

Case Report

Is A Killer Hiding Under Your Nose? Case Reports on Advanced Oral Squamous Cell Carcinoma

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Abstract

Oral cancer is an important health problem worldwide. According to the World Health Organization, oral cancers have increased in the past few decades. Early diagnosis is of vital importance for the prognosis of the patients with oral squamous cell carcinomas. An early diagnosis is not necessarily easy because both patients and health care professionals underrate the initial lesions, which are generally asymptomatic. This reality suggests that physicians have gaps in their knowledge of pathology, that patients delay seeking medical care and that access to and the quality of medical care are deficient, all of which reflect the absence of preventive public health programs and an effective health care system. In this article, we present case reports of oral squamous cell carcinoma with delayed diagnosis emphasizing the pitfalls in diagnosis.

Keywords: Oral cancer, squamous cell carcinoma.

Introduction

Oral cancer is among the top three types of cancers in India. In India, 20 per 100000 populations are affected by oral cancer which accounts for about 30% of all types of cancer out of which 90-95% of the oral cancers are squamous cell carcinoma. Early recognition, diagnosis and treatment of OSCC significantly enhances patient survival and minimizes the need for extensive surgery. For this reason, dentists play a crucial role in the early detection and prevention of oral cancers. [1, 2]

Case Report

A 75 year old female patient reported with the chief complaint of swelling and pain in the right lower back tooth region since 40 days. She had earlier visited a dentist one week prior for the same problem and extraction was done in the same region after which the swelling increased in size. History revealed that she had used tobacco containing powder (GuI) to clean her teeth since last 40 years. On extraoral examination, there was a solitary irregular swelling on the right side lower one third of face, approximately 5 cm in size extending anteroposteriorly from corner of mouth to ramus of mandible and super inferiorly from alaragus line to inferior border of mandible. On palpation it was tender to touch, borders were indurated and right submandibular lymph nodes were enlarged, fixed and tender to touch. Intraorally, the swelling extended from premolar to molar region and involved right buccal mucosa

and vestibule. Patient had a partially edentulous upper and lower arch. Provisional Diagnosis based on clinical features was stage IV ulcer oproliferative lesion of right buccal mucosa.



Figure 1: Intra Oral View (Case 1)



Figure 2: OPG (Case 1)



Figure 3: H & E Stained Section

Another patient aged 72 years male patient reported with the chief complaint of swelling and pain in the right lower back tooth region since 2 months. He too visited a dentist and extraction was done in the same region after which pain and swelling became unbearable. History revealed no evidence of tobacco consumption but he used tobacco containing powder to clean his teeth since childhood. Extraorally, there was facial asymmetry due to swelling involving right lower one third of the face, a solitary, roughly oval swelling approximately 4 cm was present extending antero posteriorly from corner of mouth to ramus and supero inferiorly from occlusal plane to inferior border of mandible. On palpation it was tender to touch, there was loss in continuity of lower border of mandible near angle of mandible and borders were indurated. Right submandibular lymph node was enlarged, tender and fixed. Intraorally, the swelling was involving lower right alveolar ridge and extending from premolar to molar region. Provisional diagnosis based on clinical features was Stage-IV Ulcerproliferative type of carcinoma of right lower residual alveolar ridge. Biopsy was done and diagnosis was confirmed histopathologically in both cases (fig. 3,6).



Figure 4: Intra Oral View (Case 2)



Figure 5: OPG (Case 2)

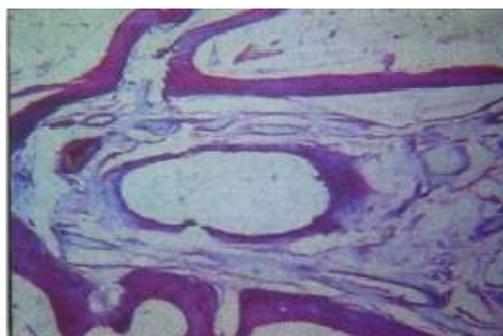


Figure 6: H & E Stained Section

Discussion

In India, oral squamous cell carcinoma is commonly observed to involve the alveolobuccal region of oral cavity. This could very well be a sequela of the fact that smokeless tobacco is used widely in various forms, such as chewable paan masala, khaini, gutka, mawa etc., and the common habit of holding the tobacco quid in buccal vestibule, and under the tongue. These are also the regions where keratinisation of oral epithelium is relatively less and blood supply richer. This leads to a higher chance of development of premalignant lesions and subsequently malignant change in the same. This is also a reason why carcinomatous transformation in the posterior aspect of oral cavity carries the risk of metastasis to regional lymph nodes.

One tricky point in recording the history in both the cases mentioned in this article is the lack of overt tobacco use. Neither of the patients was in favour of chewing tobacco but both of them reported with a dependency on using GuI- a preparation sold as medicament for gum pain. Unknown to the gullible populace however this ‘medicament’ contains smokeless tobacco and its use results in addiction over a period of time. As a consequence, even patients, who are otherwise aware of the dangerous

effects of tobacco, end up using Gul and similar products and eventually develop tobacco related oral diseases.

Points to consider while making diagnosis are symptomatic and/or non-symptomatic non-healing lesions of oral mucosa, history of smoking, chewing tobacco, alcohol consumption, oral human papilloma virus infection, drug use, long-term exposure to sunlight, advanced age, the presence of immunodeficiency, the presence of genetic disease and poor oral hygiene. Tumours found towards the posterior aspect of oral cavity often remain unnoticed in screening examinations, and once symptoms arise from regional lymph node metastases, the tumors are at an advanced stage at the time of initial diagnosis. Some of the pitfalls in diagnosis come from misinterpretation of history/incomplete history, overlooking abnormalities, overlapping clinical features, expensive oral cancer screening methods, no follow up, improper management of potentially malignant lesions. The survival ratio of patients with head and neck cancers is 76% in cases of early diagnosis without metastasis, 41% in cases involving cervical lymph node metastases and 9% if there is metastasis under the neck region. Dysplastic oral mucosal lesions may develop into oral squamous cell carcinomas without early diagnosis and treatment. The survival duration of patients with oral squamous cell carcinomas may be lengthened to five years in stages I and II compared with stages III and IV. Patients in stages III and IV are reported to have a minimum six months or maximum one year survival duration. [4, 5]

Discussion

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