

Cutaneous Squamous Cell Carcinoma

- A common cancer caused by malignant proliferation of epidermal keratinocytes.

Epidemiology

- 2nd most common skin CA after basal cell
- ~20% of skin CA
- Estimated 3.5 million non-melanoma skin CA in US in 2006
- Less than 1% AK's progress to SCC
- Greater than 90% cure rate with local therapy

Risk factors: Cumulative UV light exposure, skin that burns easily, light hair, older age, northern European, immunosuppression, exposure to radiation, smoking, geographic location.

Prevention: Limit sun exposure, use sunscreen, hats, sun-protective clothing.

Clinical features

Location – Anywhere on skin but most commonly in sun-exposed areas.

Appearance:

- **SCC in situ (Bowen's disease)** – Well demarcated, scaly patch or plaque, slow growing over years, asymptomatic.
- **Invasive SCC** – Often asymptomatic, but sometimes painful or pruritic.
 - **Well-differentiated lesions** - Indurated, firm, hyperkeratotic papules, plaques or nodules, possible ulceration.
 - **Poorly-differentiated lesions** – Fleshy, soft, granulomatous papules or nodules w/o hyperkeratosis, possible ulceration, hemorrhage, or necrosis.

Diagnosis: histologic

- Biopsy: shave, punch, or excisional. Should be into dermis.
- Indications for bx: Tenderness, bleeding, or palpable underlying substance.
- Actinic keratosis is partial thickness, Bowens is full epidermis, invasive SCC is into dermis.

Treatment

- Low risk SCC's and Bowen's – local excision, cryotherapy, or electrosurgery. Possible topical chemotherapy w/5-FU or RT.
- High-risk SCC's – Surgical excision, Mohs surgery, possible RT.

Follow-up: Q3-6 months x 2 years then yearly for visual inspection and palpation.