**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.