SCC 250 Times More Likely in Transplant Patients

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WILLIAMSBURG, VA. — More than half of patients who undergo organ transplantation will develop a skin cancer, often within the first 5 years after surgery, according to Dr. Henry Randle.

Most of the cancers associated with transplant surgery are squamous cell carcinomas (SCC), which tend to appear as multiple lesions that grow rapidly and exhibit a high rate of recurrence, said Dr. Randle of the Mayo Clinic, Jacksonville, Fla.

These tumors are very aggressive and 5%-8% more likely to metastasize. They require aggressive treatment and frequent follow-up—like every 1-3 months. Don’t let these patients get by without seeing you every 6 months to 1 year,” he said at a meeting of the American Society for Mohs Surgery.

SCCs are up to 250 times more likely to develop in transplant patients than the rest of the population, according to Dr. Randle. These patients also have a 10-fold increased risk of basal cell carcinoma (BCC), a 3- to 5-fold increased risk of malignant melanoma, and up to an 85-fold increased risk of Kaposi sarcoma.

“It is now recognized that skin cancer constitutes 37%-50% of all de novo neoplasms in transplant patients. The typical patient has multiple actinic keratoses andwarts, a reversal of the basal cell-squamous cell carcinoma ratio, and aggressive squamous cell carcinomas that may metastasize and cause death within months to years after the transplant.”

He cited three severity groups:

- **Isolated carcinogenesis.** Patients have a few lesions scattered about, which can be treated with basic therapies.
- **Moderate carcinogenesis.** Patients have up to 10 skin cancers per year. They need more aggressive treatment (usually Mohs surgery), and more frequent follow-up.
- **Catastrophic carcinogenesis.** These patients can get more than 100 SCCs each year and are likely to die from the tumors. They require frequent visits and very aggressive treatment, perhaps with “megasessions,” in which several lesions are removed with Mohs surgery in one treatment. This can be problematic as it usually requires general anesthesia and the sessions can be quite long, Dr. Randle said.

Mohs is not the only treatment that can benefit transplant patients, however. “We need to use all our options to treat them. That includes excisional surgery, Mohs, topical anti-cancer creams, and chemotherapy and radiation in selected patients,” he said.

For superficial, low-risk SCC lesions, aggressive electrodesiccation and curettage or laser surgery should suffice. For large lesions, wide excision including the subcutaneous fat is necessary. For high-risk, rapidly growing, or recurrent SCCs, Mohs is probably the choice. However, because these lesions are more prone to metastasize, a sentinel node biopsy should be considered, Dr. Randle said.

SCC lesions with in-transit metastases will require a wide excision plus radiation, “and very close follow-up, because this treatment will probably fail,” Dr. Randle said.

Transplant patients with skin cancers will do better if they can reduce or eliminate their immunosuppressive medication, “but the transplant surgeons don’t like that suggestion, of course. You need to walk a tightrope between rejection and skin cancer, and it’s not easy,” he said.