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The News in the Treatment of the Oral Cavity Cancers

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Mini Review

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Abstract

Cancers of the oral cavity are within the scope of cancers upper aero digestive tract with similar epidemiological peculiarities. In our country these cancers are the 2nd location of head and neck cancers. In The squamous cell carcinoma is the most common with 90% of cases, the average age of patients is 60 years. The two main risk factors are aloccolo-tobacco consumption. The tumor occurs most often in the form of an ulcerated lesion, the periphery is burgeoning based on an indurated base [1]. The functional signs are late, pain predominates. The paraclinical is radiological, endoscopic and biological. The therapeutic management is decided collegially at a poly disciplinary consultation. The therapeutic step is always followed by regular clinical and Para clinical monitoring. The relative survival to 5 years of these injuries is around 45% for both sexes.

Introduction

Cancers of the oral cavity fit into the general framework of the upper aerodigestive tract cancers. These cancers can be localized in different parts of the oral cavity namely mobile tongue, floor of the mouth, inside of the cheek, retromolar trigone and gingival region. The two main risk factors are tobacco, especially when consumption exceeds 20 pack-years, and alcohol. The diagnosis is usually late in our context, which explains the difficulty in their care, which needs a multidisciplinary consultation [2].

Epidemiology

In the world we are seeing 275,000 new cases per year, or 54 % of the oral cavity cancers, including 40 to 50% seat at the tongue. Incidence in France is among the highest in the world (15 400 new cases in 2000) and so is the 8th cause of death [3]. In Casablanca we have 8180 new cancer cases (2005-2007) oral cavity comes in 2nd position in head and neck cancers, and represents 2% of all cancers.

Risk factors

The study of these factors allows the implementation of a prevention and screening especially for the controllable risk factors such as the alocoolo tobacco intoxication and bad dental status. But the lack of contact with classical carcinogens is a problem for young patients, and in this case raises two probabilities, genetic predisposition and the role of HPV. Genetic predisposition is found in many studies of literature. She results in susceptibility to genetic mutations found in malignant tumors, these mutations are found in tumor biopsies and biopsies of mucous "healthy" surrounding [4]. For HPV, it is involved in carcinogenesis of the skin and mucous carcinoma in situ and invasive (Positive Serology / Sub type 16 +++). HPV infection is most often associated with squamous cell carcinoma in Oro pharyngeal locations (35.6 to 72%), mouth (23.5%) and laryngeal (24%) all histological types are concerned with a predominance basaloid type [5].

Precancerous lesions

The oral cavity cancers appear most often on apparently healthy mucosa. However, they can occur over

a long known preexisting lesion. Localized in 23% of cases on the tongue, leukoplakia is a lesion of an important potential degeneration. Among the precancerous lesions we see the erythroplakia that are rare and observed in 1% of the oral cavity cancers, particularly in the elderly. They often sit in the pelvilingual and retrocommissural region. The management of precancerous lesions is based on the eviction of risk factors and detection of suspicious lesions (role of the dentist and general practitioner), and whenever the lesion's appearance changes (increase in size, appearance mosaic, or hyperplasia appearance warty or papillomatosis florida) it must be excised surgically or by laser with surgical margins of 3 to 4 mm [6].

Pathology

Over 90% of oral cavity cancers are squamous cell carcinomas, born of the overlying mucosa, the remaining fraction is composed for the most part carcinomas developed from the salivary glands, and much more rarely by lymphoma or rare tumors arising from underlying tissues in the lining. There are several sub types of squamous cell carcinomas, like warty carcinoma well-differentiated but infiltration is difficult to determine (requires many levels of middlings after resection), The fusiform with polypoid aspect falsely reassuring and which at its foot an invasive component and others like papillary (invasive), adenosquamous (aggressive poor prognosis ....) [7].

The endoscopic assessment

The panendoscopique must be systematic because the entire lining of the oral cavity is a potential field cancerization. According to various studies the rate of synchronous lesions in the tongue cancers vary between 3 and 6%, which justifies the endoscopic evaluation should be systematic and include bronchoscopy and esophagoscopy.

Radiological Assessment

Dental panoramic

He appreciates the dental status and search any bone loss that appears only if there is a massive invasion.

The head and neck CT

In tumor level, this review provides an excellent evaluation of bony structures. The cervical, visualizing radiologically suspicious lymph nodes involved in the classification of the lesion (much higher reliability in the clinical examination of about 93% against 70% for the isolated palpation) and weighs on the surgical indication (bilateralization a recess). The exploration of the soft parts (oral cavity and oropharynx) in the absence of metal artifact can often sufficient. However, for the assessment of soft tissue invasion, the images produced by magnetic resonance imaging (MRI) are better.

MRI

IT gives valuable information on the extension to soft tissues and the midline especially basilingual or pelvilingual. The cervical lymph nodes are fully explored in this review but require complementary sequences, the following table shows the correlation between MRI and histology in lymph node [8,9].

The management

The management of oral cavity cancer should be a multidisciplinary consultation

Tooth preparation

It must be Systematic because firstly it is incriminated in the local causes of cancer and other hand it the necessary conditions for radiotherapy [2]. Surgical techniques in oral cavity cancers depend on the tumor site: in the tongue cancers, the surgery can range from simple tumor resection in hemiglossectomy more or less wide associated to a lymphadenectomy of the territory I to IV if centerline and the point not reached, if not, it is the indication to perform a glossectomy. In the oral floor cancers according to the invasion of the tumor, we can achieve pelvectomy either orally, interrupted or non-interrupted pelvi-mandibulectomy. These techniques sometimes imposes chirutgicales achieve a tracheotomy to avoid respiratory hazards due to lingual edema and mouth bleeding. For the retromolar trigone cancers often we are led to be aggressive and make a bucopharyngectomy transmaxillary. The surgery of the oral cavity is mutilating thereby reconstruction is fundamental to avoid the risk of orostomes and functional sequelae of amputation. Currently the reconstruction processes are very well developed. We are witnessing the chest myo-cutaneous flap (pectoralis major and latissimus dorsi flap), local flaps (pedicled buccal mucosal flap on facial artery, muscle and fascia temporalis flap, nasolabial and infrahyoidien). Bone reconstruction is made by the graft compound by the fibula of miniplates or by shaping plates [10]. Therapeutic indications vary according to the anatomic sites of the tumor. Decisions are made in accordance with the patient during a polydisciplinary carcinology committee, involving surgeons, anesthesiologists, radiotherapists and medical

oncologists. If small lesions are generally accessible to an isolated treatment (usually surgery or radiation), the larger lesions are part of a combination therapy comprising nodal and tumor removal surgery, reconstruction, and radiation therapy. Associated treatments include the treatment of pain, withdrawal poisoning, nutritional rebalancing, psychological and social monitoring [2,10].

Monitoring

Locoregional control: it is a major problem because despite surgery "sufficient" associated with adjuvant treatment, some patients develop some early locoregional recurrence. The surgical margins are a poor prognosis factor in local control, however, it is unlikely that the limit related to the histological analysis of the resection margins fashion can explain 15 to 20% of small tumors relapsed despite resection sufficient.

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Monitoring of patients: The post treatment follow faces two problems: Patients should be monitored for life which puts a lot of (lost sight), and the diagnostic difficulty of recurrence due to remodeling and fibrosis masking recurrence detection by conventional clinical examination or imaging (CT / MRI). The 5-year survival of the oral cavity cancer does not exceed 45%.

Conclusion

Squamous cell carcinomas of the oral cavity are frequent cancers whose risk factors are clearly identified (alcohol and tobacco intoxication). The land on which they grow so elective is responsible for a late diagnosis. This has consequences for the increase therapeutic effects and an unfavorable prognosis in the medium and long terms, hence the need to make early detection of precancerous lesions and avoid risk factors. The management of these cancers requires adequate multidisciplinary collaboration.

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