

Cutaneous Squamous Cell Carcinoma Case Studies

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Disclosure Information

Consulting or Advisory Role: Bristol-Myers Squibb, Regeneron, Pfizer

Case #1: 63 year old man with cSCC scalp

- Past Medical History: Diabetes mellitus type II, hypertension, hyperlipidemia, peripheral neuropathy, nonmelanoma skin cancers including cutaneous squamous cell carcinoma and basal cell carcinoma
- 1/11/22: Biopsy – poorly differentiated squamous cell carcinoma of scalp
- 2/2/22: Mohs surgery completed for cSCC scalp
- 9/13/22: Recurrent lesion on scalp – seen by dermatology
- 9/23/22: Oncology consult - imaging recommended
- 10/10/2022: MRI of head - soft tissue abnormality noted at the vertex of the scalp measuring 4-5 cm.
- 10/21/22: Consult with radiation oncology
- 10/25/22-12/12/22: Received radiation to total dose of 6000 cGy. Grade 1 dermatitis reported.
- January 2023: Persistent scalp defect noted during dermatology follow up visit – referred for 2nd opinion to Atrium Health Levine Cancer Institute Cutaneous clinic

1/12/23

- Picture of patient's scalp at presentation for his 2nd opinion visit.
- What would be your recommended next steps?
 - Refer to head and neck surgery
 - Refer for consideration of Mohs
 - Recommend imaging
 - Recommend further radiation
 - Initiate systemic therapy



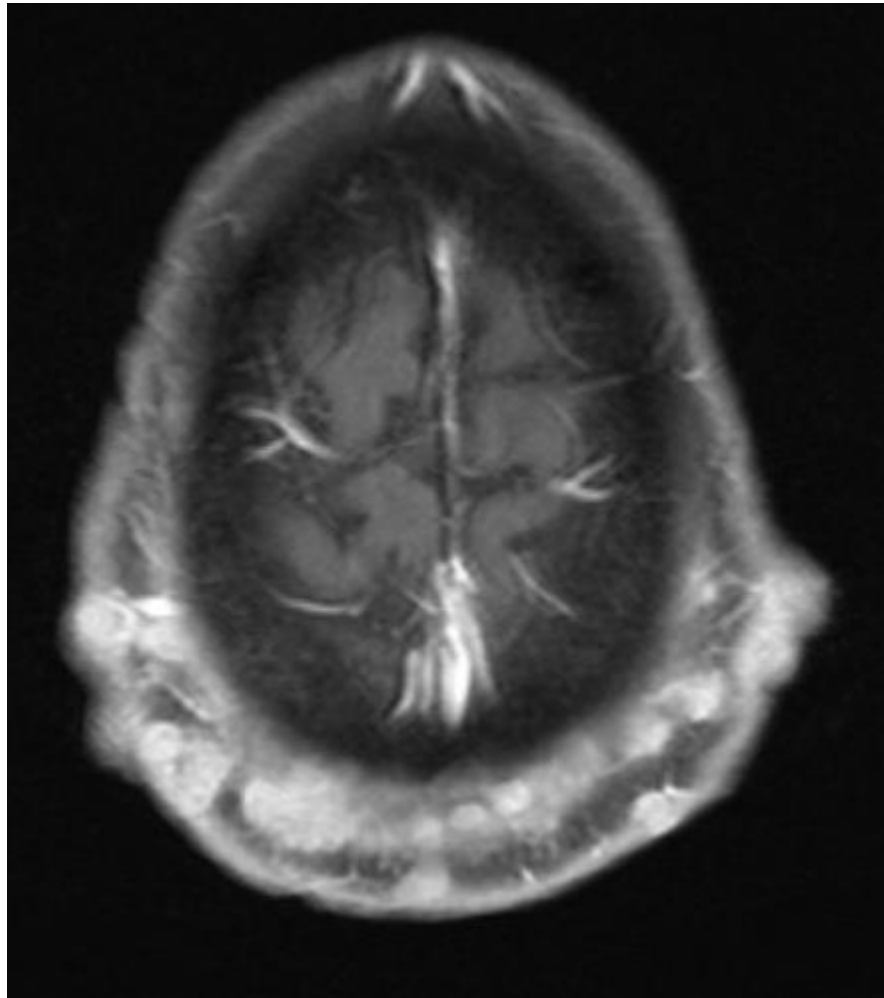
Patient presentation

1/12/23

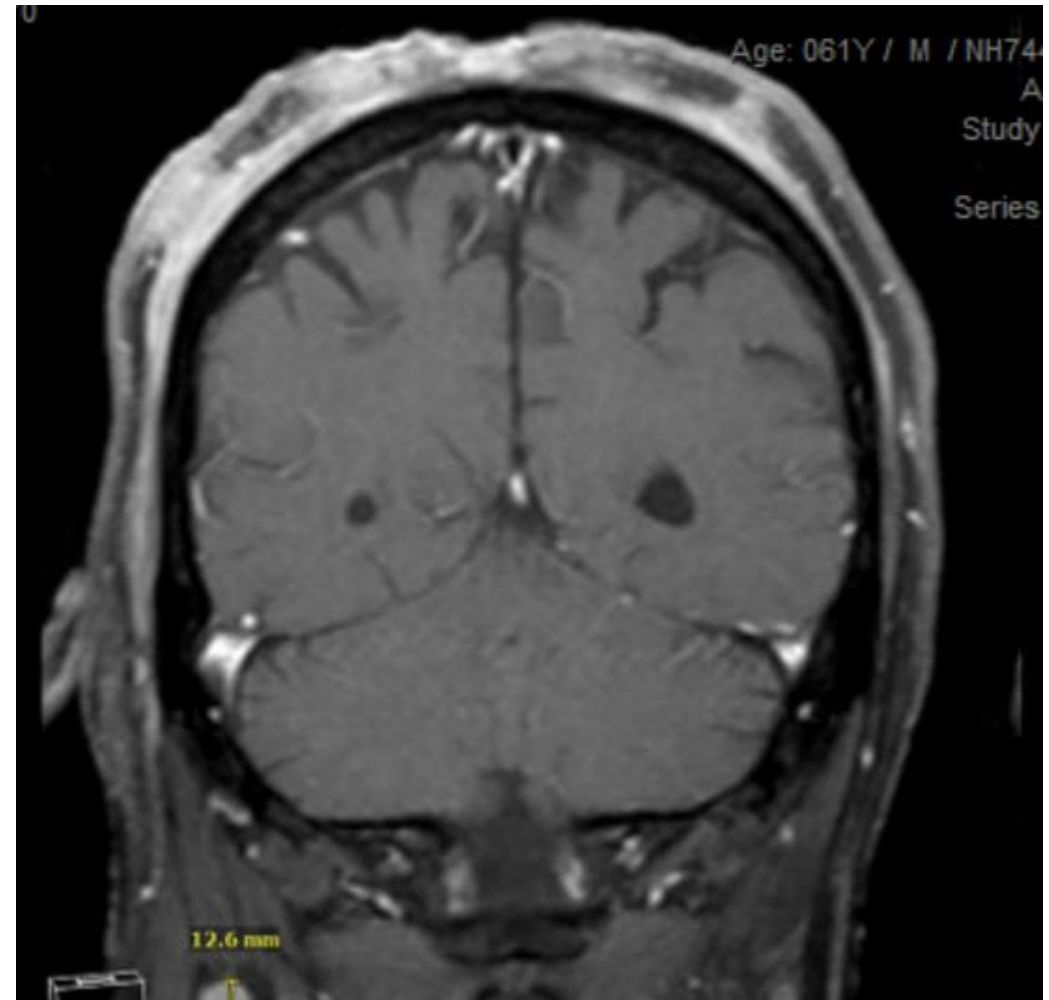
- 1/12/23: 2nd opinion Levine Cancer Institute Cutaneous Oncology clinic – Dermal and subcutaneous lesions noted suspicious for in-transit metastases
- Multifocal punch biopsies performed - Consistent with squamous cell carcinoma, poorly differentiated.
 - A. Skin, right vertex of scalp, punch biopsy: Squamous cell carcinoma, poorly differentiated
 - B. Skin, right parietal, punch biopsy: Squamous cell carcinoma, poorly differentiated
 - C. Skin, left vertex, punch biopsy: Squamous cell carcinoma, poorly differentiated
- 1/18/23: Discussed imaging and pathology at multidisciplinary cutaneous malignancy tumor board. Plan to initiate anti-PD1 antibody therapy for biopsy proven unresectable in transit disease.



Staging imaging



02/03/2023



02/03/2023

Clinical Photos – initiation of systemic therapy with Cemiplimab 350 mg IV every 3 weeks



2/06/23



2/06/23

Clinical Photos – 2nd infusion of anti-PD1 antibody



3/02/23



3/02/23



3/02/23

Clinical photos – 3rd infusion of anti-PD1 antibody

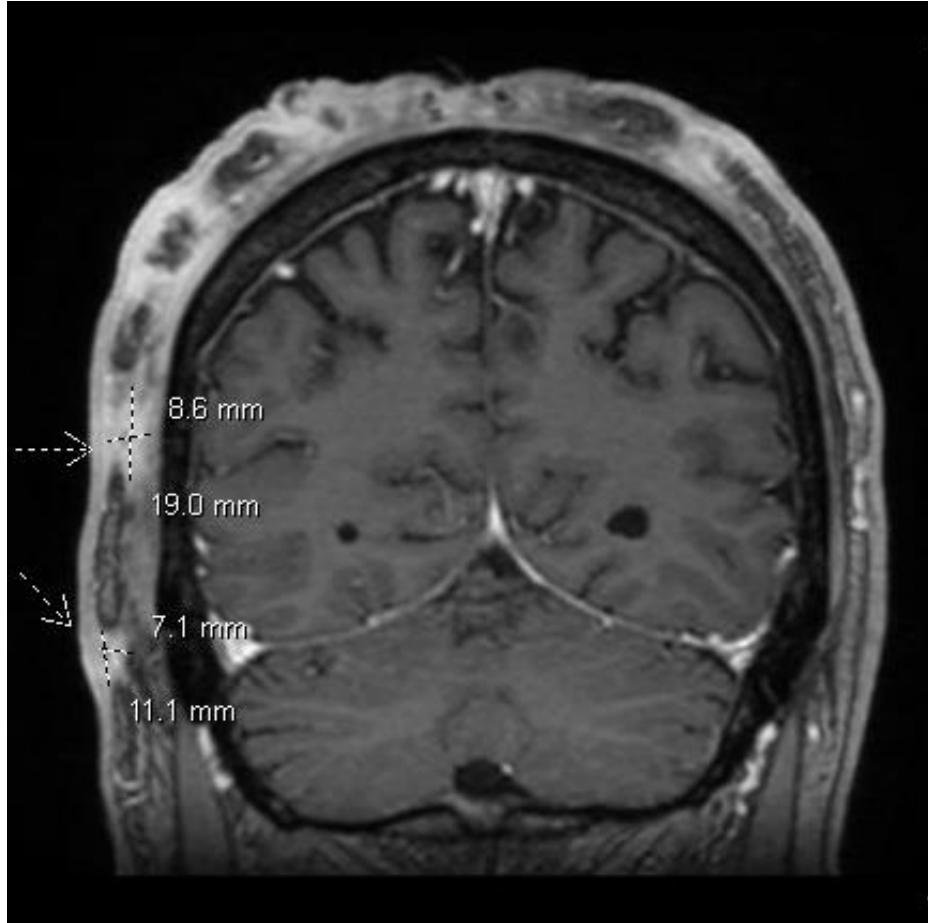


3/30/23

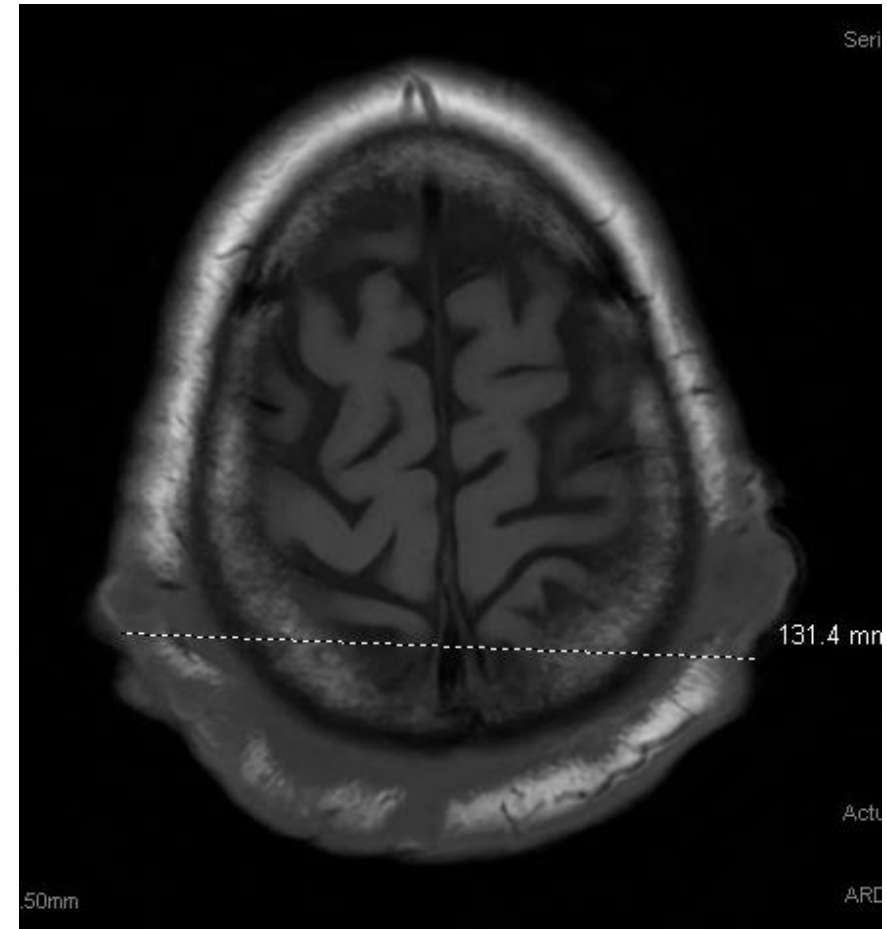


3/30/23

Imaging – After 2 infusions of anti-PD1 antibody



3/27/23



3/27/23

Clinical photos – 5th infusion of anti-PD1 antibody

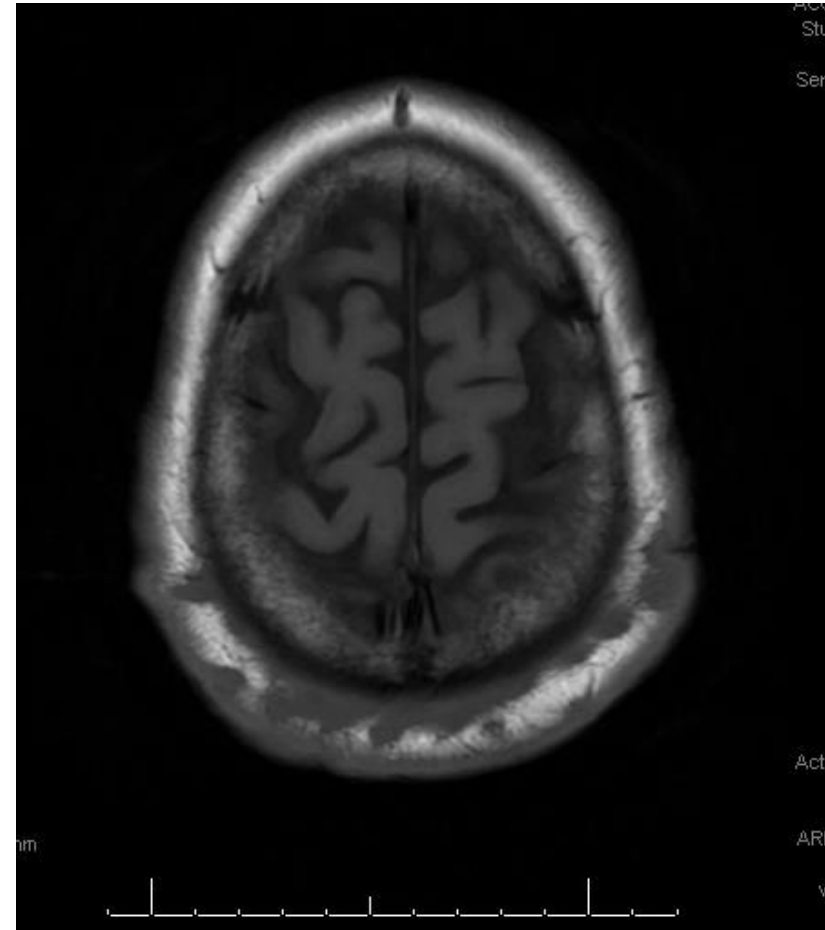
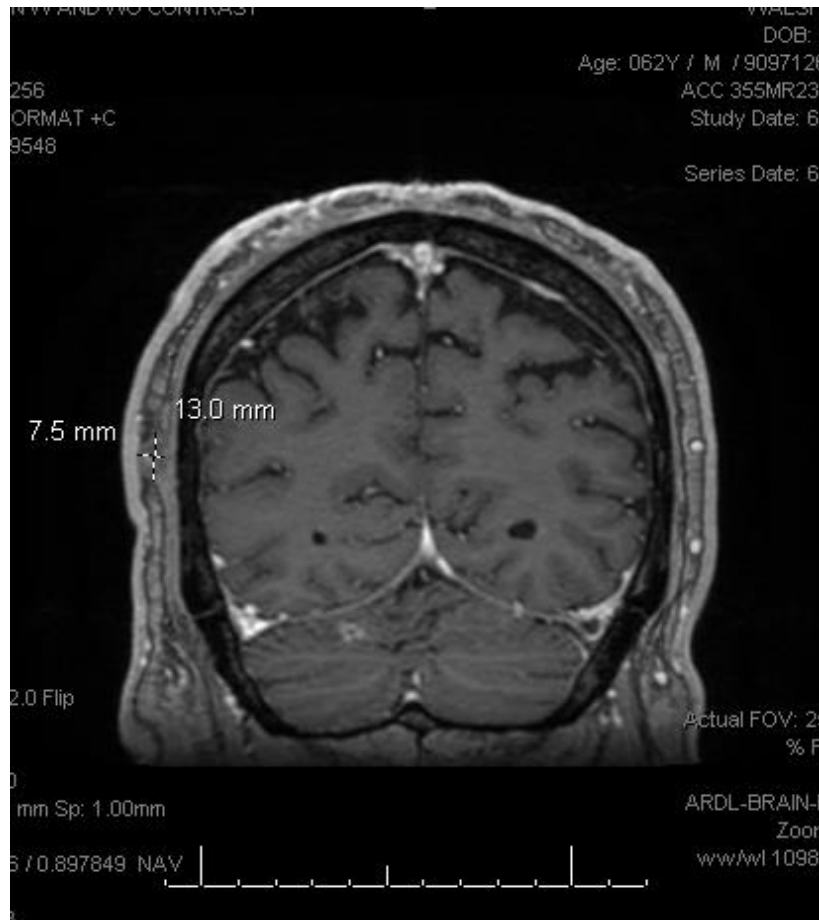


5/9/23



5/9/23

Imaging – after 6 infusions of anti-PD1 antibody



Treatment Course

- Patient remains on systemic therapy with excellent tolerance.
- No clinically palpable disease
- Continued radiographic improvements in subcutaneous metastases noted on most recent restaging imaging.



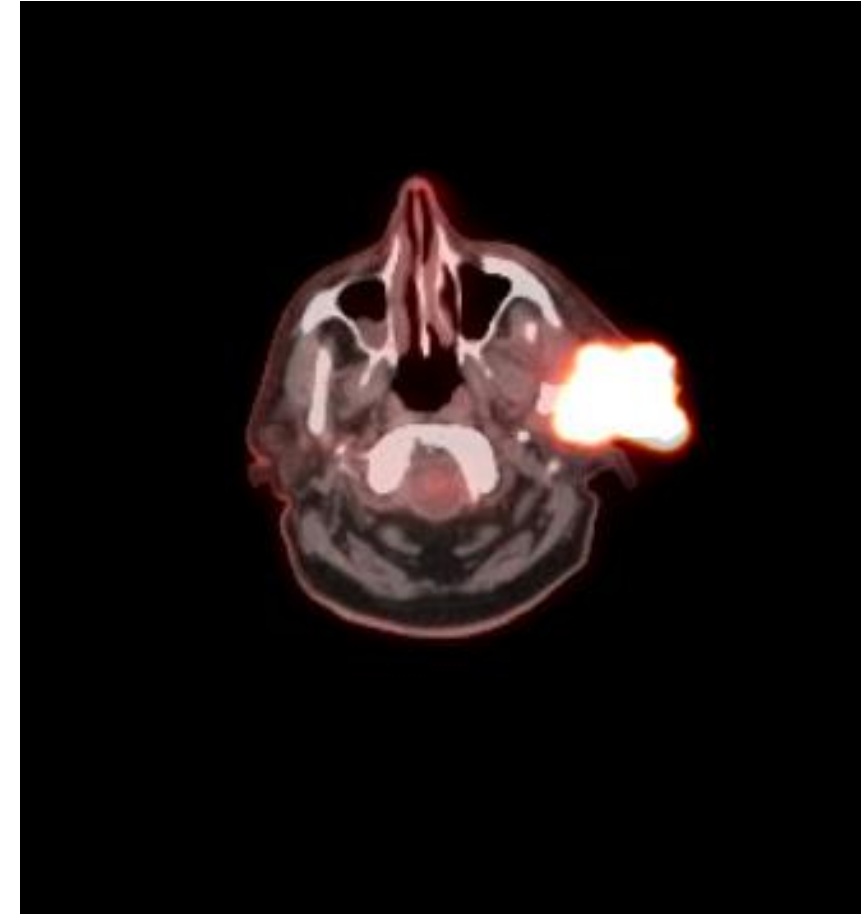
Case #2: 74 year old man with cSCC of the left lateral malar cheek – local regionally advanced disease

- Past Medical History: Hypertension, hyperlipidemia, nonmelanoma skin cancers including cutaneous squamous cell carcinoma basal cell carcinoma
- 10/25/22: Patient was seen by dermatology – left lateral malar cheek/preauricular mass present for 1-2 months. Biopsy performed consistent with keratinizing squamous cell carcinoma
- 11/16/2022: Seen by head and neck surgery who recommended staging imaging with PET/CT and multidisciplinary consultations with medical oncology and radiation oncology.
- 12/01/2022: PET/CT completed for staging.
- 12/2022: Medical oncology consultation in the Atrium Health Levine Cancer Institute Cutaneous clinic.
- 12/2022: Radiation oncology consultation.

Clinical photos and Imaging at presentation – 12/2022

- 12/1/22 PET/CT:

- Hypermetabolic exophytic soft tissue mass involving the left cheek extending into the left parotid gland and left masseter muscle measures 5.4 x 6.3 cm with an SUV max of 29.
- Hypermetabolic intraparotid and left level 2 neck lymph nodes. Inferior left parotid lymph node measures 0.7 x 1.4 cm with an SUV max of 4.7. Left level 2A lymph node measures 0.9 x 1.3 cm with an SUV max of 4.2.
- Multiple asymmetric prominent left level 3, level 4, and left supraclavicular lymph nodes with low-level FDG activity.
- No metabolic evidence of distant metastatic disease.



What would be your recommendation for initial treatment?

- Surgery
- Radiation
- Systemic therapy
- Concurrent radiation and systemic therapy



Treatment:

- Discussed at the multidisciplinary cutaneous malignancy tumor board
- Initiated neoadjuvant systemic therapy with Cemiplimab 350 mg IV every 3 weeks.



Clinical photos



12/08/22



12/20/22



1/10/23

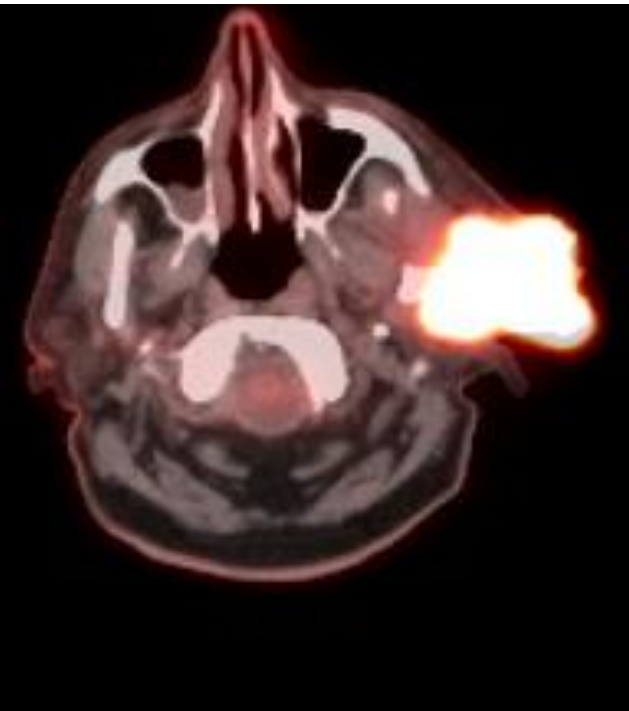


4/25/23

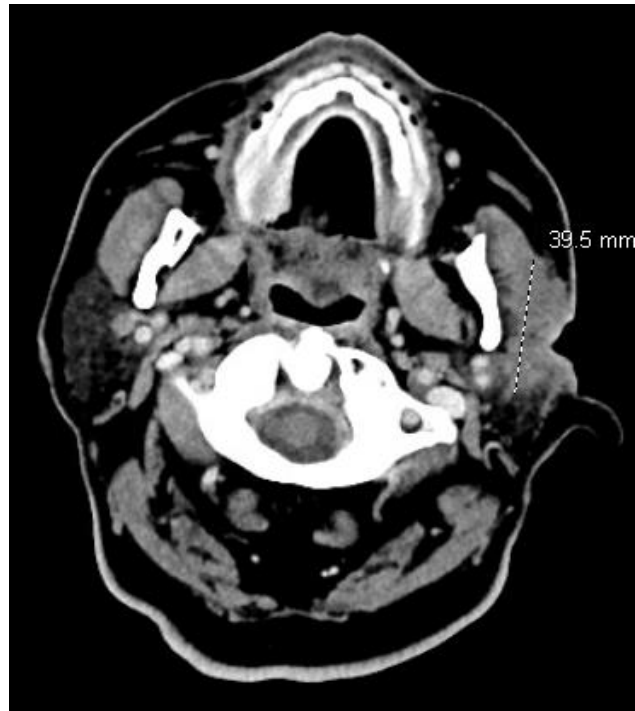


8/16/23

Imaging



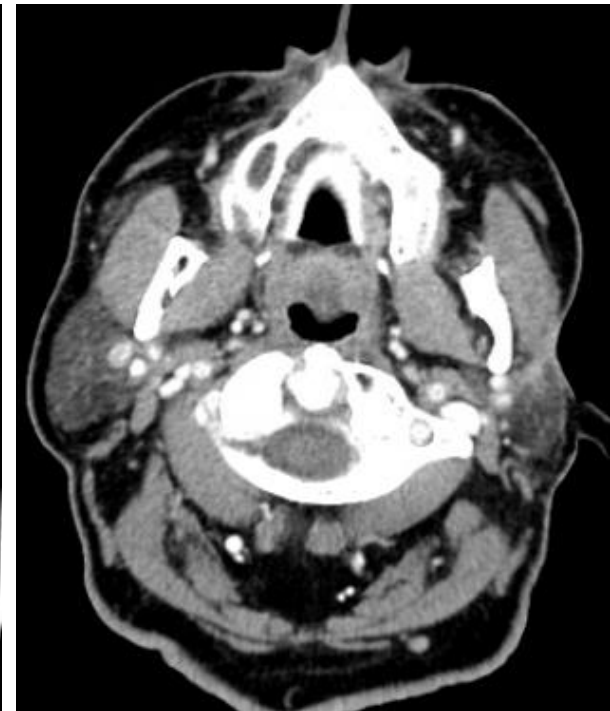
12/01/22



2/10/23



6/01/23



11/27/23

Treatment Course

- Patient had clinical and radiographic response.
- He declined definitive surgical management after initial neoadjuvant therapy in setting of his comorbidities and excellent tolerance to systemic therapy.
- He completed intermittent scouting biopsies to assess progress.
- He completed 1 year total duration of systemic treatment and remains on active surveillance.

Questions