

Oral Squamous Cell Carcinoma: A Malignant Tumor

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Description

The most frequent oral malignancy is Oral Squamous Cell Carcinoma (OSCC), which accounts for 80%–90% of all malignant neoplasms of the mouth. Although the prevalence of oral cancer varies highly around the world, it is generally agreed that the oral cavity is the 6th to 9th most common anatomical site for cancer depending primarily on the country (and even specific region in some countries) and gender of the patients. Despite this average incidence, it might be the most common site for cancer in some areas, particularly in Southeast Asia. The most common etiological and predisposing factors for OSCC are smoking and drinking habits, as well as ultraviolet radiation (particularly for lip cancer), but other factors such as Human Papilloma Virus (HPV) and candida infections, nutritional deficiencies, and genetic predisposition have also been associated. OSCC is a disease that affects adults and the elderly with the most common clinical manifestation being an ulcerated lesion with a necrotic centre area and raised rolling edges [1]. Although most studies report similar demographic and clinicopathological data on OSCC, it is acknowledged that several variables change significantly from country to country and even between regions within the same nation. Oral cancer that develops between the vermilion border of the lips and the junction of the hard and soft palates, or the posterior one-third of the tongue is known as oral cancer. Oral squamous cell carcinoma affects almost 95% of those who smoke, drink, or do both. Early treatable lesions are rarely symptomatic, so early diagnosis through screening is essential for preventing deadly disease. Surgery, radiation, or both are used to treat oral cavity cancer, albeit surgery plays a larger role in most cases. The total 5-year survival rate (across all sites and stages) is greater than 50% [2].

Risk Factors

Smoking (particularly >2 packs/day) and alcohol consumption are the two main risk factors for oral squamous cell cancer. When you drink more than 6 ounces of distilled liquor, 15 ounces of wine, or 36 ounces of beer each day, your risk rises considerably. Heavy smoking and alcohol abuse are expected to increase the risk to 100-fold in women and 38-fold in males when combined [3]. Any chronic irritation such as dental caries, overuse of mouthwash, chewing tobacco, or the use of betel quid, can cause squamous cell carcinoma of the tongue. Oral Human Papilloma Virus (HPV) which is usually acquired through oral-genital contact may have a role in the etiology of some oral malignancies. Nevertheless, HPV is found in oral cancer far less frequently than in oropharyngeal cancer. The floor of the mouth or the lateral and ventral surfaces of the tongue are the sites of

about 40% of intraoral squamous cell carcinomas. The lower lip is home to about 38% of all oral squamous cell carcinomas, which are mainly solar-related malignancies on the exterior surface. Oral squamous cell carcinoma can be diagnosed using biopsies, endoscopies to detect secondary malignancies, chest X-rays and CT scans of the head and neck [4].

Treatment of Oral Squamous Cell Carcinoma

Surgery is followed by radiation or chemoradiation if necessary. Surgery is the first-line treatment for the majority of oral cavity malignancies. If the disease is progressing or has high-risk characteristics, radiation or chemoradiation is added postoperatively. Selective neck dissection is recommended if the likelihood of nodal illness is greater than 15% to 20%. Neck dissections are commonly performed for any lesion with a depth of invasion greater than roughly 3.5 mm, notwithstanding the lack of unanimity. Routine surgical rebuilding, ranging from local tissue flaps to free tissue transfers, is the key to decreasing postoperative oral impairments. Following major resections [5], speech and swallowing therapy may be required. Radiation therapy is a primary treatment option and chemotherapy is not frequently used as a primary therapy but it is suggested as an adjuvant therapy in patients with severe nodal disease in addition with radiotherapy. Surgical excision with reconstructing to maximise postoperative function is the treatment for squamous cell carcinoma of the lip. When extensive sections of the lip show signs of premalignant alteration, the lip can be surgically shaved or all the damaged mucosa can be removed with a laser. Mohs surgery is an option. Following that, sunscreen should be used as needed.

References

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