	Low risk	High risk	Very high risk
Tumour Factors	Tumour diameter ≤20 mm (= pT1) Tumour thickness ≤4 mm Invasion into dermis No perineural invasion Well differentiated or moderately differentiated histology No lymphovascular invasion (ALL ABOVE FACTORS SHOULD APPLY to denote a low-risk tumour)	Diameter >20 – 40 mm (= pT2) Thickness >4 mm – 6 mm Invasion into subcutaneous fat Perineural invasion present – dermal only; nerve diameter <0.1 mm Poorly differentiated histology Lymphovascular invasion Tumour site ear or lip Tumour arising within scar or area of chronic inflammation (ANY SINGLE FACTOR denotes a high-risk tumour)	Diameter >40 mm (= pT3) Thickness >6 mm Invasion beyond subcutaneous fat Any bone invasion Perineural invasion present in named nerve; nerve ≥0.1 mm; or nerve beyond dermis High-grade histological subtype – adenosquamous, desmoplastic, spindle/ sarcomatoid/metaplastic In-transit metastasis (ANY SINGLE FACTOR denotes a very high-risk tumour)
Margin status	Clear pathology margins in all dimensions (≥1 mm)	One or more involved or close (<1 mm) pathology margin in a pT1 tumour. Close pathology margins (<1 mm) in a pT2 tumour.	One or more involved or close (<1 mm) pathology margin in a high-risk tumour
Patient Factors	Immune-competent	Iatrogenic immunosuppression or biological therapies; frailty &/or comorbidities likely to cause some degree of immune compromise; HIV infection stabilised on HAART	AS FOR HIGH-RISK especially: solid organ transplant recipients; haematological malignancies such as chronic lymphocytic leukaemia or myelofibrosis; other significant immunosuppression
Referral to MDT *(Scotland has no LSMDT/ SSMDT division)*	LSMDT discussion not needed	LSMDT discussion of patients with close or involved pathology margins; if margins are not involved other factors alone may not require LSMDT discussion unless more than one factor pertains. Patient factors increase risk, but do not mandate LSMDT discussion in absence of tumour risk factors.	SSMDT discussion should be considered for all patients with very high-risk tumours except those which require straightforward standard surgical excision. A referral to or opinion from an appropriate site-specific MDT may be required to ensure the best management.
Follow-up	Follow-up in secondary care not needed after single post-treatment appointment, where appropriate. Full skin check, examination of regional lymph node basin, discussion of diagnosis and patient education, this may take place before the histological diagnosis. Patient education about sun protection and skin surveillance is advised. Patients and their GPs should be informed of the risk of further cSCCs. There is a 40% risk of a further keratinocyte cancer within 5 years. If this is suspected, refer via the 2-week wait pathway.	4-monthly for 12 months (+ 6-monthly for the second year) especially if several risk factors apply. Full skin check, examination of regional lymph node basin,* discussion of diagnosis and patient education. Advise patient education about sun protection and skin surveillance. Patients with more than one prior keratinocyte carcinomas have a 80% risk of a further keratinocyte cancer within 5 years.	4-monthly for 2 years and 6-monthly for a third year. Full skin check, examination of regional lymph node basin,* discussion of diagnosis and patient education. Advise patient education about sun protection and skin surveillance. Patients with more than one prior keratinocyte carcinomas have a 80% risk of a further keratinocyte cancer within 5 years.