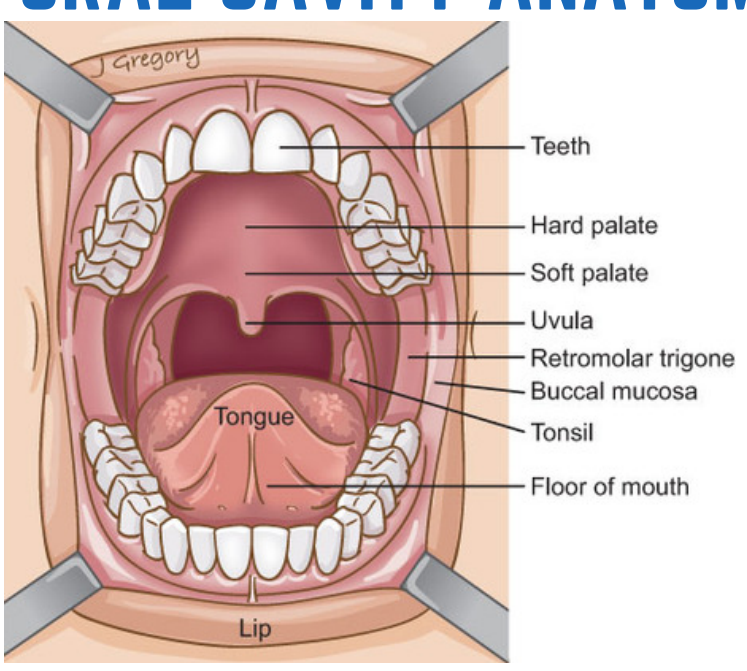
ORAL CAVITY NEOPLASMS

NAT'S NOTES IN OTOLARYNGOLOGY HEAD AND NECK SURGERY

Episode 17.1

ORAL CAVITY ANATOMY



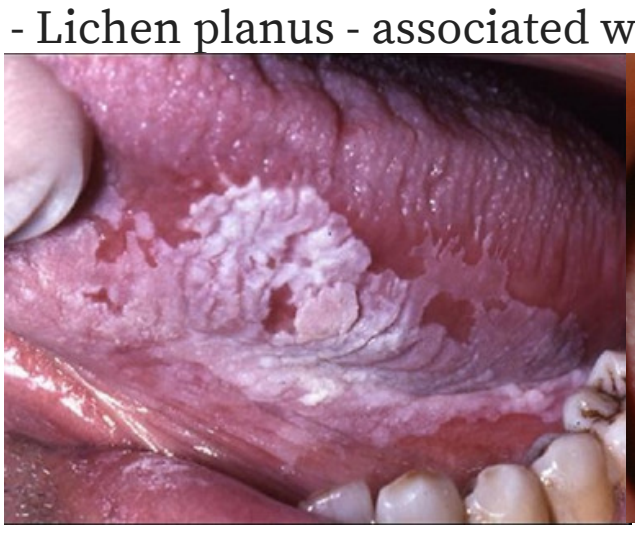
- Vermillion junction of lips to junction of hard and soft palates
- Communicates with the oropharynx posteriorly
- Lymphatic drainage primarily level II neck nodes. Hard palate / alveolus to level I, medial tongue to level III

RISK OF NEOPLASM

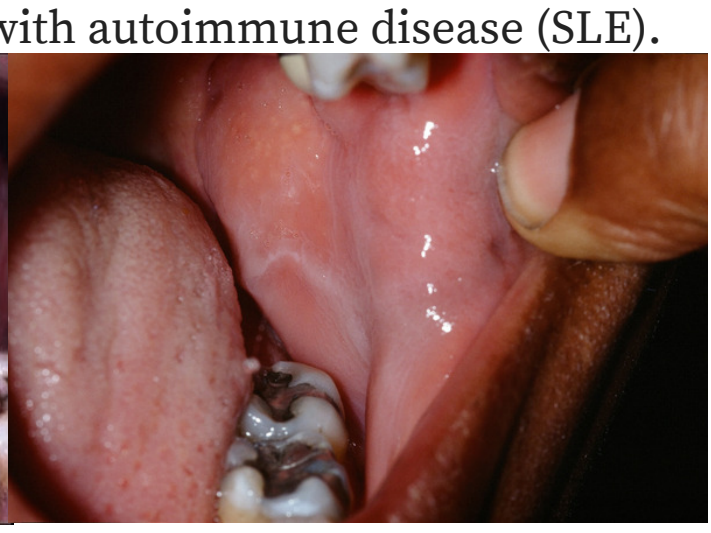
- Tobacco use (dose dependent)
- Carcinogen contaminated saliva
- ?Alcohol works synergistically with tobacco
- HPV-related disease primarily oropharynx

PREMALIGNANT ORAL CAVITY LESIONS

- Leukoedema - disappears when stretched
- Leukoplakia - most common. 4% conversion to malignancy
- Lichen planus - associated with autoimmune disease (SLE).



Leukoplakia



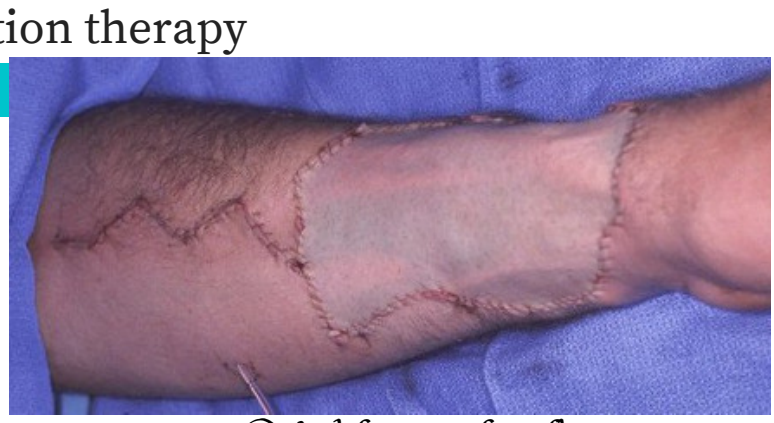
Leukoedema

ASSESSMENT AND MANAGEMENT

- Often referred by dentist or family physician. Simple biopsy under local anesthetic for diagnosis. Subsequent referral and staging endoscopy ("quadroscopy")
- If lesion T3 or greater (>4 cm), obtain CT or MRI for regional and distant metastases
- Major resection of tumour with autograft reconstruction (consider free flap or local rotational flap)
- +/- adjuvant chemoradiation therapy

COMPLICATIONS

- Bleeding
- Obstruction
- Functional loss
- Sialorrhea



Radial forearm free flap