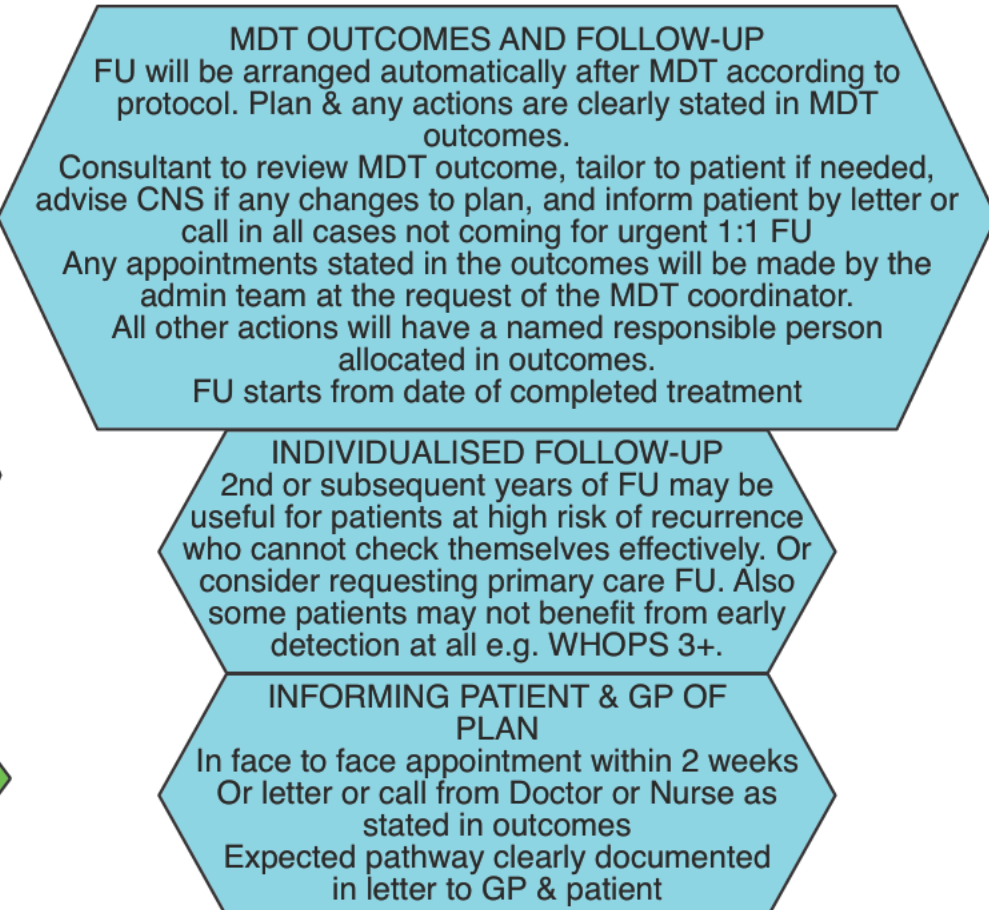
ASSESSMENT & TREATMENT



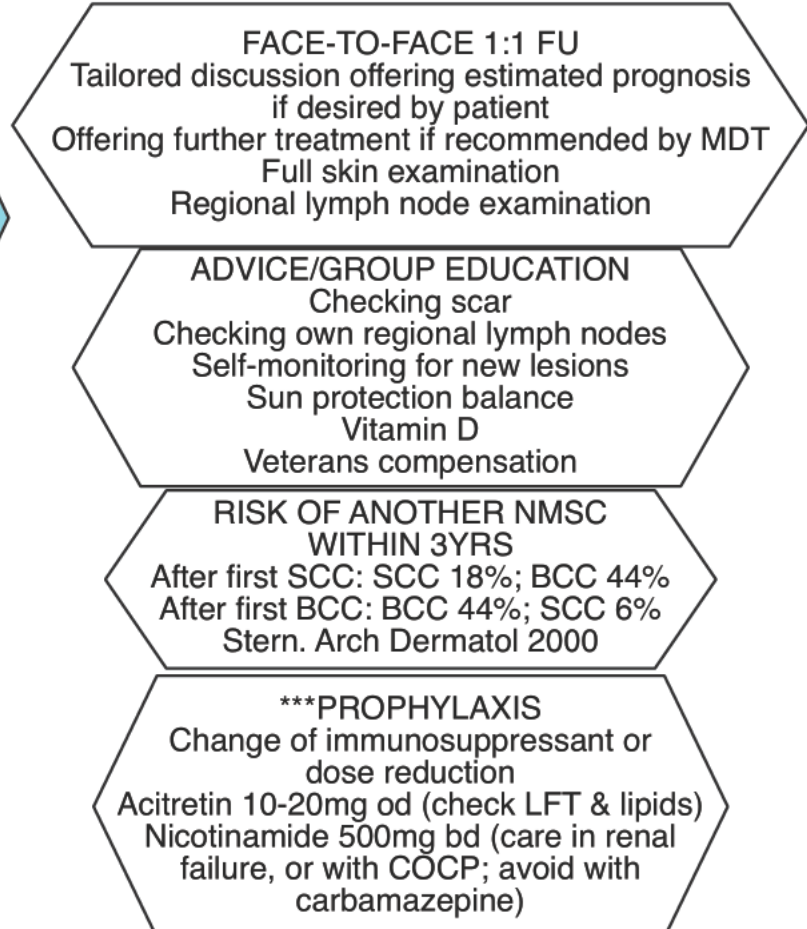
MDT



MDT OUTCOME & RESULTS



FOLLOW UP



EVIDENCE

