WHAT'S**NEW**

Cancers of The Oral Cavity

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Cancers of the oral cavity are not uncommon. They form approximately 20 to 25 per cent of all head and neck cancers in Singapore. In USA, it is reported to be the sixth most common cancer, while in India, it is one of the most common cancers. The oral cavity is defined by the lips anteriorly, the hard plate superiorly, the anterior two-thirds of the tongue as well as the floor of mouth inferiorly and laterally the buccal mucosa and gingiva with its upper and lower sets of teeth. The most common sites that are affected include the tongue, the gums (gingiva), as well as the palate and buccal mucosa. Tongue cancers are probably the more common types of oral cavity cancers. The vast majority of these cancers are squamous cell carcinomas.

Aetiology

Patients with cancers of the oral cavity are associated with heavy smoking as well as drinking. Poor dental hygiene is also a known factor, probably a result of chronic inflammatory changes which leads to dysplasia and eventually frank malignant changes. Precursors of malignant change such as leukoplakia (a white patch on the mucosa which cannot be removed) or erythroplakia (an intense red patch) are well known. Leukoplakia carries a smaller risk than erythroplakia but nonetheless any symptomatic leukoplakic patch or suspicious patch should be excised because early malignant changes may be present. Habits such as betel nut chewing and tobacco chewing are associated with oral cavity cancers. The lower lip is believed to be at risk for developing cancers because of exposure to sunlight. There is however a group of oral cavity cancer patients without any of these well known associated factors. They are young (< 50 years), female, non smokers and non drinkers. There is some evidence to suggest that human papilloma virus (HPV) may play a role in these non high-risk patients who develop oral cavity cancers.

Clinical presentation

The usual presentation is that of a non-healing ulcer that is usually painful. It may bleed. The ulcer never heals and in fact will progress in size and symptoms. On the tongue, it will usually be located at the lateral aspect (Figure 1). Occasionally, the patients may also have a lymph node enlargement. The nodal enlargement is often in the submandibular fossa or the submentum. The significance of a persistent non-healing ulcer in the oral cavity is that a biopsy needs to be performed. Pain and fungation of the tumour are usually the reasons why these patients should have treatment.

Management

Once a diagnosis is made, staging investigations are performed. The patient's problems are discussed at the Head & Neck Tumour Board. Definitive treatment for oral cavity cancers is often by surgery although radiation with/without chemotherapy may also be used in selected patients. Surgery can be performed by laser excision if the lesion is small enough. In patients with larger tumours, a neck dissection is performed to remove any nodal metastasis and the primary tumour is accessed by a split in the mandible. Reconstruction at our centre is usually achieved by using either a pedicled flap from the chest (pectoralis major) or a free tissue transfer, often from the forearm. In general, patients with small tumours, without deep invasion or nodal metastasis are the ones who survive longer.

Figure 1
A 50-year-old male smoker with a malignant right tongue ulcer