Oral Cancer

An Update on Progress & Challenges

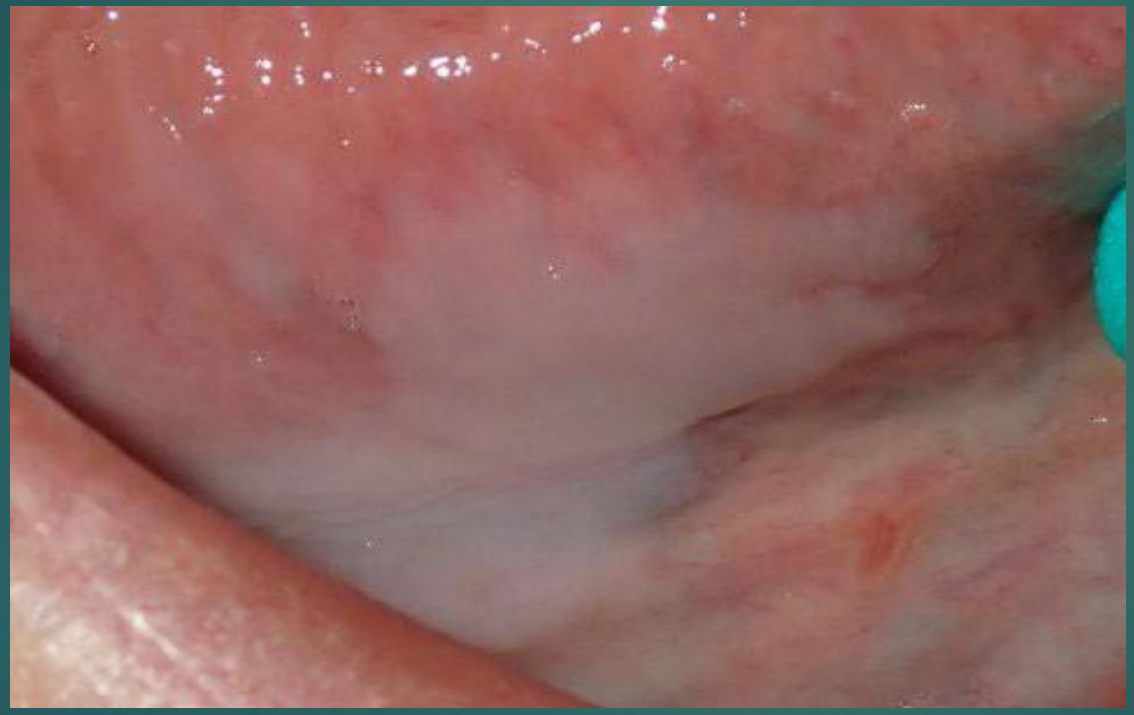
PIERCE OSBORNE, DDS
FRED CHURCH, DDS

ORAL NEOPLASTIC LESIONS

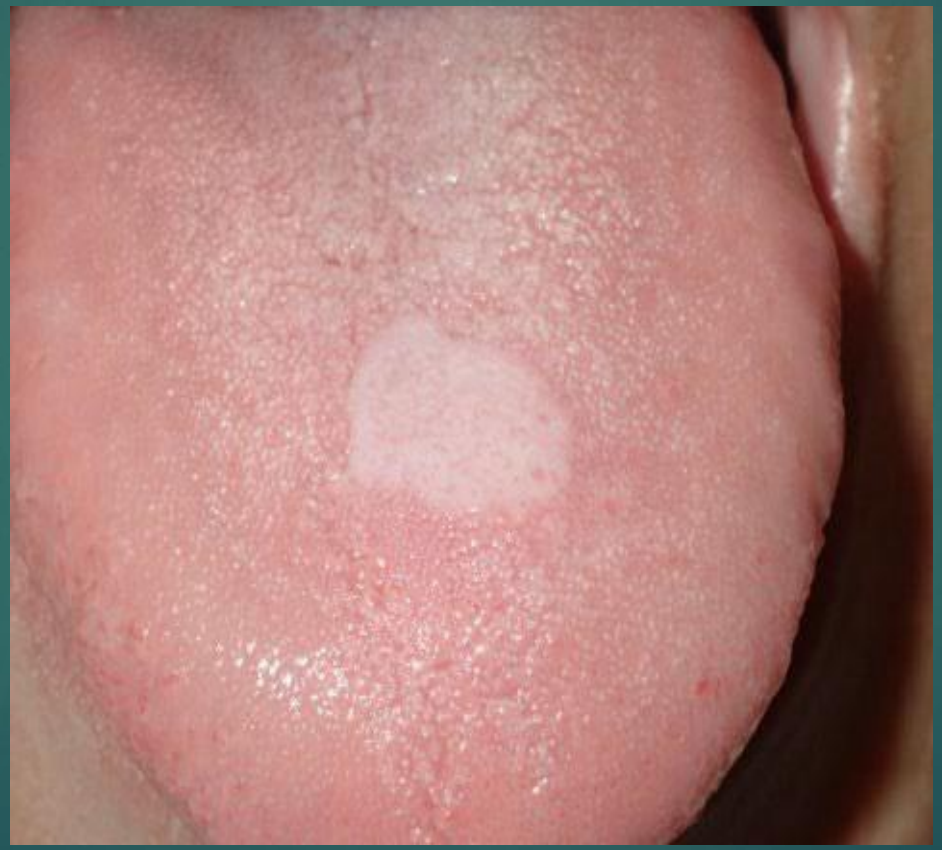
- MOST COMMON MALIGNANCIES ARE SQUAMOUS CELLS
- MELANOMAS OCCUR BUT RATHER RARE
- HIGHEST RISK AREAS ARE LATERAL BORDER OF TONGUE, FLOOR OF MOUTH, AND TRIANGLE AROUND TONSIL
- HPV LESIONS SEEM TO GAIN ACCESS THROUGH LYMPHOID TISSUES AND, AS SUCH, ARE SEEN IN POSTERIOR MOUTH AND OROPHARNYX (WALDEYER'S RING)

LEUKOPLAKIA

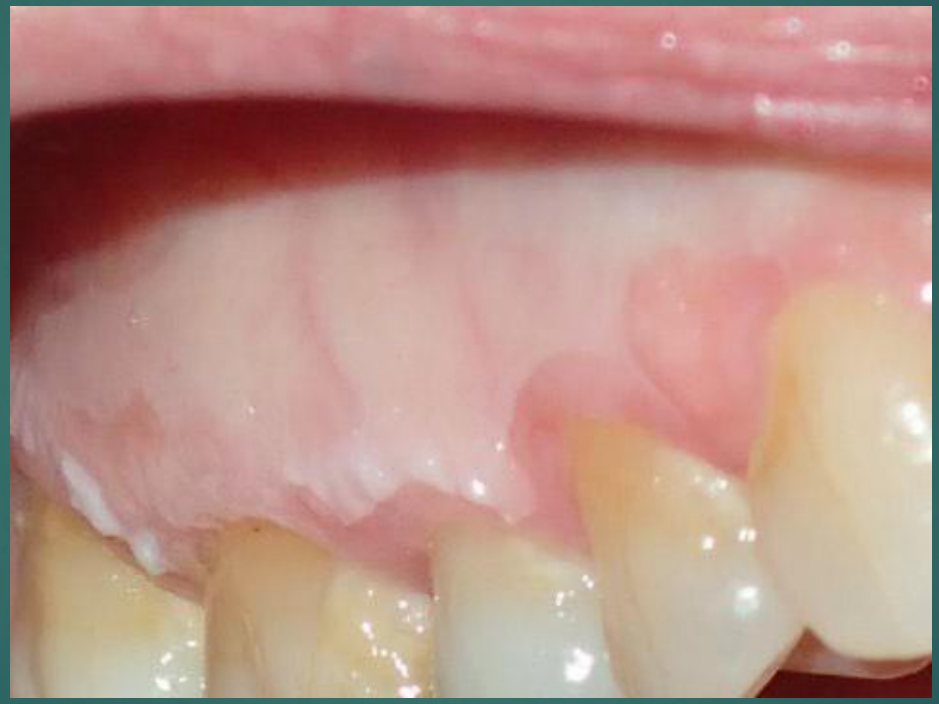
6-10% ARE MALIGNANT OR PRE-MALIGNANT



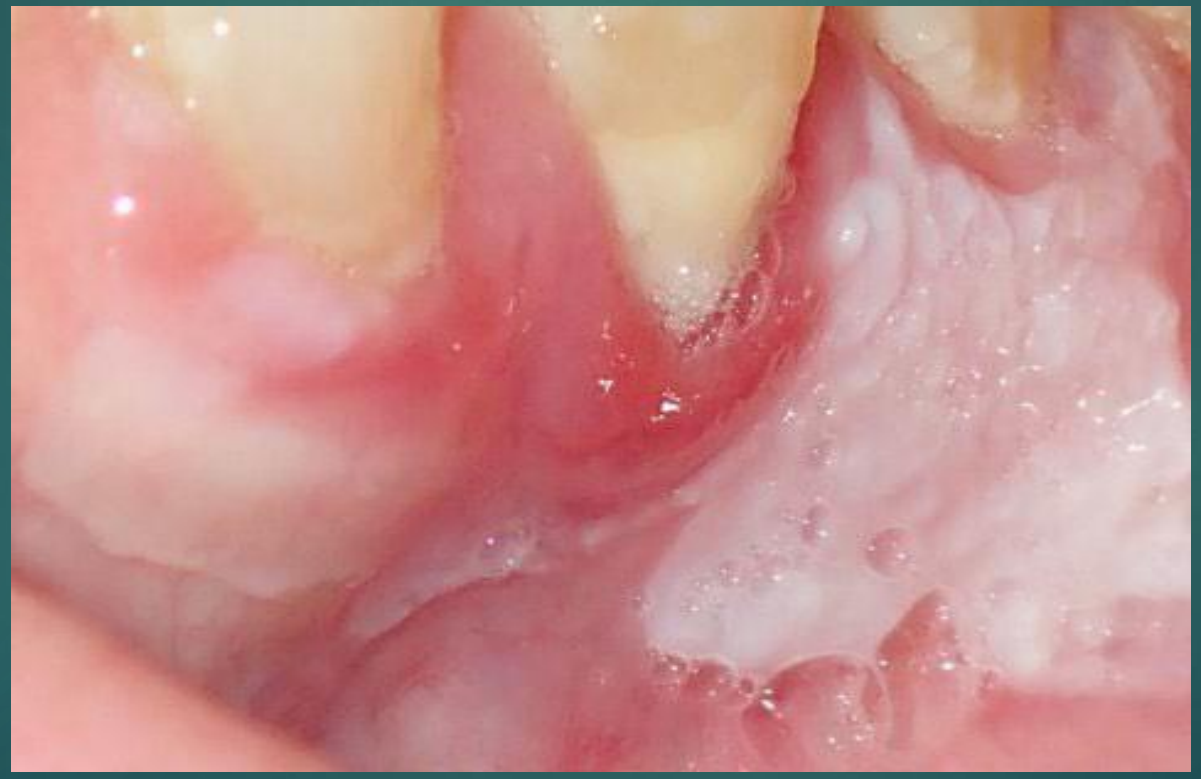
SO IS THIS A LEUKOPLAKIA?



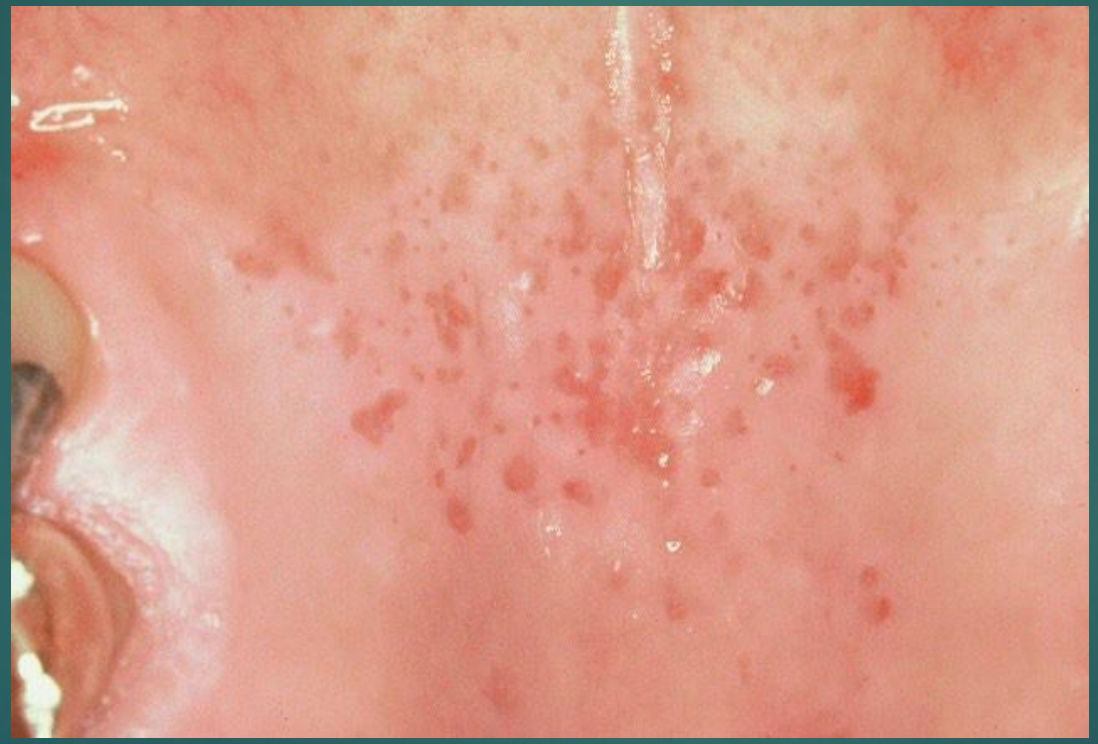
HOW ABOUT THIS ONE?



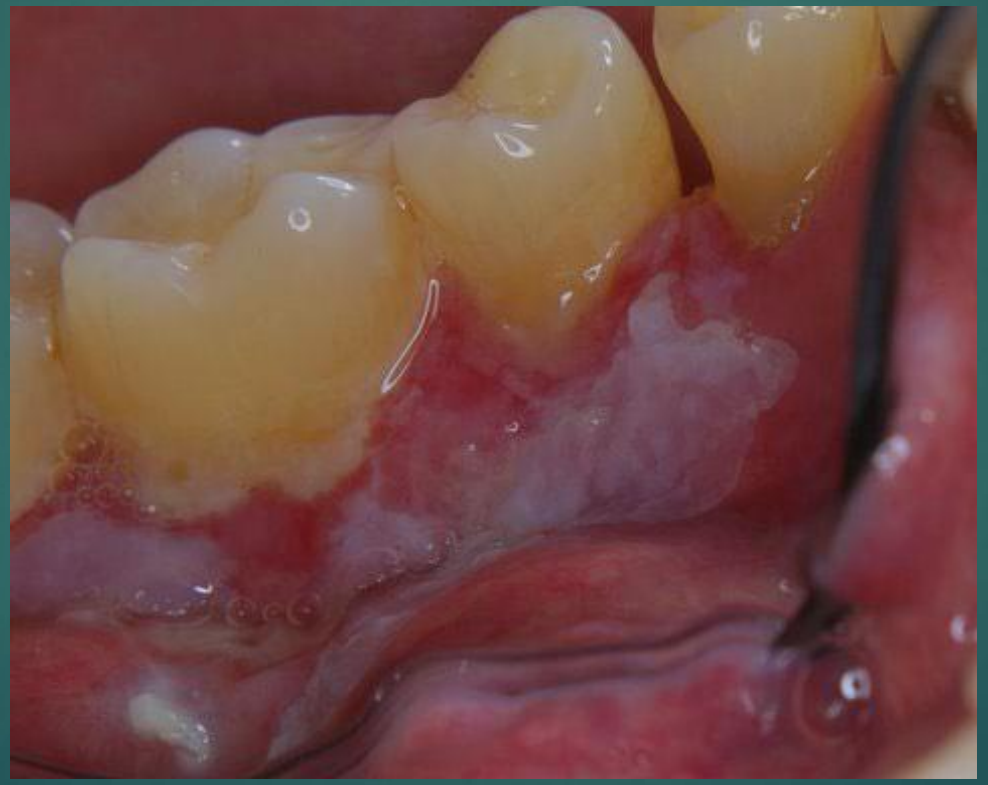
OR THIS ONE?



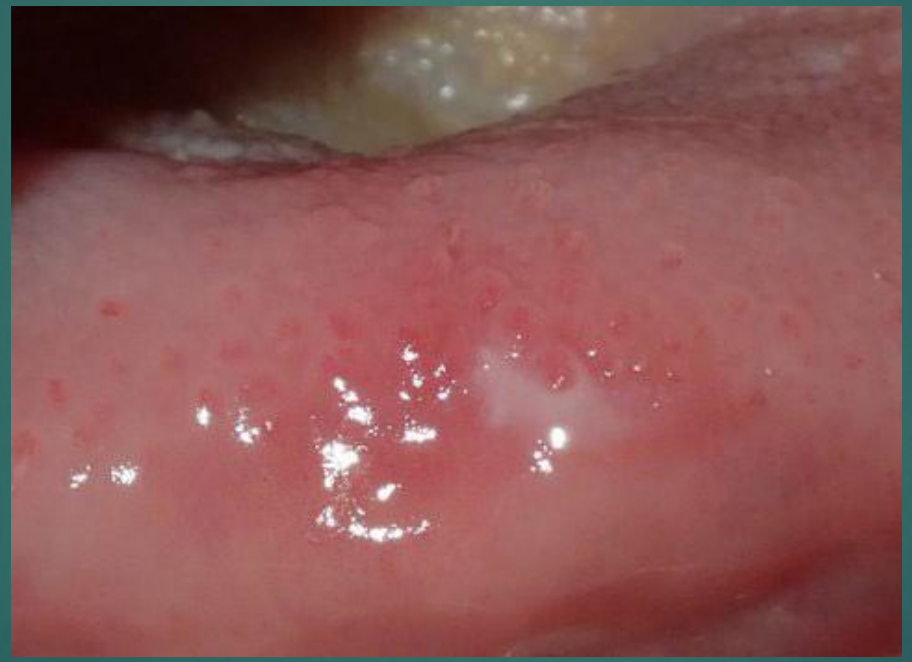
ERYTHROPLAKIA
70% MALIGNANT OR PRE-MALIGNANT



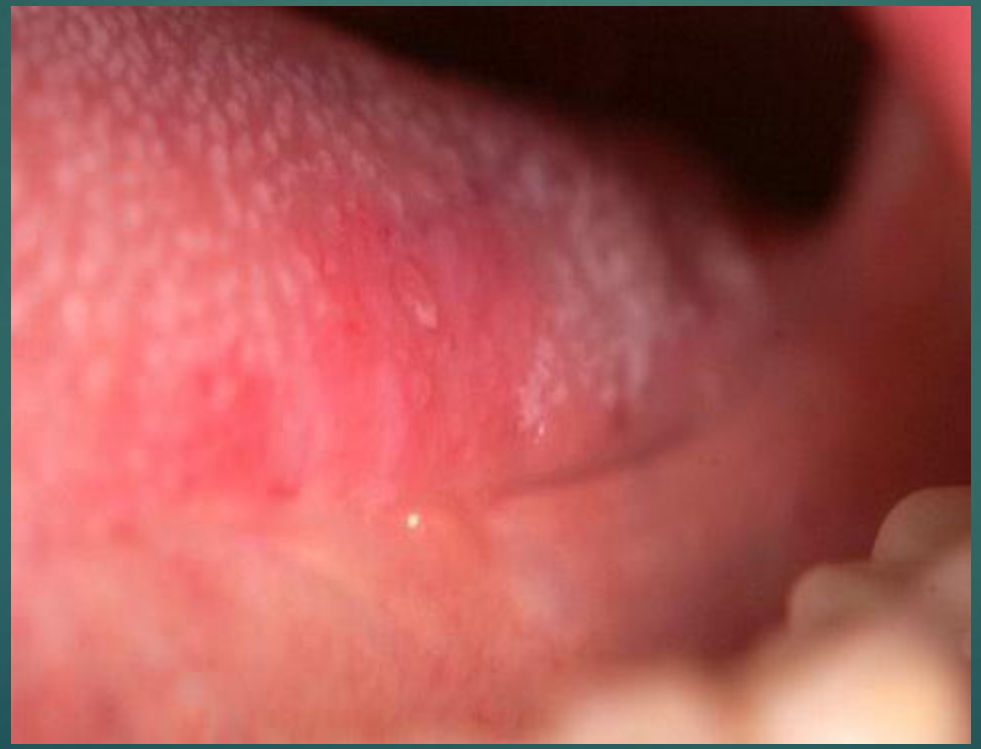
MIXED RED/WHITE LESIONS ARE ALMOST ALWAYS BAD



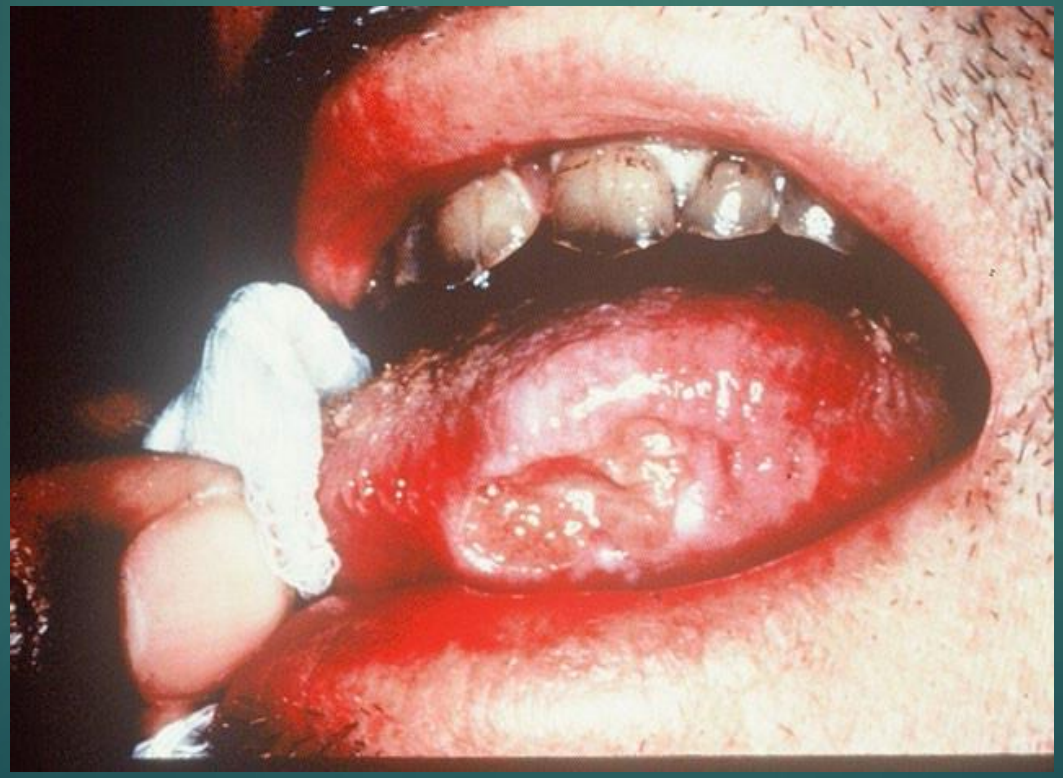
EARLY SQUAMOUS CELL



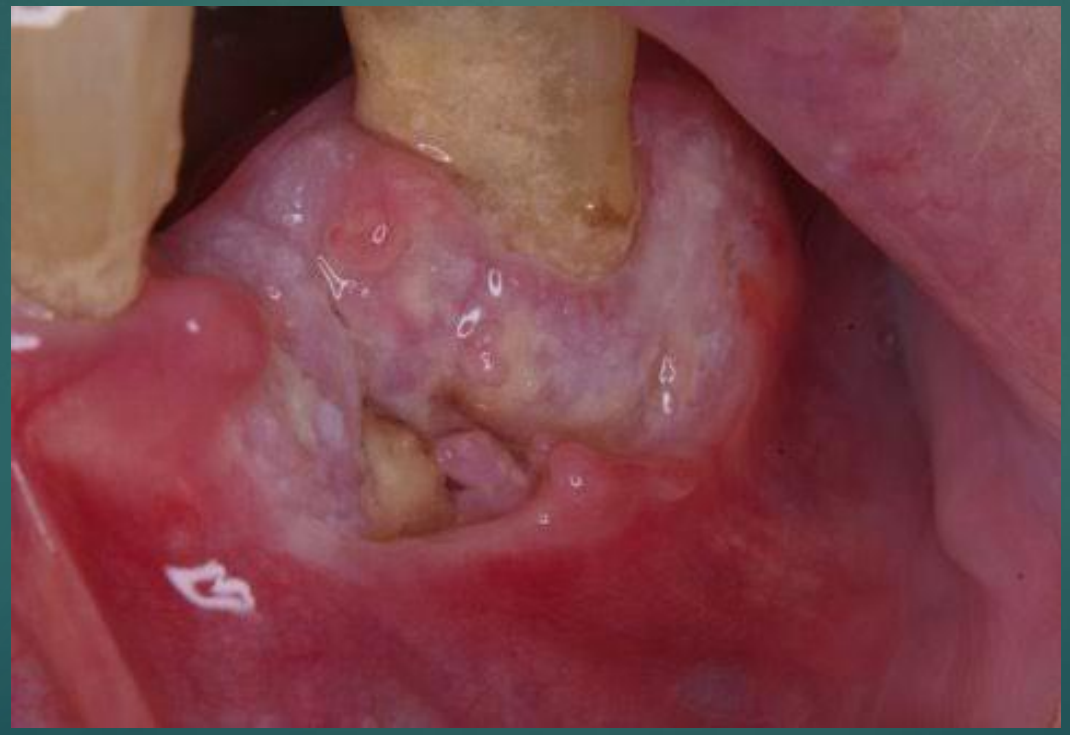
NOT IMPRESSIVE TO LOOK AT BUT A SQUAMOUS CELL



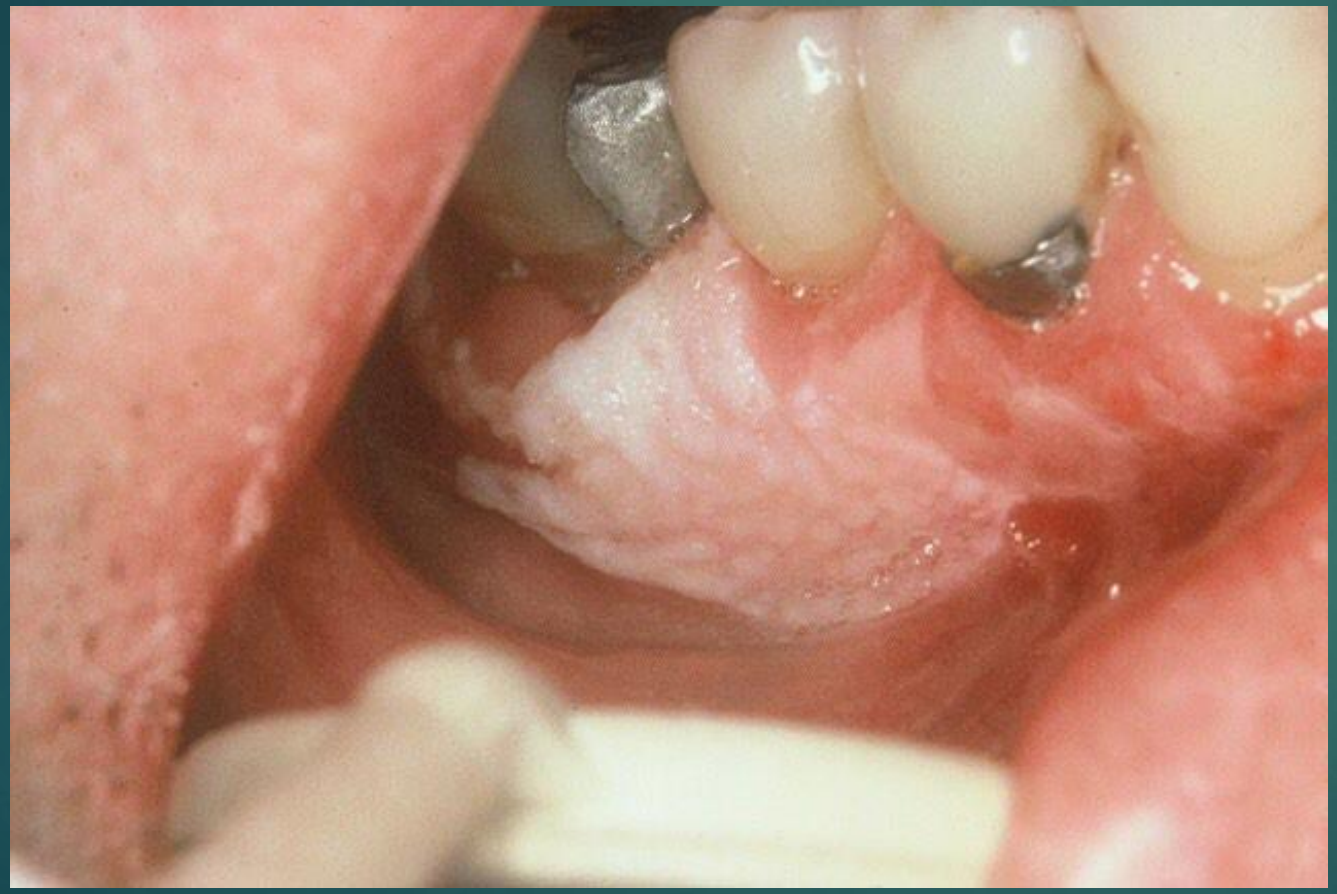
NASTY LARGE SQUAMOUS CELL



ANOTHER NASTY LOOKING SQUAMOUS CELL

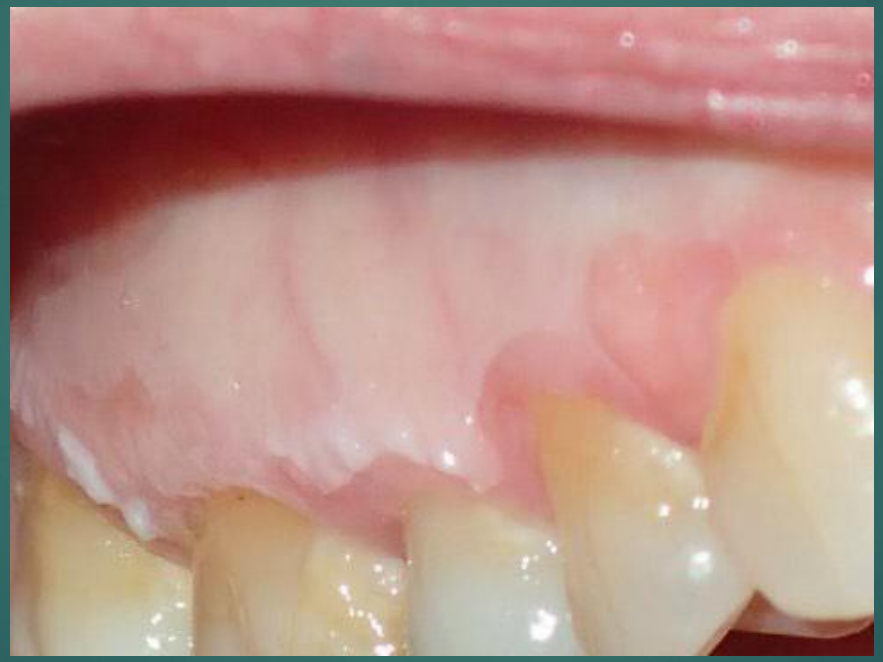


PROLIFERATIVE VERRUCOUS LEUKOPLAKIA

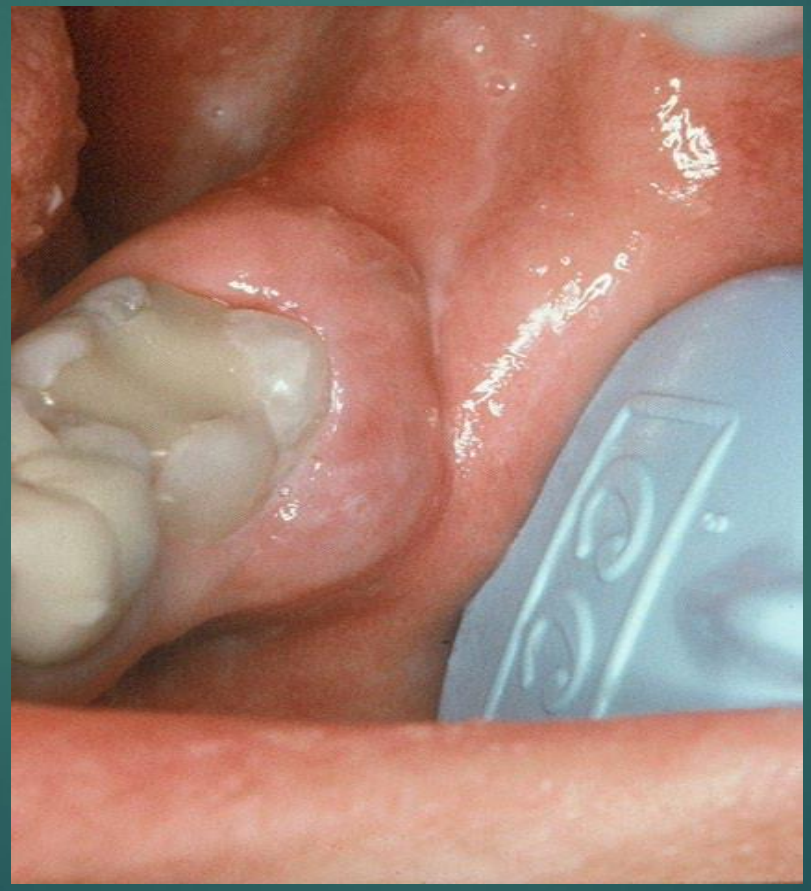


QUITE POSSIBLY THE WORST ORAL DIAGNOSIS

SO IS THIS A PVL?

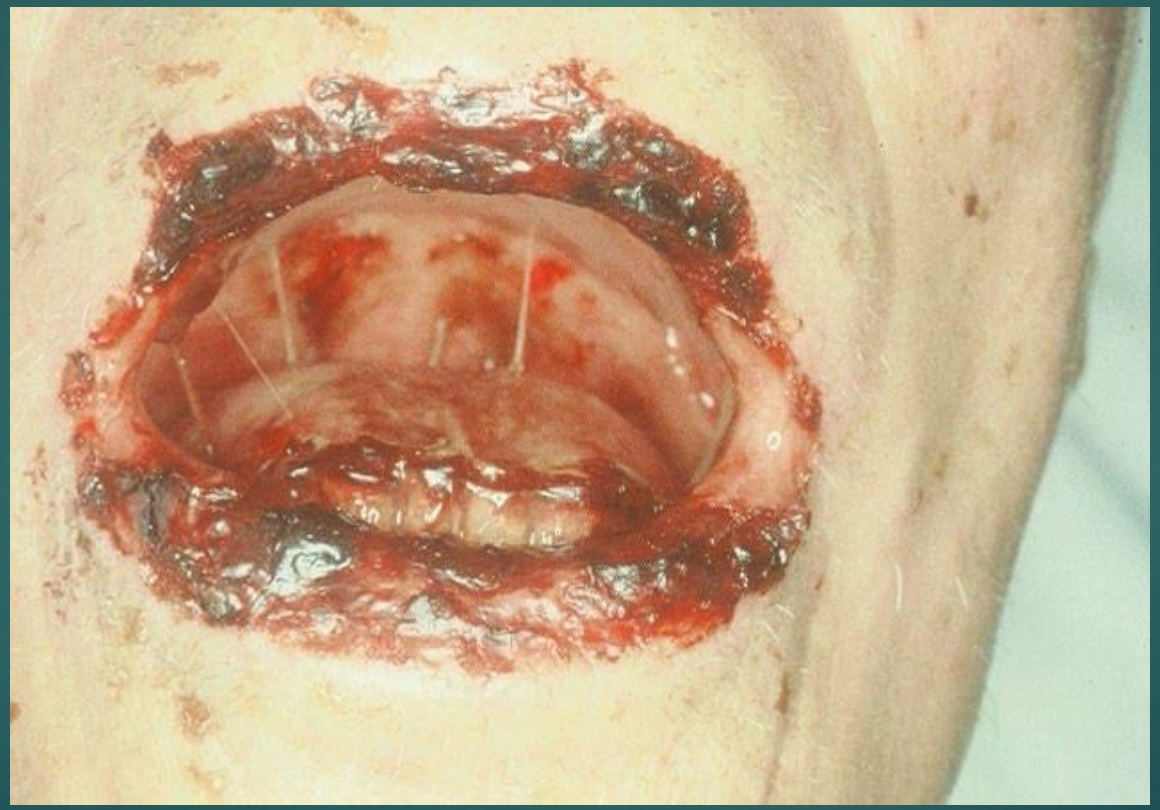


BLAST CRISIS LEUKEMIC INFILTRATE



PARANEOPLASTIC PEMPHIGUS

I COULD TELL YOU IT WAS *EM TOO*



LEUKOPLAKIA DYSPLASIA AND CANCER

- RECENT CHANGES
- NEW TERMS
- SAME OLD WORRIES

LEUKOPLAKIA

- WHO DEFINITION (2007)- A WHITE PLAQUE OF QUESTIONABLE RISK HAVING EXCLUDED OTHER KNOW DISEASES OR DISORDERS THAT CARRY NO INCREASED RISK FOR CANCER
- REALIZE THIS IS STILL A CLINICAL TERM AND THE UNDERLYING HISTOPATHOLOGY IS KEY

WE HAVE COVERED MOST WHITE LESIONS ALREADY

- LEUKOEDEMA
- WHITE STRIAE LICHEN PLANUS
- CANDIDOSIS
- LINEA ALBA
- CHEEK BITING

THERE IS A NEW ACRONYM
BARK-BENIGN ALVEOLAR RIDGE KERATOSIS

- A FRICTIONAL INDUCED LESION
- AS NAME IMPLIES, USUALLY SEEN ON AN EDENTULOUS AREA OF THE RIDGE, BUT CAN BE ON RETROMOLAR PAD OR TUBEROSITY
- HISTOLOGICALLY JUST A VERY THICK BUT NORMAL EPITHELIUM

LEUKOPLAKIA

- LOCALIZED
- PROLIFERATIVE
- MIXED RED/WHITE, NON-HOMOGENOUS (ERYTHROLEUKOPLAKIA)
- SMOOTH vs ELEVATED (ROUGH)

DEMOGRAPHICS

TRADITIONAL ISOLATED LEUKOPLAKIAS

- MALE
- TYPICALLY A SMOKER
- THE USUAL HIGH RISK AREAS- LATERAL TONGUE, FLOOR OF MOUTH
- 40% SHOW DYSPLASIA ON FIRST BIOPSY (REMEMBER THE TIGHTER NEW DEFINITION)
- 3-15% EVOLVE INTO SCC
- TREATMENT IS LOCALIZED EXCISION WHICH IS USUALLY SUFFICIENT

DEMOGRAPHICS

PROLIFERATIVE OR MULTIPLE LEUKOPLAKIAS

- FEMALE
- OLDER
- LESIONS LARGE (3+CM) OR MULTIPLE
- GINGIVA AND ALVEOLAR MUCOSA
- <10% DYSPLASIA ON FIRST BIOPSY - BUT 70+% WILL DEVELOP SCC
- EXCISION OFTEN SEEMS FUTILE DUE TO RECURRENCE AND SLOW SPREAD
- RELATIVELY HIGH HPV PRESENCE (BUT STILL <50%)

SO HOW DO WE EVALUATE A WHITE LESION

STRICTLY MY THOUGHTS

- CONSIDER THE LOCATION IN THE MOUTH
- CONSIDER THE SIZE OF THE LESION
- CONSIDER THE SURFACE TEXTURE OF THE LESION
- AGE OF PATIENT
- GENDER OF PATIENT
- ALCOHOL/SMOKING HISTORY
- DEPENDABILTY OF PATIENT FOR FOLLOW UP

BIOPSY YES/NO?

- ARE THERE ANY AREAS EVEN MINUTE OF RED
- CAN YOU TOTALLY RULE OUT A LOCAL IRRITANT
- TOLUIDINE BLUE VITAL STAINING
- UV LIGHT EVALUATION
- BRUSH BIOPSY

IF YOU DECIDE A BIOPSY IS WARRANTED

- WHAT PORTION OF THE LESION DO YOU REMOVE
- DO YOU REMOVE THE ENTIRE THING
- WHERE DO YOU SEND IT
- WHAT SHOULD YOU EXPECT IN THE REPORT

KUS-KERATOSIS OF UNKNOWN SIGNIFICANCE

ANOTHER NEW ACRONYM

- IF THE REPORT SHOWS NO DYSPLASIA BUT THERE ARE CELLULAR CHANGES SUCH AS ACANTHOSIS, CHRONIC INFLAMMATION, AND HYPERKERATOSIS
- FOLLOW UP IS MANDATORY AS ABOUT 20% WILL TRANSFORM TO DYSPLASIA OR CANCER OVER TIME
- PRUDENCE MAY LEAN TOWARDS TOTAL EXCISION OF A KUS IF POSSIBLE

PROLFERATIVE VERUCCOUS LEUKOPLAKIA

- IN MY OPINION POSSIBLY THE WORST ORAL DIAGNOSIS YOU CAN HAVE
- HAS NO HISTOPATH FEATURE, A CORRELATION OF CLINICAL FINDING/HISTORY/HISTOPATH
- BASED ON ALL WE KNOW, SOME AREAS OF PVL WILL TRANSFORM TO SCC GIVEN ENOUGH TIME
- ESSENTIALLY NO THERAPY HAS EVER BEEN FOUND TO BE PREDICTABLE
- RECURRANCE AFTER EXCISION USUAL AND QUICK

LICHEN PLANUS/MUCOSITIS/ DYSPLASIA

- WE TALK ABOUT LP A LOT, BUT SOME OF WHAT WE CALL LP IS SOMETHING ELSE
- EVEN LP CAN HAVE A RANGE OF CAUSATIVE FACTORS
- DIFFERENTIATING BETWEEN WIDE SPREAD PLAQUE LP AND PVL IS HARD, ESPECIALLY IF THERE IS ANY DYSPLASIA IN THE INFLAMMATORY INFILTRATE
- THIS CONFUSION MAY ACCOUNT FOR THE DEBATE ON THE PREMALIGNANT POTENTIAL OF LP

HPV AND ORAL CANCER

- LOT OF PRESS ON THIS
- MOST TYPICAL PATIENT IS MALE
- MOST TYPICAL LOCATION IS POSTERIOR LATERAL TONGUE
- HPV HAS A TENDENCY TO INVADE INTO LYMPHOID CRYPTS (LINGUAL TONSIL)
- TENDS TO NOT BE AS EXOPHYTIC AS YOU WOULD EXPECT BECAUSE OF WHERE IT ENTERS THE TISSUES

LEUKOPLAKIA AND DYSPLASIA *SUMMARY*

MOST WHITE LESIONS HAVE A CAUSE THAT CAN BE DETERMINED

REMOVE THE LOCAL FACTOR

IF NO DETERMINABLE CAUSE OR NO RESOLUTION, BIOPSY AND SUBMIT FOR HISTOPATH

REMEMBER A SIGN OUT OF NO DYSPLASIA DOES NOT ASSSURE THE FUTURE

IF YOU HAVE A SINGLE (OR 2) SMALL WHITE LESION, COULD BE EARLY IN THE PVL PROCESS, ESPECIALLY IF SURFACE A BIT ROUGH

IF SEEING AN EXTENSIVE INVOLVEMENT, NEED TO AGGRESSIVELY DIFFERENTIATE BETWEEN PVL & LP

Questions

Thank You

Next Session

Prioritizing Your Mental Wellness

Dr. Chris Recinos

Nurse Leader Network

Keynote Speaker