Squamous Cell Carcinoma

National Follow-up Guideline

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Approved by	WoSCAN Skin Cancer MCN, SCAN Skin Cancer Group, NCA Skin Cancer MCN
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National Follow-up Guideline Review

The purpose of a national follow-up guideline is to ensure consistency of practice across Scotland and ensure that management of patients after initial treatment for skin cancer is:

- Patient-centred;
- Aligned to recognised current best practice;
- Equitable across the region;
- Clinically safe and effective; and
- Efficiently delivered.

The guideline is developed on the basis that the key aims underpinning the purpose of follow-up are to:

- Manage and treat symptoms and complications;
- Encourage healthy lifestyle habits;
- Detect and treat recurrent disease; and
- Provide psychological and supportive care.

Follow-up practice has to be patient centred and, ideally, supported by empirical evidence of improved outcomes and survival. In the absence of good quality evidence, care should be tailored to the needs and preference of patients. The construction of appropriate follow-up guidance requires balancing perceived patient needs with effective utilisation of resources.

A review of evidence and guidance on the management of follow-up after treatment for Squamous Cell Carcinoma (SCC) has been undertaken and the follow-up guideline has been developed to reflect current practice[1,2].

Appendices 1 and 2 provide the full follow-up guidance for SCC.

This national guideline is recommended by the three regional Skin Cancer Networks whose members also recognise that specific needs of individual patients may require to be met by an alternative approach and that this will be provided where necessary and documented in the patient notes.

References:

1. British Association of Dermatologists guidelines for the management of people with cutaneous squamous cell carcinoma 2020, SG Keohane et al British Journal of Dermatology (2021) 184, 401-414 (Table extracted from correction published March 2022)

2. Scottish Intercollegiate Guidelines Network (SIGN). Management of primary cutaneous squamous cell carcinoma. Edinburgh: SIGN; 2014. (SIGN publication no. 140). [June 2014]. Available from URL: http://www.sign.ac.uk

Appendix 1: Cutaneous Squamous Cell Carcinoma Follow-up Guidelines[1]

Risk Category	Schedule of care (FUA = Follow-up appointment)	Total duration of recommended FU
Low	Follow-up in secondary care not needed after single post-treatment appointment, where appropriate. Full skin check, examination of regional lymph node basin, discussion of diagnosis and patient education, this may take place before the histological diagnosis. Patient education about sun protection and skin surveillance is advised. Patients and their GPs should be informed of the risk of further cSCCs. There is a 40% risk of a further keratinocyte cancer within 5 years. If this is suspected, refer via the 2-week wait pathway*.	Single FUA
High	4 monthly for 12 months (+ 6 monthly for the second year) especially if several risk factors apply. Full skin check, examination of regional lymph node basin, discussion of diagnosis and patient education. Advise patient education about sun protection and skin surveillance. Patients with more than one prior keratinocyte carcinomas have a 80% risk of a further keratinocyte cancer within 5 years.	2 years
Very High	4 monthly for 2 years and 6 monthly for a third year. Full skin check, examination of regional lymph node basin, discussion of diagnosis and patient education. Advise patient education about sun protection and skin surveillance. Patients with more than one prior keratinocyte carcinomas have a 80% risk of a further keratinocyte cancer within 5 years.	3 years

*In NHS Scotland, the equivalent referral category would be Urgent Suspicion of Cancer (USOC)

Patients with **metastatic cSCC** should be followed-up at 3 monthly intervals for 2 years, then 6 monthly for a further 3 years, with potential longer term review dependent on patient factors. Imaging should be based on clinical findings, with MDT discussion if appropriate.

Where a patient is treated by multiple specialties, an effort should be made to co-ordinate review appointments thus sharing the workload and reducing duplicate appointments.

Appendix 2: Risk Assessment according to BAD guidelines[1]

	Low Risk	High Risk	Very High Risk
Tumour Factors	Tumour diameter ≤20 mm (= pT1) Tumour thickness ≤4 mm Invasion into dermis No perineural invasion Well differentiated or moderately differentiated histology No lymphovascular invasion (ALL ABOVE FACTORS SHOULD APPLY to denote a low-risk tumour)	Diameter >20 – 40 mm (= pT2) Thickness >4 mm – 6 mm Invasion into subcutaneous fat Perineural invasion present – dermal only; nerve diameter <0.1 mm Poorly differentiated histology Lymphovascular invasion Tumour site ear or lip Tumour arising within scar or area of chronic inflammation (ANY SINGLE FACTOR denotes a high-risk tumour)	Diameter >40 mm (= pT3) Thickness >6 mm Invasion beyond subcutaneous fat Any bone invasion Perineural invasion present in named nerve; nerve ≥0.1 mm; or nerve beyond dermis High-grade histological subtype – adenosquamous, desmoplastic, spindle/sarcomatoid/metaplastic In-transit metastasis (ANY SINGLE FACTOR denotes a very high-risk tumour)
Margin Status	Clear pathology margins in all dimensions (≥1 mm)	One or more involved or close (<1 mm) pathology margin in a pT1 tumour.	One or more involved or close (<1 mm) pathology margin in a high-risk tumour.
Patient Factors	Immune-competent	Iatrogenic immunosuppression or biological therapies; frailty &/or comorbidities likely to cause some degree of immune compromise; HIV infection stabilised on HAART	AS FOR HIGH-RISK especially: solid organ transplant recipients; haematological malignancies such as chronic lymphocytic leukaemia or myelofibrosis; other significant immunosuppression