Non-Melanoma Skin Cancer:
BCCA and SCCA of the Head & Neck

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• No disclosers
Non-Melanoma Skin Cancer of the Head and Neck

• Key factors in successful treatment:

  Recognize aggressive histologic subtypes

  Identify high risk anatomic locations

  Understand indications and limitations of treatment options

  Carefully plan reconstruction of defects
Non-Melanoma Skin Cancer (NMSC)

- Most common form of malignancy in humans
  95% of all cutaneous neoplasms
- ~3.5 million cases annually
  - Not reported in national cancer registries
- 4.5% of total Medicare cancer costs
  - (Ranks 5th amongst all cancer types)
  - ~$400 Million in Medicare costs annually
- Incidence
  - Increased yearly 3%-8% since 1960’s
  - Estimated increase of 50% by 2030

Dubas 2013
Non-Melanoma Skin Cancer (NMSC)

- Most important risk factor is cumulative exposure to ultraviolet radiation.

- Ultraviolet B radiation (290 to 320 nm) is the most harmful segment of the ultraviolet spectrum
  - promotes DNA damage
  - inactivation of tumor suppressor genes such as p53

- Additionally, ultraviolet radiation, especially ultraviolet A
  - induces suppressor T-cell activity and decreases the number of epidermal Langerhans antigen presenting cells
  - leading to altered detection and elimination of malignant NMSC cells
Non-Melanoma Skin Cancer (NMSC)

• BCCA is **most common**
  – 75% of NMSC

• SCCA
  – 20% of NMSC

• Other rare neoplasms
  – Merkel cell, adnexal malignancies, others
Basal Cell Carcinoma

- Older age and male sex are associated with higher risk

- 30-40% of patients with a BCCA will develop second cancer within 10 yrs
  - Need to educate patient on self exam

- 90% of lesions occur in the head and neck

- Risk Factors:
  - Skin pigmentation, UV radiation, ionizing radiation, burn scars, smallpox scars, xeroderma pigmentosum, basal cell nevus syndrome

McGuire 2009
BCCA: Pathology

• Malignant neoplasm of keratinocytes that reside in the basal layer of epidermis

• Growth rate is slow
  – Growing to 1-2cm after several years

• Remains local and almost never metastasizes
  – 0.003%-0.05% rate of metastasis

McGuire
BCCA: Clinical Findings

Divided into 4 major subtypes

• Nodular ulcerative
• Superficial
• Pigmented
• Morpheaform (aka Sclerosing)
Nodular Ulcerative BCCA

• MOST COMMON
• Pearly papule or nodule
• Telangiectasias
• Elevated rolled borders
• Centrally ulcerate with progression
• Can invade critical structures
Superficial BCCA

- Present as erythematous scaly patches
- Often on neck/shoulders
- Mimic SCCA or eczema
Pigmented BCCA

- Appear similar to Malignant Melanoma
Morpheaform

- Worst prognosis
- Present as depressed, indurate plaques
- Poorly defined borders
Squamous Cell Carcinoma

• Estimated life time risk 9-14%
• Ultraviolet light is major cause (UVA, UVB)
• “Marjolin’s Ulcer”
  – SCCA from chronic ulcers, scars, BURNS
• Blonde hair, fair skin, blue eyes = higher risk
• Other risk factors:
  – Chemical carcinogenesis, chronic radiation dermatitis, HPV (16, 18, 30), xeroderma pigmentosa, oculocutaneous albinism
SCCA: Pathology

- Malignant neoplasm of keratinocytes and involves full thickness of epidermis

- May arise de-novo or from Actinic Keratosis
  - 0.5%-16% conversion rate

- Histopathologic Spectrum:
  - AK = involves only part of epidermis
  - SCC in situ = involves full thickness of epidermis
  - Invasive SCC = penetrates basement membrane of epidermis

McGuire
SCCA: Clinical Findings

Two major forms

• SCCA in situ ("Bowen disease")

• Invasive SCCA
  – Well differentiated
  – Moderately differentiated
  – Poorly differentiated
    • Most aggressive
    • Higher rate of recurrence and metastasis
SCCA: Recurrence and Metastasis

- Degree of differentiation correlates with tumor aggressiveness

- **Well Differentiated SCCA**
  - Recurrence: 13.6%
  - Metastasis: 9.2%

- **Poorly Differentiated SCCA**
  - Recurrence: 28.6%
  - Metastasis: 32.8%

Dubas 2013
SCCA in situ

- Well-defined
- Erythematous, scaly papule or plaque
Invasive SCCA

- Poorly defined
- Indurated, scaling papules or nodules
- Ulceration may signal dermal invasion
- Need to examine regional lymph nodes for mets
Treatment

Non-Surgical treatment

Surgical treatment
Non-Surgical Treatment

- Cryotherapy
- Curettage and electrodessication
- Radiotherapy
- Lasers
- Topical 5-FU
Cryotherapy

- Causes tissue destruction by application of vaporizing liquid nitrogen
- -25°C
- Requires 2-3 freeze/thaw cycles
- Destroys tumor cells
  - High water content and metabolism, microcirculation

- Simple, rapid, inexpensive
- **Indications:** Previously untreated superficial and small nodular BCCA, small well-diff SCCA
Curettage and Electrodesiccation

• Bulk of tumor is removed with vigorous curettage
• Followed by electrodesiccation of the base
  – With 2-3mm margin of skin

• Indications: BCCA < 2cm, small SCCA in situ, SCCA < 1cm
Radiotherapy

- External beam radiation given in fractionated treatments (10-30 treatments over 3-6 wks)

- 1-1.5cm margins are typically treated

- Non-invasive, can provide good cosmetic outcome

- Second primary lesions can arise in radiated fields
Indications for Radiation Therapy

- SCCA – patients who are medically unfit or who refuse surgery
- Adjuvant (post-op) therapy for recurrent or advanced SCCA
- Residual tumor (when re-resection is unfeasible)
- Management of metastases
- BCCA – when surgery will leave poor functional or cosmetic result
Lasers

• Induce coagulative necrosis, ablation and hyperthermia = tumor destruction

• Costly and relatively inaccessible

• Rarely used, but data supports use for some cancers

  – Covadonga et al 2008  
    • CO₂ laser treatment, 44pt with SCCA in situ  
      – 97.7% response rate

  – Moskalik 2009  
    • Nd:YAG lasers, 3461 pts  
    • Recurrence rates: 1.8% for BCCA, 4.4% for SCCA
Topical 5-FU

- Decreases cell proliferation and induces cellular death
- Good cosmetic results

**Indications:** Superficial BCCA and SCCA in situ

- Apply 5% cream or solution to lesions twice daily
- Treatment should continue for at least 3 to 6 weeks and may be required for as long as 10 to 12 weeks to resolve the lesions.
Surgical Treatment

• Surgical excision is the most effective treatment option for most NMSC’s.

Goals:
- complete eradication of the cancer
- good cosmetic and functional outcome

• complete eradication of the tumor should be the primary goal.
High risk vs Low risk Tumors

• Important for treatment planning

• Help to determine risk of recurrence and metastasis

Must recognize high risk tumors
Tumor Location: “H”-Zone

- Skin and subcutaneous tissue is thin
- Permits spread along periosteum & perichondrium
- Embryologic fusion planes provide path for spread

Akcam 2012
“H” Zone

- **High risk of Recurrence**
  - Nose, Cheek
  - Auricular area
  - Periorbital area
  - Scalp, Forehead

- **High risk of Metastases**
  - Ear
  - Temple
  - Forehead
  - Anterior scalp
Tumor Size

• Important prognostic risk factor for NMSCs

Larger tumors (>2cm) have:
- Higher recurrence and metastasis rates
- Unpredictable subclinical extension
- Deeper invasion

Tumors > 4cm = diminished disease-specific survival

Bhatti 2006
Takenouchi 2001
Tumor Thickness & Depth of Invasion

• Tumor thickness or depth of invasion is another important prognostic predictor of SCCs.

• Deep invasion diminishes disease-specific survival in cutaneous SCCs.

• Brantsch et al. – tumor thickness of SCC $>6$ mm to be an independent risk factor for local recurrence
  – divide SCC into three main risk categories for metastasis according to tumor thickness:
    1. no detectable risk ( $<2$ mm tumor thickness)
    2. low risk (2–6 mm tumor thickness)
    3. high risk ($>6$ mm tumor thickness).
Other factors....

- **Histologic Subtypes (high risk)**
  - BCCA: basosquamous, morpheaform, infiltrating
  - SCCA: Invasive Bowen disease, Desmoplastic, Adenosquamous

- **Degree of Differentiation (SCCA)**
  - Poorly differentiated
    - Higher rates of metastases and more aggressive

- **Perineural invasion**
  - Associated with worse disease-specific survival

Akcam 2012
Surgical Options

• Surgical Excision with **Standard Margins**

• Surgical Excision with **Frozen Section Assessment**

• Surgical Excision with **Delayed Repair**

• Mohs Micrographic Surgery
Margin Concepts

- Surgical Margin
- Pathologic Margin
- Clinical Margin
Surgical Excision with Standard Margins

- Traditional surgical treatment based on the removal of tumor relying on the clinical margins

- Preferred for the treatment of tumors with well-defined clinical margins

- Indications: treatment of low-risk NMSCs
Surgical Excision with Standard Margins

• Tumors excised under local anesthesia.

• Identifying the clinical margin of the tumor preoperatively is crucial.
  – Inspect lesion under optimal lighting

• Use a ruler for marking the surgical margins.
  – tendency to underestimate surgical margins for large lesions
  – to overestimate for small lesions.

• Marking surgical margins with aid of magnification reduces the incidence of incomplete resection.
Surgical Margins - BCCA

• Low risk BCCA: 0.4cm >95% cure rate (well defined primary lesions, <2cm in size)

• Breuninger et al
  95 % “cure rate”  5 year tumor-free interval
  – Tumors < 1cm = 0.5cm margin
  – Tumors 1-2cm = 0.8cm margin
  – Tumors >2cm = 1.2cm margin
Surgical Margins - SCCA

• Low risk SCCA: 0.4cm >95% cure rate (well defined primary lesions, <2cm in size)

• Broadland et al.
  95% complete resection rate:
  - Tumors < 2cm = 0.4cm margins
  - Tumors > 2cm = 0.6cm margins
Surgical Excision with Standard Margins

• Good treatment option, especially for small NMSCs

• Short operation time and costs less compared with other surgical options

• When tumor is larger than 2 cm, has poorly defined borders, and high-risk to recur or metastasize, it is better to prefer other treatment options.
Surgical Excision with Frozen Section

• Intraoperative frozen sectioning is effective tool to obtain tumor-free margins
  – peripheral or deep biopsies are taken for assessment of the histologic margins

• Indications:
  – Presence of poorly defined clinical margins
  – Tumor types with infiltrative growth pattern
  – Large or recurrent lesions
  – Tumors located in areas where skin preservation is desirable
  – Before extensive reconstructive efforts
Surgical Excision with Frozen Section

- Surgical excision is performed in standard fashion
  - proper orientation of the margins is crucial

- Important to have good communication between the surgeon and pathologist
  - different color dyes or sutures are used to identify the margins of the tumor.
Surgical Excision with Frozen Section

- Onajin et al. 2015
- Retrospective chart review
- 300 cases of NMSC
  - BCCA: 153/300  SCCA: 56/300
- Frozen section = permanent section 83.3%
- Other studies: 70-90%

Ghauri 2005
Dinehart 2010
Surgical Excision with Delayed Repair

- Simple excision with permanent margin assessment, with delayed repair

- **Indications:**
  - Ensure tumor-free margins prior to flap or graft reconstruction
  - When tissue preservation is crucial
    i.e. For function and cosmesis, narrow margin excision
Surgical Excision with Delayed Repair

• Standard excision is used to excise the tumor with preferred surgical margin

• After hemostasis is achieved, the wound is covered with nonadherent surgical dressing

• If permanent sections are negative, reconstruction is performed

• Otherwise, subsequent excisions are performed until clearance of margins is obtained
Mohs Micrographic Surgery

• Dr. Frederic Mohs, 1930’s

• Removing tumors in a “microscopically controlled serial manner”

• **Indications:**
  – Subtypes with infiltrative growth pattern
  – Poorly defined clinical margins
  – High risk anatomic locations
  – Tumors > 2cm
  – Incompletely excised or recurrent tumors
  – Immunocompromised patients
  – Presence of perineural or lymphovascular invasion
  – Tumors arising at the site of chronic wound or scar
Surgical Excision vs. Mohs

• Recurrence:
  – Five-year recurrence rate of NMSCs was found to be 4% for excision and 2.6% for MMS (Chren 2011)
  – Mosterd et al 2008:
    • Prospective, randomized study
    • 408 primary facial BCCs and 204 recurrent facial BCCs
    • Primary: 5-year recurrence rates were 4.1% for surgical excision and 2.5% for MSS.
    • Recurrent: 12.1% for excision and 2.4% for MMS
    • Conclusion: Recurrence rates are only significant for RECURRENT tumors
Surgical Excision vs. Mohs

• **Cost:**
  - Smeets et al 2004
    - Operative costs for a primary BCC:
      - Surgical excision: $272.11
      - Mohs: $509.18
    - For a recurrent BCC:
      - Surgical excision: $405.93
      - Mohs: $613.69
    - Higher cost of MMS mainly accounted for higher staff costs because of longer operation times compared with surgical excision.
  - Rogers et al 2009
    - Mohs is estimated to be about 25% more expensive than excision with immediate repair
    - only 8% more expensive than excision with delayed repair
  - Cook and Zitelli
    - MMS is 6% more expensive than office excision with permanent sections
    - 12% less expensive than office excision with frozen sections
    - 27% less ambulatory surgical facility excision
Management of Incomplete Excision

• Incomplete excision rates of NMSC’s range from:
  3% to 15% for BCCA
  6% to 30% for SCCA

• most commonly occur in the midface region
  – nose
  – periorbital region
  – nasolabial fold and cheek
  – chin.

• Factors that affect incidence of incomplete excision
  – Histologic subtype
  – Anatomic site and size of lesion
  – Multiple synchronous excisions
  – Experience of surgeon

Akcam
Management of Incomplete Excision: Recurrence Rates

- Recurrence rates of incompletely excised NMSC’s can be as high as 27%

- Ocanha 2011
  - Recurrence in BCCA on the face 14.7%

- Sherry et al 2010
  - 25% recurrence rates for observed positive margins

- Hallock and Lutz 2001
  - Prospective study, lesions with + margins
    Recurrence occurred in 13.3% of SCCA
    Recurrence occurred in 0% of BCCA

NMSC’s with positive margins DO NOT necessarily recur
Incomplete Excision: When to Re-Excise?

**Consider re-excision**
- If there is deep and lateral margin involvement
- Cases of aggressive/infiltrative subtype of BCCA
- For any SCCA
- Large tumors or those located in high risk areas
- Young patients

**Wait-and-see approach**
- If only lateral margin +
- Nodular, superficial BCC
- Small tumors (<1cm)
- Elderly patients
- Patient preference

Akcam et al
Management of the Parotid: Elective Parotidectomy

- SCCA located in pre-auricular and temporal regions have increased potential for parotid metastasis
  - Elective parotidectomy should be considered in certain cases
- True incidence of parotid involvement is unknown
  - Some reports show 9-18% for auricular tumors
- Moore et al 2005
  - 52% of patients with parotid metastasis had primary lesions found in pre-auricular and temporal areas
Management of the Parotid:
Elective Parotidectomy

• Kadakia et al 2015
  – Retrospective review
  – 93 patients with SCCA of temporal area
  – Tumor size 2cm or greater
  – No parotid involvement on exam/imaging
  – Treated with WLE and parotidectomy

• 25% had occult parotid metastasis
• 93 patients (58 males, 35 females)
• Tumor size:
  2cm – 2.9cm (n=44) = 21% positive nodal rate
  3cm – 3.9cm (n=33) = 35% positive nodal rate
  4cm or larger (n=18) = 43% positive nodal rate

Size of primary was strongly associated with development of parotid disease (p=0.0001)

Perineural invasion (p<0.0001) and vascular invasion (p=0.0016) shows greater risk of parotid involvement

Conclusion:
Pt’s with Temporal SCCA >2cm should undergo elective parotidectomy and perineural/vascular invasion are additional risk factors
Basal Cell Skin Cancer

PRINCIPLES OF TREATMENT FOR BASAL CELL SKIN CANCER

- The goal of primary treatment of basal cell skin cancer is the cure of the tumor and the maximal preservation of function and cosmesis. All treatment decisions should be customized to account for the particular factors present in the individual case and for the patient's preference. Customary age and size parameters may have to be modified.

- Surgical approaches often offer the most effective and efficient means for accomplishing cure, but considerations of function, cosmesis, and patient preference may lead to choosing radiation therapy as primary treatment in order to achieve optimal overall results.

- In certain patients at high risk for multiple primary tumors, increased surveillance and consideration of prophylactic measures may be indicated.

- In patients with low-risk, superficial basal cell skin cancer, where surgery or radiation is contraindicated or impractical, topical therapies such as 5-fluorouracil, imiquimod, photodynamic therapy (eg, aminolevulinic acid [ALA], porfimer sodium), or vigorous cryotherapy may be considered, even though the cure rate may be lower.
Basal Cell Skin Cancer

**PRIMARY TREATMENT**

- **Curettage and electrodesiccation:**
  - Excluding terminal hair-bearing areas, such as scalp, pubic, axillary regions, and beard area in men
  - If adipose reached, surgical excision should generally be performed

- **Standard excision:**
  - If lesion can be excised with 4-mm clinical margins and second intention healing, linear repair, or skin graft

- **RT** for non-surgical candidates

**ADJUVANT TREATMENT**

- **Meds or resection with complete margin assessment**
  - or
  - Standard re-excision for area L regions
  - or
  - RT for non-surgical candidates

**Follow-up** (BCC-4)
Basal Cell Skin Cancer

PRIMARY TREATMENT

High-risk basal cell skin cancer

- Standard excision
  Wider surgical margins with linear or delayed repair are recommended when excising high-risk tumors with standard re-excision

- Mohs or resection with complete margin assessment

- RT for non-surgical candidates

ADJUVANT TREATMENT

Positive

Margins

Mohs or resection with complete margin assessment

or

RT

If residual disease is present, and further surgery and RT are contraindicated, consider multidisciplinary tumor board consultation (consider a hedgehog pathway inhibitor or clinical trial)

Negative

Margins

If extensive perineural or large-nerve involvement recommend adjuvant RT

RT and/or
Multidisciplinary tumor board consultation (consider a hedgehog pathway inhibitor or clinical trial)

See Follow-up (BCC-4)

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
PRINCIPLES OF TREATMENT FOR SQUAMOUS CELL SKIN CANCER

- The goals of primary treatment of squamous cell skin cancer are the cure of the tumor and the maximal preservation of function and cosmesis. All treatment decisions should be customized to account for the particular factors present in the individual case and for the patient’s preference.

- Surgical approaches often offer the most effective and efficient means for accomplishing cure, but considerations of function, cosmesis, and patient preference may lead to choosing radiation therapy as primary treatment in order to achieve optimal overall results.

- In certain patients at high risk for multiple primary tumors, increased surveillance and consideration of prophylactic measures may be indicated. (See Identification and Management of High-Risk Patients [SCC-D])

- In patients with squamous cell carcinoma in situ (Bowen’s disease) that is low-risk, alternative therapies such as 5-fluorouracil, imiquimod, photodynamic therapy (eg, amino levulinic acid [ALA], porfimer sodium), or vigorous cryotherapy may be considered even though cure rate may be lower.
**NCCN Guidelines Version 1.2016**

**Squamous Cell Skin Cancer**

**PRIMARY TREATMENT**

<table>
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**ADJUVANT TREATMENT**

| Mohs or resection with complete margin assessment\(^i\) or |
| Standard re-excision for area L regions\(^j\) or |
| RT\(^3\) for non-surgical candidates |
| Positivity in margins |
| Negative |

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\(^{i}\)See Risk Factors for Local Recurrence or Metastases (SCC-A).

\(^{j}\)See Principles of Treatment for Squamous Cell Skin Cancer (SCC-B).

\(^{k}\)Closure of adjacent tissue transfers, in which significant tissue rearrangement occurs, are best performed after clear margins are verified.

\(^{l}\)See Principles of Radiation Therapy Squamous Cell Skin Cancer (SCC-C).

\(^{m}\)RT is often reserved for patients over 60 years because of concerns about long-term sequelae.

\(^{n}\)Excision with complete circumferential peripheral and deep margin assessment (CCPDA) with frozen or permanent section is an alternative to Mohs surgery.

\(^{o}\)Area L = trunk and extremities (excluding pretilia, hands, feet, nail units, and ankles). (See SCC-A)

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*Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.*
Squamous Cell Skin Cancer

PRIMARY TREATMENT

- Standard excision
  - Wider surgical margins with linear or delayed repair are recommended when excising high-risk tumors with standard re-excision.
  - Mohs or resection with complete margin assessment.

ADJUVANT TREATMENT

- Mohs or resection with complete margin assessment.
  - Positive → Margins
    - Positives → RT
  - Negative → Margins
    - Positive → RT
    - Negative → If extensive perineural or large-nerve involvement, recommend adjuvant RT

Local, high risk squamous cell skin cancer

- RT ± systemic therapy for non-surgical candidates

See Risk Factors for Local Recurrence or Metastases (SCCA).

Any high-risk factor places the patient in the high-risk category.

See Principles of Treatment for Squamous Cell Skin Cancer (SCC-B).

Closures like adjacent tissue transfers, in which significant tissue rearrangement occurs, are best performed after clear margins are verified.

See Principles of Radiation Therapy Squamous Cell Skin Cancer (SCC-C).

RT is often reserved for patients over 60 years old because of concerns about long-term sequelae.

Excision with complete circumferential peripheral and deep margin assessment (COPD) with frozen or permanent section is an alternative to Mohs surgery.

In certain high-risk lesions consider sentinel lymph node mapping, although the benefit of this technique has yet to be proven.

For complicated cases, consider multidisciplinary tumor board consultation.

If invasion to parotid fascia, superficial parotidectomy.

Negative margins unachievable by Mohs surgery or more extensive surgical procedures.

Consider multidisciplinary consultation to discuss chemoradiation or clinical trial. RT may be supplemented by chemotherapy in select patients.

See NCCN Guidelines for Head and Neck Cancers.

If large nerve involvement is suspected, consider MRI to evaluate extent and base of skull involvement or intracranial extension.

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Squamous Cell Skin Cancer

CLINICAL STAGING AND PREOPERATIVE ASSESSMENT

- Palpable regional lymph node(s) or abnormal lymph nodes identified by imaging studies

  - FNA or core biopsy
  - Imaging to determine size, number, and location of nodes and to rule out distant disease

  - Surgical evaluation

  - Consider re-evaluation: clinical, imaging, repeat FNA, core biopsy, or open lymph node biopsy

  - Negative
  - Positive

  - Head and Neck
  - Trunk and extremities

  - Operable disease
  - Inoperable disease

  - RT\textsuperscript{g} ± concurrent systemic therapy\textsuperscript{g,r}

  - Observe\textsuperscript{g}

  - Regional lymph node dissection

  - Consider RT\textsuperscript{g} especially if multiple involved nodes or extracapsular extension (ECE) is present

  - See Regional Lymph Nodes (SCC-5)

  - Regional lymph node dissection

  - See Follow-up (SCC-6)

PRIMARY TREATMENT\textsuperscript{g}

- Negative

ADJUVANT TREATMENT

- See Follow-up (SCC-6)

\textsuperscript{a}See Principles of Treatment for Squamous Cell Skin Cancer (SCC-B).

\textsuperscript{b}See Principles of Radiation Therapy for Squamous Cell Skin Cancer (SCC-C).

\textsuperscript{c}Consider multidisciplinary consultation to discuss chemoradiation or clinical trial. RT may be supplemented by chemotherapy in select patients. See NCCN Guidelines for Head and Neck Cancers.

\textsuperscript{d}Regional lymph node dissection is preferred, unless the patient is not a surgical candidate.

\textsuperscript{e}Multidisciplinary consultation recommended. Consider systemic therapies recommended for use with radiation to treat head and neck squamous cell carcinomas. See NCCN Guidelines for Head and Neck Cancers.

\textsuperscript{f}Re-evaluate surgical candidacy for post-radiation lymph node dissection as indicated.

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Regional Lymph Nodes

Solitary node ≤3 cm → Excision of primary and ipsilateral selective neck dissection as indicated

One positive node ≤3 cm, no extracapsular extension (ECE) → RT or Observation

≥2 positive nodes or 1 node >3 cm, no ECE → RT

Any node with ECE → RT and consider concurrent systemic therapy

RT and consider concurrent systemic therapy

Solitary node >3 cm, or multiple ipsilateral nodes → Excision of primary and ipsilateral comprehensive neck dissection as indicated

Bilateral nodes → Excision of primary and comprehensive bilateral neck dissection as indicated

Parotid nodes involved → Excision of primary and superficial parotidectomy and ipsilateral neck dissection as indicated

RT and consider concurrent systemic therapy

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

See Principles of Treatment for Squamous Cell Skin Cancer (SCC-8).
See Principles of Radiation Therapy for Squamous Cell Skin Cancer (SCC-C).
Multidisciplinary consultation recommended. Consider systemic therapies recommended for use with radiation to treat head and neck squamous cell carcinomas. See NCCN Guidelines for Head and Neck Cancers.
References


