4.7 Skin Cancer of the Head and Neck (lip, ear and face)

For more detail on the management of malignant melanoma, see the Cancer Care Nova Scotia “Guidelines for the Management of Malignant Melanoma” (2008).

All skin cancers (basal cell (BCC), squamous cell (SCC) and malignant melanoma) are common on the head and neck. BCC is the most common skin cancer and 85% are found on the head and neck. Melanoma on the face most often takes the form of an in situ (Hutchinson's melanotic freckle or lentigo maligna) or thin invasive lesion.

Prognosis

BCC rarely metastasizes but can cause significant morbidity, particularly when invasion is around areas such as the eye, nose or skull.

SCC is locally aggressive with ability to metastasize.

Melanomas diagnosed at an early stage are highly curable but the median survival for metastatic melanoma is poor.

Referral Information

Delay, misdiagnosis or mismanagement of malignant melanoma can have a serious effect on patients’ chances of survival. Therefore these patients need to be urgently referred to and managed by a hospital-based multidisciplinary team with specialist skills.

Local Recurrence (Melanoma)

Local recurrence in a patient with malignant melanoma is an ominous clinical event and is almost always associated with the development of systemic metastases.

Complete surgical resection with primary wound closure is the most straightforward means of treating single recurrent lesions or multiple subcutaneous metastases grouped within a single site with skin grafting or flap closure as necessary for wound coverage. Radiotherapy may be considered where surgery is undesirable because of functional or cosmetic concerns.

Metastatic Disease (Melanoma)

Melanoma is the third most common cause of metastases to the central nervous system. About 2/3 of these are multiple; the other third are solitary metastases.

The management of the patient with distant metastatic melanoma must take into account several important factors. Modalities include chemotherapy, immunotherapy and combined with varied results. Because of the limited efficacy, careful consideration of these therapies must be assessed on an individualized basis. The aims of therapy in stage IV melanoma must be clearly defined and generally include one or more of the following: (1) to relieve symptoms of a life-threatening problem, (2) to increase length of survival and (3) to evaluate new therapies.
Recommended Treatment:

Refer to palliative care.

Resectable disease – resect with appropriate margins with observation or interferon alfa 2B

Unresectable disease:
1. Dacarbazine or temozolomide
2. Radiation remains the primary treatment modality for symptomatic bone metastases.
3. Radiotherapy where appropriate (i.e. brain mets, advanced axillary or groin disease and extensive cutaneous lesions not amenable to surgery or for functional or cosmetic reasons)
4. Consider clinical trial
   • Cisplatin as second line chemotherapy if Performance Status is 0-2
Consider ABCD.
Lesions that are: Asymmetric, irregular Borders, Colour variation and Diameters exceeding 6 mm are considered suspicious.
Also any lesion that becomes lighter or darker in colour, increases in size or becomes raised or itches or bleeds

Biopsy
Shave biopsies and ablation NOT recommended
Punch biopsies should be referred to Surgical Oncologist

Complete surgical excision

If positive or close margins and re-resection is not possible gross residual disease
multiple positive lymph nodes or single node >= 3 cm extra nodal and soft tissue extension

Yes
No

Refer to Oncologist for discussion of observation vs interferon

T4 N0 or any T N+

Refer to Oncologist for discussion regarding loco-regional radiotherapy

Refer to Radiation Oncologist for discussion regarding loco-regional radiotherapy

See also Guideline for the Management of Malignant Melanoma (CCNS 2008)

Bone scan
Advanced scanning with IV contrast of the chest, abdomen and pelvis
CT or MRI brain scan

Metastatic work up negative
Yes
No

Metastatic work up negative

Refer to Multidisciplinary H&N team

No metastatic workup required
CXR routine lab work including LDH

Clinically negative

Clinically positive

CT – head & neck, chest & abdomen Lab investigations including LDH

>4 mm

1-4 mm

>4 mm

Clinically negative

Nodal status

Radical lymph node dissection

Sentinel lymphadenectomy at time of wide and deep excision of the primary melanoma

Yes

Palpable lymph node

Refer to Multidisciplinary H&N team

Information and Supportive/Psychosocial Care services are available to patients throughout the continuum of care (see Part 5 p48)
Practice Pathway for the Management of Non-melanoma Skin Cancer (Basal Cell Carcinoma (BCC) and Squamous Cell Carcinoma (SCC))

**Presenting symptoms**
- Pearly/waxy bump (BCC)
- Flash-coloured, brown scar-like lesion (BCC)
- Visible blood vessels (telangiectases) (BCC)
- Sore that does not heal (BCC)
- Firm red bump (SCC)
- Flat lesion with scaly, crusty surface (SCC)

**Initial Workup**
- Lesion excised by incision
- Pathology review
- Appropriate wide local excision or incisional biopsy depending on size and location

**Treatment of Primary**
- Positive or close margins
- Consider re-excision or referral to H&N team at QEIH HSC
- Other non-SCC/BCC malignancies on pathology
- Individualized management or referral to H&N team for assessment & specialized management

**Management of the Neck**
- SCC/BCC with clear margins
- Nodal status
- Selective neck dissection
- Management of the neck not required
- SCC >4 cm should consider elective nodal management

**Follow Up and Surveillance**
- Individualized follow up by family physician or local team
- Followed by H&N team
- History and Physical Exam
  - Year 1 and 2 every 2-4 months
  - Years 3-5 every 6 months
  - > 5 years every 12 months
- If recurrence detected, refer to Management of Recurrence (p 34)

Information and Supportive/Psychosocial Care services are available to patients throughout the continuum of care (see Part 5 p48)

Skin Cancer of the Head and Neck