Disclaimer

Management of Oral Tumours

- Mr Philip Fisher
- ENT Surgeon

Staging

- TNM classification
- Basis of our treatment management
- Basis of our communication
- Same for all tumours

T(umour)

- T1 less than 2 cm Dia(small)
- T2 2-4 cm Dia(a little larger but still smallish)
- T3 4-6 cm Dia(large but not huge)
- T4 >6cm Dia or invading bone or major structures(Huge)
- T4a Resectable
- T4b Unresectable

N(odes)

- N1 single node less than 3cm
- N2a single node 3-6cm
- N2b multiple nodes <6cm
- N2c bilateral or contra lateral nodes
- N3 >6cm

M(etastasis)

- M0 none
- M1 distant metastasis

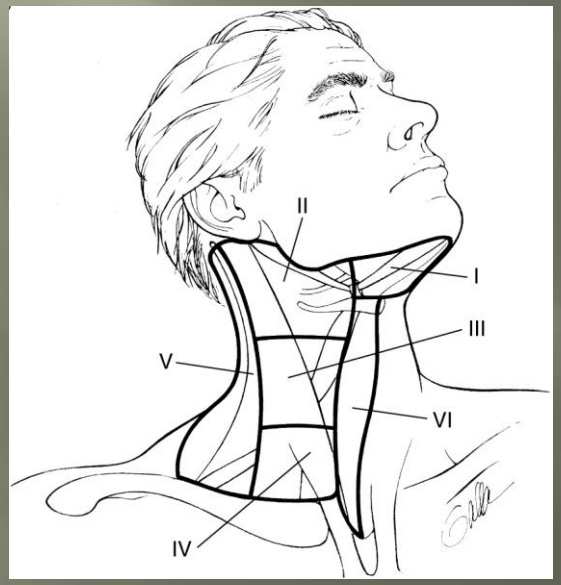
Stages

- Stage 1 T1N0M0
- Stage 2 T2N0M0
- Stage 3 T3N0M0
  T1-3N1M0
- Stage 4 T4
  N2+
  M1

Stages

- Early Stage Stages 1 and 2
- Late Stage Stages 3 and 4

Levels in Neck



Oral Tumours

- Mucosal Tumours
- Salivary Tumours
- Odontogenic Tumours
- Lymphomas

Mucosal Tumours

- Leukoplakia
- Dysplasia
- Carcinoma in situ
- Invasive SCC

Risk Factors

- Smoking/Chewing Tobacco
- Chronic irritation: sharp teeth, poor fitting dentures
- Alcohol
- Chronic infection
- HPV
- Immuno compromised: HIV, Transplant patients, Rx for Lymphoma, other malignancies

HPV

- HPV 16, 18 and 11
- Same as Cervical Carcinoma
- Increasing cause of Oral Tumours
- Rate increasing while larynx decreasing with decreasing smoking
- Incidence HPV increased since early 60s
- Worldwide
- Arise deep in crypts of Tonsil and Lingual Tonsil so present late

HPV

- Risk in HPV + Smoking greater
- Prognosis better
- Increased chemo and rads sensativity
- Younger non smoking patients
- Gardisil protects
- Proof of concept in Qld cervical Ca trial
- Available for boys (not free)
- Before 12yo

Leukoplakia

DO YOU BIOPSY OR WATCH

DO YOU BIOPSY OR EXCISE COMPLETELY

Dysplasia

BIOPSY OR EXCISION?

BIOPSY DYSPLASIA- DO YOU EXCISE?

SCC in situ

- Excision with narrow margin
- Watch closely!!

SCC

- T1N0M0
- SCC right Buccal Mucosa
- Stage 1
- Early Stage Tumour
- Single Modality Treatment

SCC

- T1N0M0
- SCC lateral tongue

Early Stage SCC

- Surgery or Radiotherapy?
- Do you treat the neck?
- 10-15% risk occult metastatic disease
- 90%+ 5 year survival either treatment modality

Surgery

- Wide local Excision with 2cm margin at operation
- Primary closure/FAMM flap/ Mucosal free graft/Split Skin Graft
- Selective neck dissection

FAMM Flap

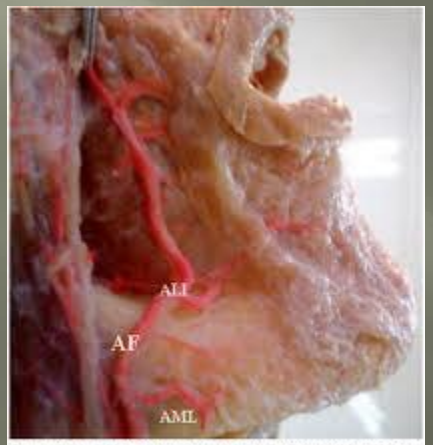


Fig. 1. Disección lado derecho. AF: arteria facial; ALI: arteria labial inferior; AML: arteria mentolabial.

Pro's

- Quick : 2-3 hours surgery
- 5 days in hospital
- 2 weeks to heal
- Good cosmetic and functional results
- Definitive pathology of neck for prognosis
- Easy to examine for follow-up
- Avoids complications of Radiotherapy
- Radiotherapy option available for recurrence or second Tumour

Cons

- Surgery with all usual risks and complications
- Some patients significant risk of anaesthetic
- High rate anti-coagulation medication in at-risk population
- May still require Radiotherapy if positive margins or positive neck disease

Radiotherapy

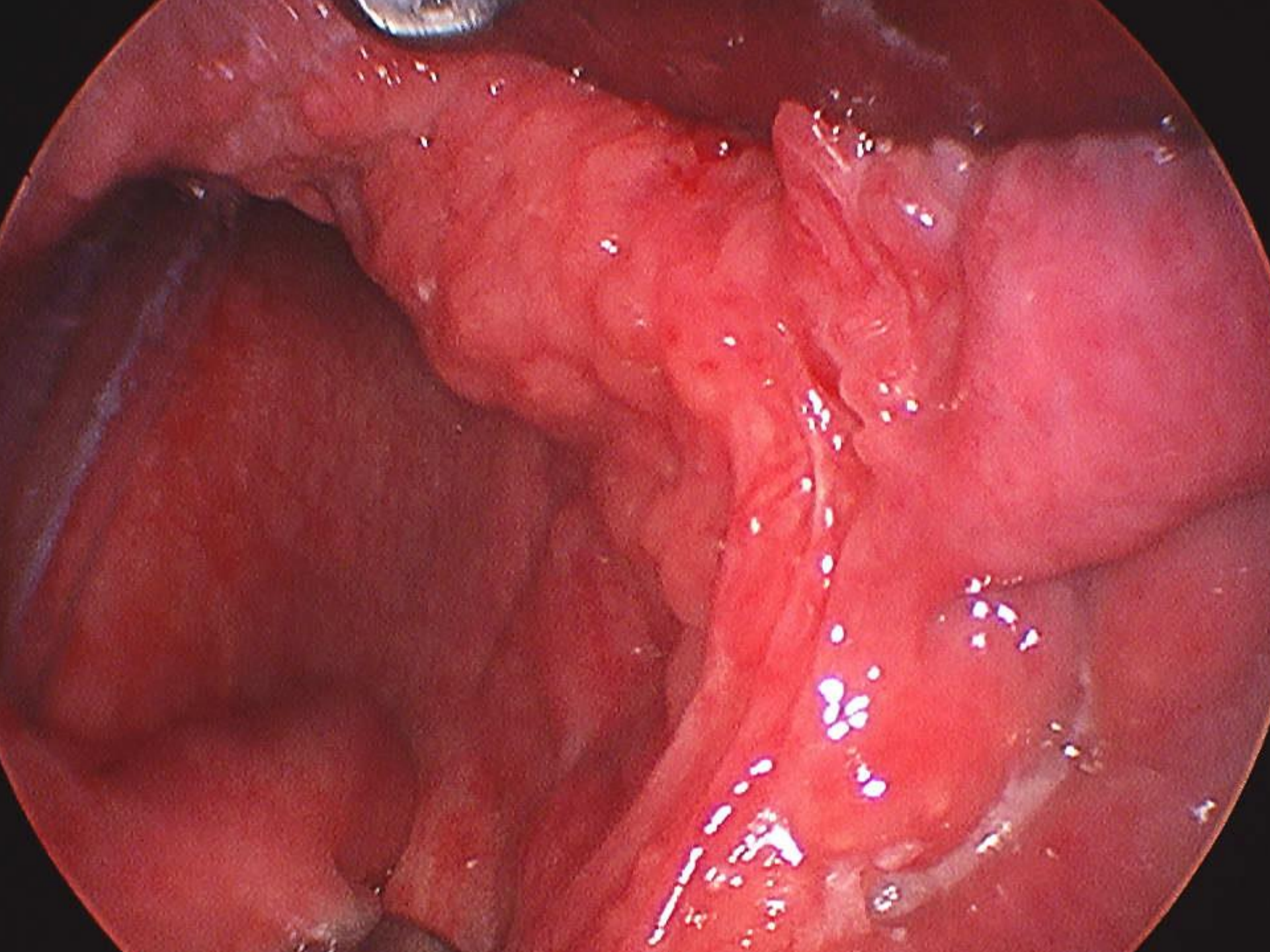
- 6-7 weeks treatment
- Outpatient
- Primary site and Neck

Pro's

- No surgery
- Treat wider area including lymphatics between Oral cavity and neck
- Useful in patients with Field change
- Treat entire neck
- Can treat contra lateral neck at same time

Cons

- Do not have pathology
- Dental disease: may require pre-treatment extractions
- Xerostomia
- ORN
- Cannot use Twice in same region



SCC

- T3N1M0
- Tonsil/Retromolar Trigone
- Single 3cm level 2 node
- Stage 3
- Late Stage

Treatment

- Combined Modality
- Surgery with post op radiotherapy/concurrent ChemoRadiotherapy
- Neo-Adjuvant Chemotherapy with concurrent ChemoRadiotherapy

Surgery/Rads

- Lateral Pharyngectomy with partial Glossectomy
- Modified neck dissection
- Radial fore arm Free flap reconstruction
- Tracheotomy
- 6-7 weeks Radiotherapy with Chemotherapy
- Cisplatin or Cetuximab

- Pre radiotherapy dental assessment and appropriate extractions
- PEG tube
- 8 hours surgery, 2 teams
- 2-3 weeks in hospital
- 6 weeks until radiotherapy
- 6-7 weeks radiotherapy
- 6 weeks to recover
- 18+ weeks treatment

ChemoRads

- 3 cycles Taxol 3 weeks apart
- 6-7 weeks radiotherapy with chemotherapy
- 6 weeks recover
- Dental assessment prior to treatment
- PEG tube
- 18+ weeks treatment

Pro's and Con's

- Chemo rads avoids major surgery and associated risks
- ChemoRads more toxic with major systemic complications
- Many patients may not tolerate treatment with poorer prognosis from incomplete course
- ChemoRads may well have better long term function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- Stage 4
- Involvement of mandible
- PET scan excluded distant metastatic disease

Treatment

- Combined modality
- Surgery and post op Concurrent Chemotherapy with Radiotherapy
- PEG
- ChemoRads inappropriate because of significant bone involvement

Surgery

- Tracheotomy
- Segmental mandibulectomy
- Lateral pharangectomy with partial glossectomy
- Modified neck Dissection
- Free Fibula Osteocutaneus Flap
- 16 hours

Salivary Tumours

- Minor Salivary Glands
- Pleomorphic Adenoma
- Muco-epidermoid Carcinoma
- Adenoid Cystic Carcinoma
- Acinic Cell Carcinoma

Pleomorphic Adenoma Palate

Treatment

- Wide local excision
- Remove periostium but do not require bone margin
- Preserve nasal floor mucosa
- Granulate
- Palatal Flap
- FAMM
- Radiotherapy not necessary

Muco epidermoid Carcinmoa

Muco epidermoid Carcinoma

- Low grade
- Wide local excision
- Granulate or flap
- No neck dissection
- No radiotherapy

- High Grade
- Wide local excision
- Bony margin
- Flap
- Post op radiotherapy including neck

Adenoid Cystic Carcinoma

Adenoid Cystic Carcinoma

- Malignant
- High incidence peri neural invasion
- MRI to assess local spread
- Metastatic neck disease
- Radio sensitive but not radio curable
- High risk of late distant metastasis

Adenoid cystic

- Wide resection
- Chase major local nerves involved
- Appropriate neck dissection
- Reconstruction
- ? Role of radiotherapy
- ? Early or late
- ? palliative

Acinic cell carcinoma

- Greater risk local metastasis
- Less peri neural spread
- Less risk late metastasis
- Stage 3 and 4 post op radiotherapy

Odontogenic tumours

- Odontogenic Cysts
- Inflammatory :
- Radicular Cyst
- Developmental :
- Dentigerous Cyst
- Odontogenic Keratocysts
- Calcifying Odontogenic Cyst (Gorlin Cyst)
- Glandular Odontogenic Cyst

Odontogenic Tumours

- Non Odontogenic Cysts
- Nasopalatine duct cyst
- Stafne Bone Cyst
- Idiopathic Bone Cavity

Odotogenic Tumours

- Odontoma
- Ameloblastoma
- Calcifying Epithelial Odontogenic Tumour (Pinborg Tumour)
- Odontogenic Myxoma
- Ameloblastic Fibroma
- Ossifying Fibroma

Odontogenic Tumours

- Fibrous Dysplasia
- Giant Cell Lesion
- Aneurysmal Bone Cyst

Treatment

- All benign cysts and lesions need Excision/Enucleation
- Malignant Lesions need resection with appropriate margin and reconstruction

Lymphoma

- Biopsy or excision (Tonsillectomy) for diagnosis
- Appropriate systemic therapy