key points

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Cutaneous squamous cell carcinoma (cSCC) is the second most common non-melanoma skin cancer after basal cell carcinoma, with an estimated incidence of 77 per 100,000 patient-years. cSCC can develop de novo or from pre-existing chronic actinic damage, although the probability and speed of transition from actinic keratosis to cSCC is highly variable.

The occurrence of cSCC is related to chronic UV exposure, particularly occupational exposure. Risk factors include fairer skin, significant exposure to sunlight or therapeutic UV radiation (PUVA). Incidence is also significantly increased in patients who are immunosuppressed, either due to disease or medications. Solid organ transplant recipients have a 65 to 250-fold increased risk. Long-term exposure to azathioprine, which is photocarcinogenic, is a significant risk factor as is immunosuppression caused by haematological disease, especially chronic lymphocytic leukaemia which confers an 8 to 10-fold increased risk.

cSCC usually presents as an enlarging, indurated, scaly, keratotic or crusted lump over a course of weeks to months. The lesions can be domed, crateriform or peaked in shape. They may ulcerate and can often be tender or painful. Common sites are sun exposed areas such as the scalp, temples, face, helical rim, lateral neck, forearms, hands and lower legs. They can range in size from a diameter of a few millimetres to several centimetres. Any evidence of surrounding sun damage should be recorded and the lesion should be palpated to elicit tenderness and determine whether it is mobile or fixed to deeper tissues. The draining lymph nodes should be palpated and a full skin check for other lesions should be performed.

All patients with suspected cSCC should be referred via the two-week wait pathway to a dermatology department. The differential diagnosis includes basal cell carcinoma, hypertrophic actinic keratosis and keratoacanthoma. A keratoacanthoma is a well differentiated self-healing SCC and, as it is not possible to differentiate a keratoacanthoma from a cSCC clinically with confidence, all lesions should be referred for excision.

A definitive diagnosis is made histologically following excisional or incisional biopsy. Once a diagnosis is made the tumour is then staged using the TNM classification. The vast majority of cSCCs are treated by surgical excision with a 4-10 mm margin depending on the size of the tumour.

The risk of metastasis is low (1.1-2.6%), but once metastasis has occurred the prognosis is poor with a mortality rate of more than 70%. Those lesions which are at particular risk of recurrence and metastasis to lymph nodes can be determined from the tumour size, site and histology, and the patient's immune status. Follow-up should include a full skin check, palpation of draining lymph nodes and patient education on skin surveillance. The duration and frequency of follow-up varies according to the risk status.