PDA

STUDY CLUBS

Q2 STUDY CLUB: ORAL CANCER--WHAT YOU NEED TO KNOW

FEATURING DR. VINCENT CARRAO

NADG-SUPPORTED ORAL & MAXILLOFACIAL SURGEON

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TODAY'S AGENDA:

ORAL CANCER: WHAT YOU NEED TO KNOW

THE EXAMINATION & DIAGNOSIS

TREATMENT

STUDY CLUBS

ORAL CANCER: THE FACTS

60 1 PERSON DIES FROM ORAL CANCER EVERY HOUR

40% OF THOSE DIAGNOSED DIE WITHIN FIVE YEARS

3X INCIDENT OF ORAL CANCER IS 3X GREATER THAN CERVICAL CANCER

40 MORTALITY RATE HAS NOT IMPROVED IN 40 YEARS

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STUDY CLUBS

WELCOME

DR. VINCENT CARRAO, DDS, MD, FACS

NADG-SUPPORTED ORAL & MAXILLOFACIAL SURGEON

ORAL HEALTH BOARD: SPECIALTY CHAIR

DIRECTOR OF ORAL & MAXILLOFACIAL SURGERY

ORAL MALIGNANCIES

SQUAMOUS CELL CARCINOMA

SALIVARY GLAND

- MUCOEPIDERMOID CARCINOMA
- ADENOCYSTIC CARCINOMA
- ACINIC CELL CARCINOMA
- ADENOCARINOMA

OSTEOSARCOMA

CHONDROSARCOMA

FIBROSARCOMA

MELONOMA

METASTATIC

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SQUAMOUS CELL CARCINOMA

MOST COMMON FORM OF ORAL CANCER	95.0%
UNITED STATES	2.0–5.0%
MALES	2:1
AVERAGE AGE	50–60
RACIAL PREVALENCE	2:1 (AA:W)
RECURRENCE	50.0%
MORTALITY	50.0%
THIRD WORLD	30–40%

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WORLD HEALTH ORGANIZATION

DEATH RATES WORLDWIDE SCCA

- NO INFO GREY
- 0-2% BRIGHT YELLOW
- 6-8% YELLOW
- 22-25% DEEP ORANGE
- OVER 25% RED

ETIOLOGY

- TOBACCO
  - SMOKING, CHEWING

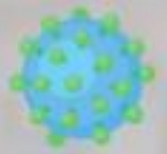
- ALCOHOL
  - POOR NUTRITION

- BETEL NUT LEAF /ARECA NUT

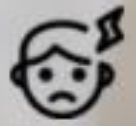
- GENETICS

- IMMUNE STATUS

- SUN EXPOSURE



- VIRUSES
  - HPV 16



- TRAUMA

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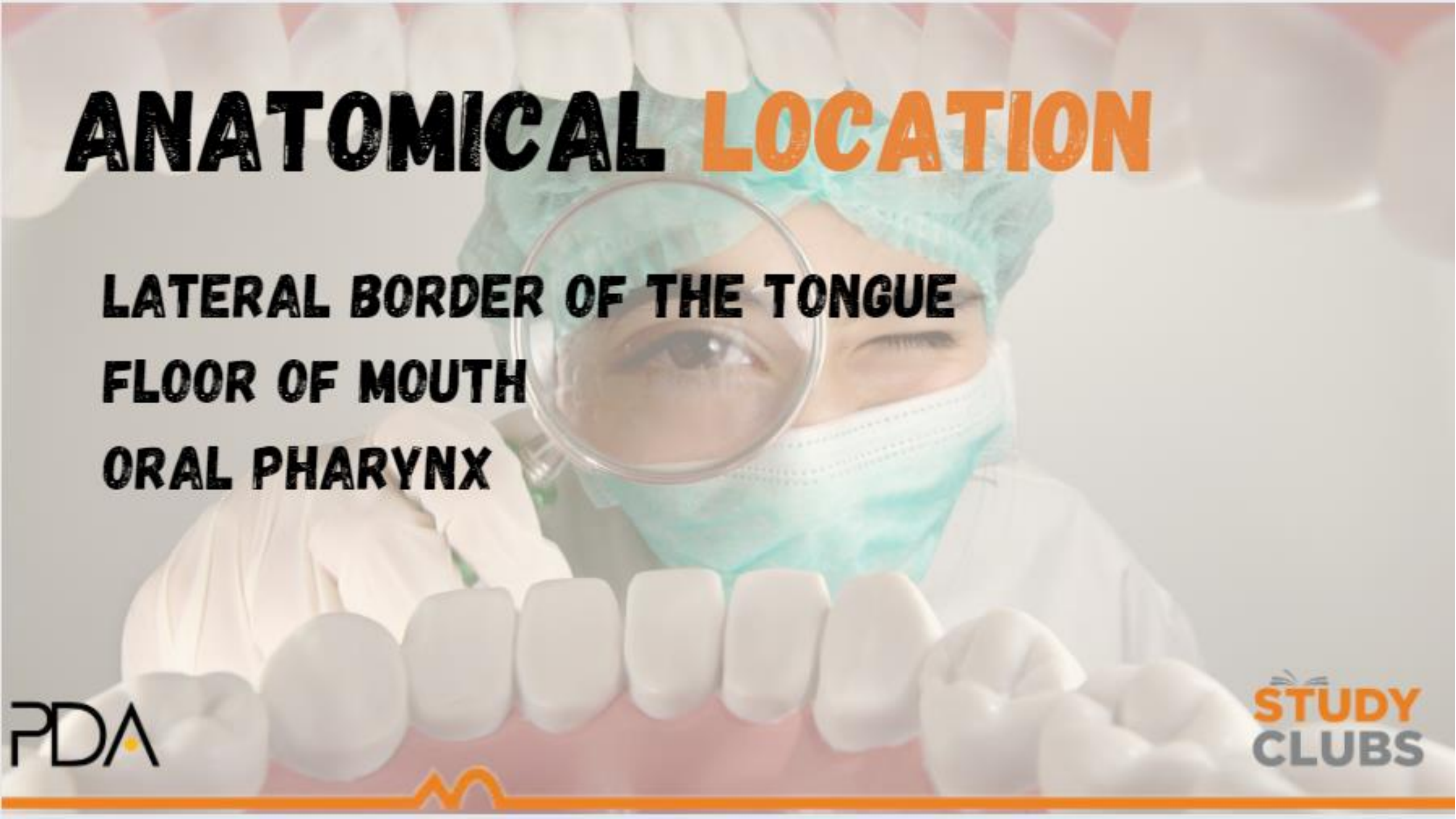
ANATOMICAL LOCATION

LATERAL BORDER OF THE TONGUE

FLOOR OF MOUTH

ORAL PHARYNX



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PRESENTATION

PRESENTATION

- VARIABLE

CHARACTERISTIC DESCRIPTION

- RAISED, WHITE/RED, ULCERATED, PAINLESS

EARLIER THE BETTER

RULE OF THUMB

- LESION PRESENT FOR MORE THAN 14 DAYS
  - BIOPSY

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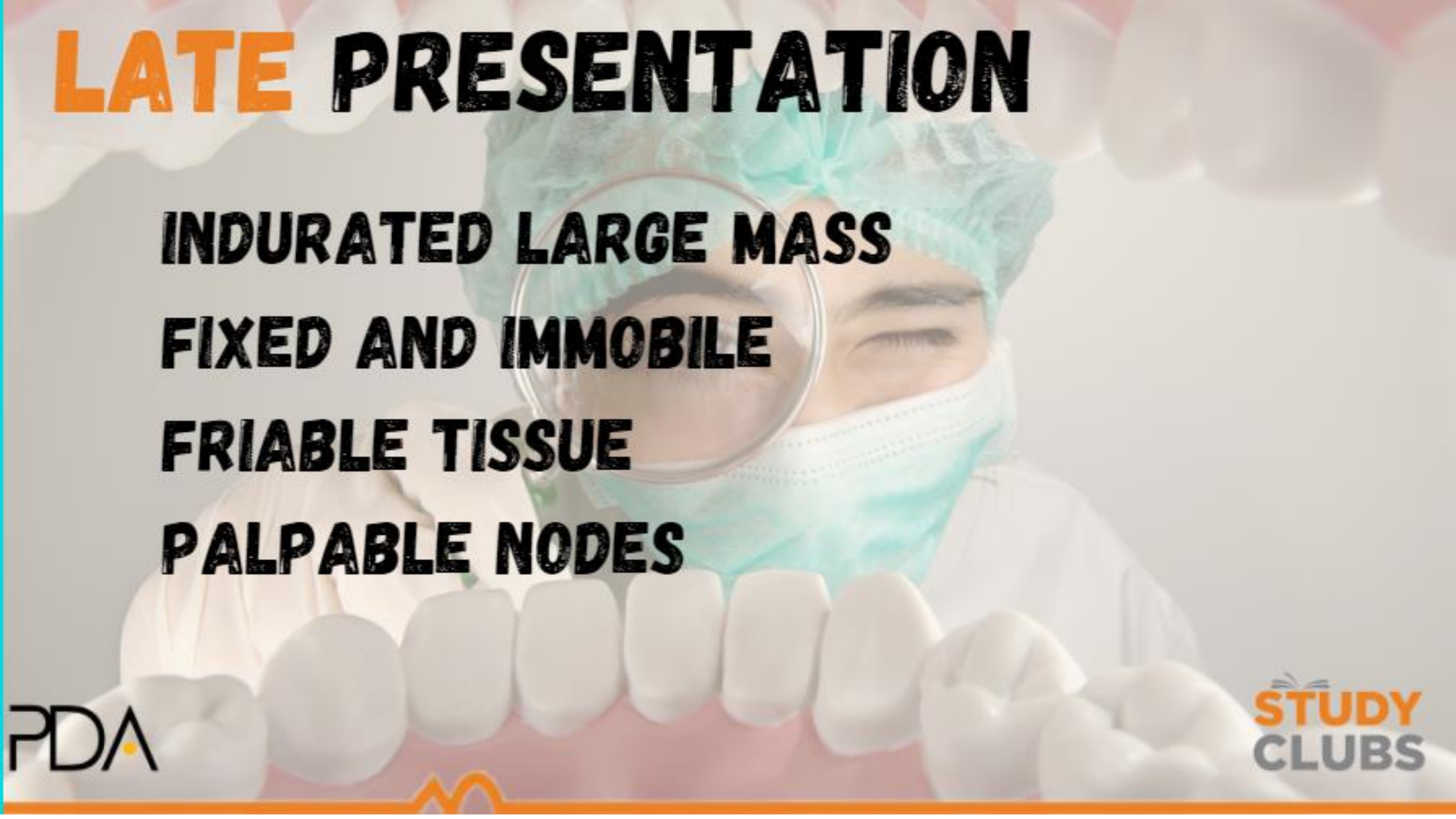
LATE PRESENTATION



- INDURATED LARGE MASS
- FIXED AND IMMOBILE
- FRIABLE TISSUE
- PALPABLE NODES

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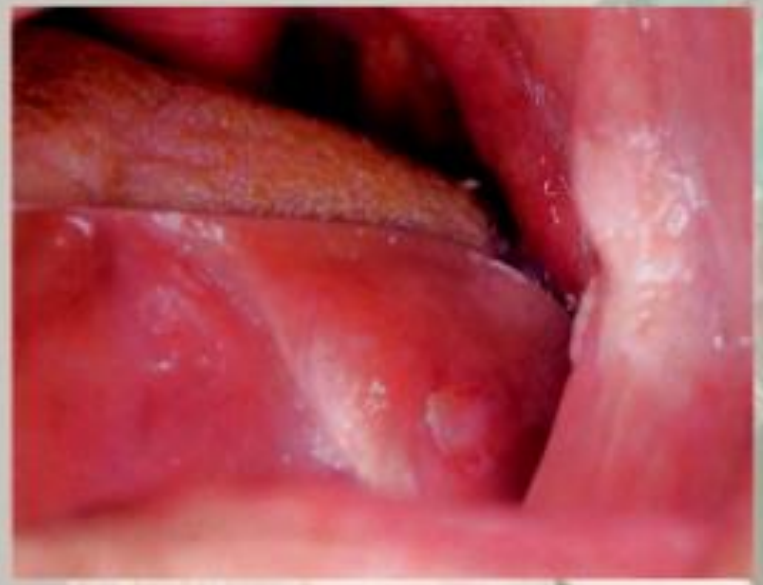
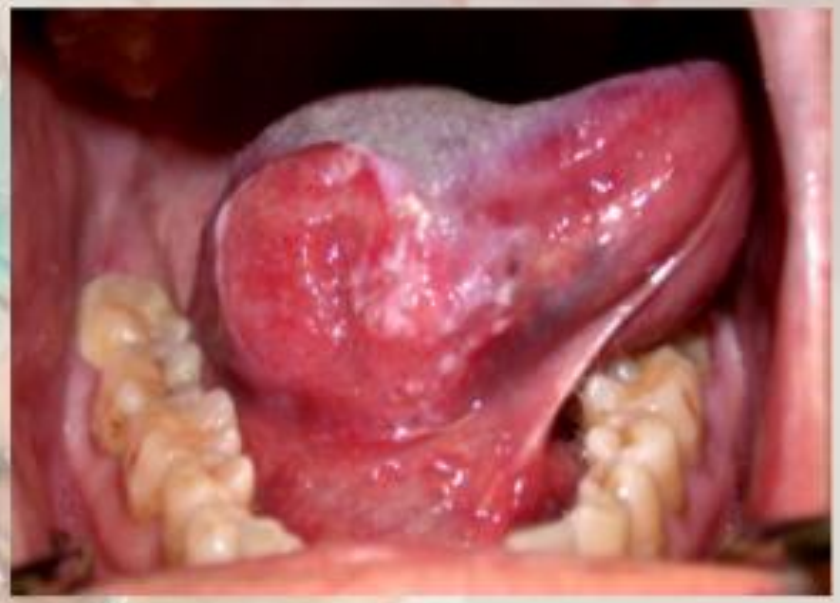
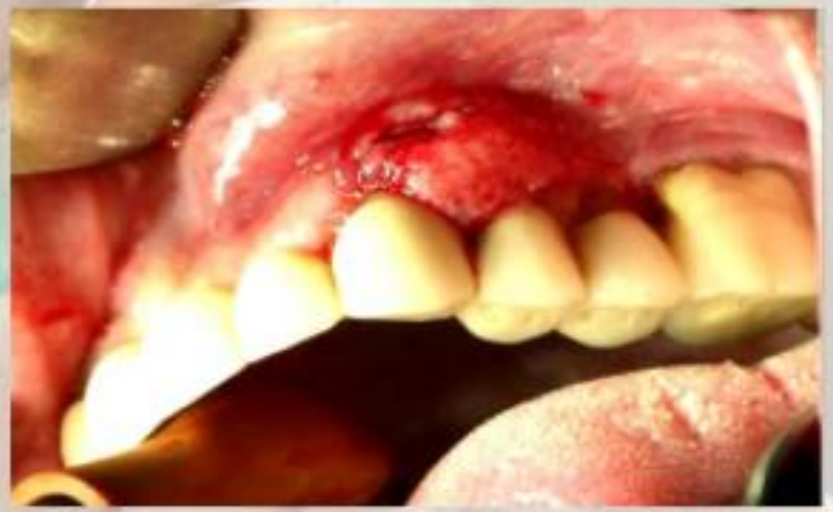
TUMORS







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DIAGNOSIS

- HISTORY
- CHIEF COMPLAINT
- HISTORY OF PRESENT ILLNESS
- PAST MEDICAL HISTORY
- REVIEW OF SYSTEMS
- MEDICATIONS
- ALLERGIES
- FAMILY HISTORY
- SOCIAL HISTORY

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DIAGNOSIS

PHYSICAL EXAM

BEGINS WHEN THE PATIENT WALKS INTO THE ROOM

HEAD & NECK

ASYMMETRY

VISUAL

PALPABLE

EENT

PALPATE THE NECK FOR LUMPS, BUMPS, OR MASSES

BILATERAL ANTERIOR

BILATERAL POSTERIOR

THYROID GLAND

ORAL EXAM

MAX /MAN VESTIBULES

PALATE

HARD AND SOFT

TONSILLAR PILLARS

ORAL PHARYNX

TONGUE

DORSUM

VENTRAL

FOM

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VELSCOPE

INTENDED USE

- AN ADJUNCT TO TRADITIONAL ORAL EXAMINATION BY INCANDESCENT LIGHT TO ENHANCE THE VISUALIZATION OF ORAL MUCOSAL ABNORMALITIES
- USED BY A SURGEON TO HELP IDENTIFY DISEASED TISSUE AROUND A CLINICALLY APPARENT LESION AND THUS AID IN DETERMINING THE APPROPRIATE MARGIN FOR SURGICAL EXCISION.

USEFULNESS

- TAKES PRACTICE TO USE AND HAS SOME SUBJECTIVITY TO INTERPRETATION
- IT FORCES US TO LOOK
- IF IT'S A FALSE POSITIVE "NO HARM DONE"

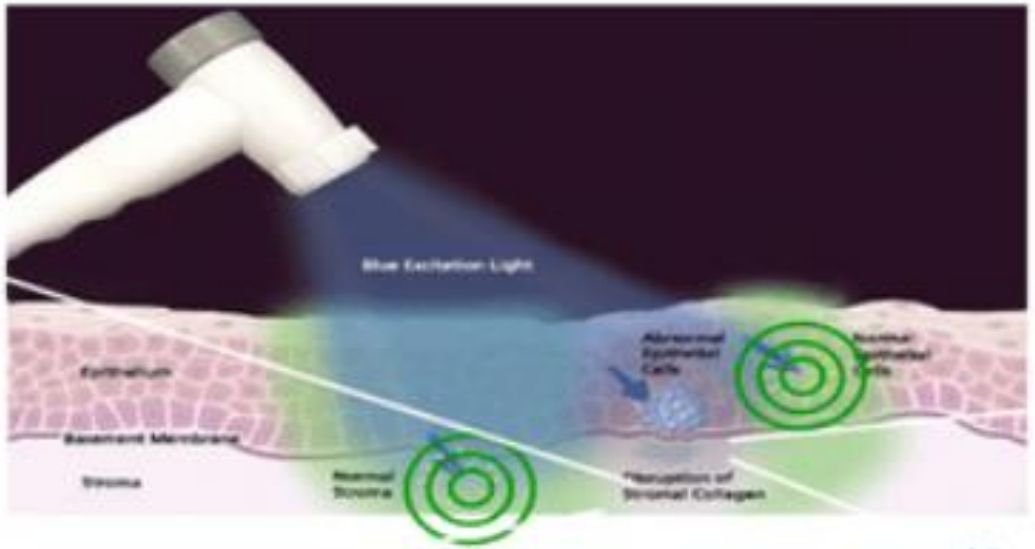
Tissue Fluorescence & Dysplastic Progression

Breakdown of Collagen Matrix (prelude to invasion)
Collagen cross-links ↓

Fluorescence ↓

Micro-Vascularization
(recruitment of new blood supply)
Inflammation
Blood absorption ↑

Fluorescence ↓



Metabolic Activity ↑
FAD ↓

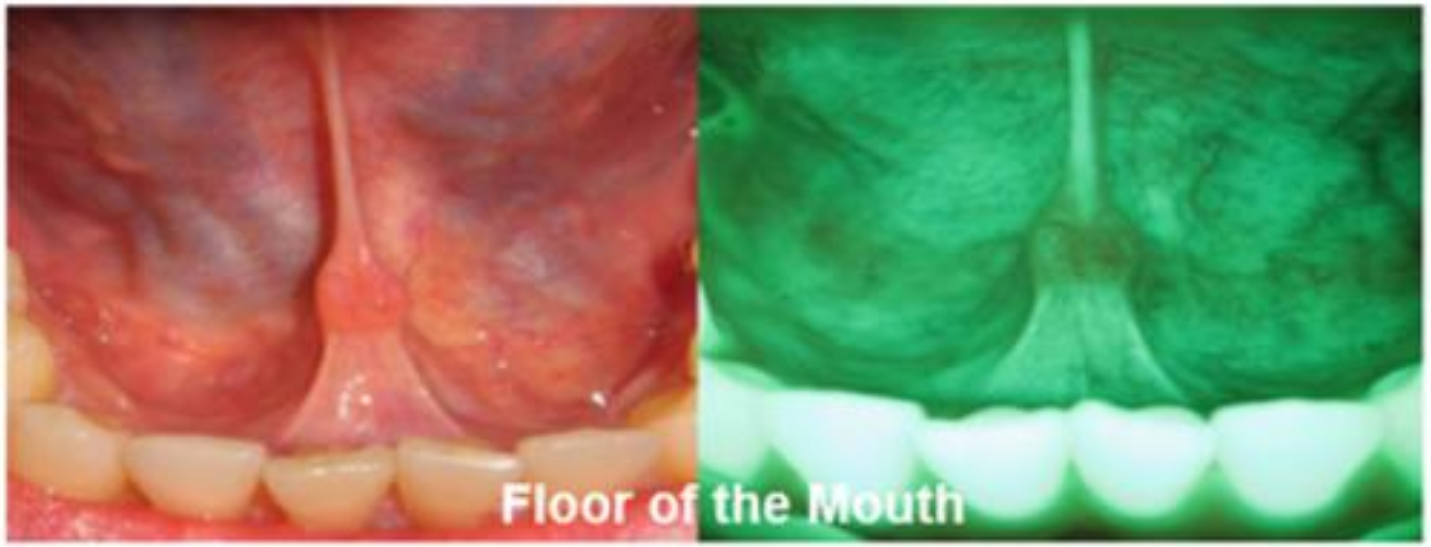
Fluorescence ↓

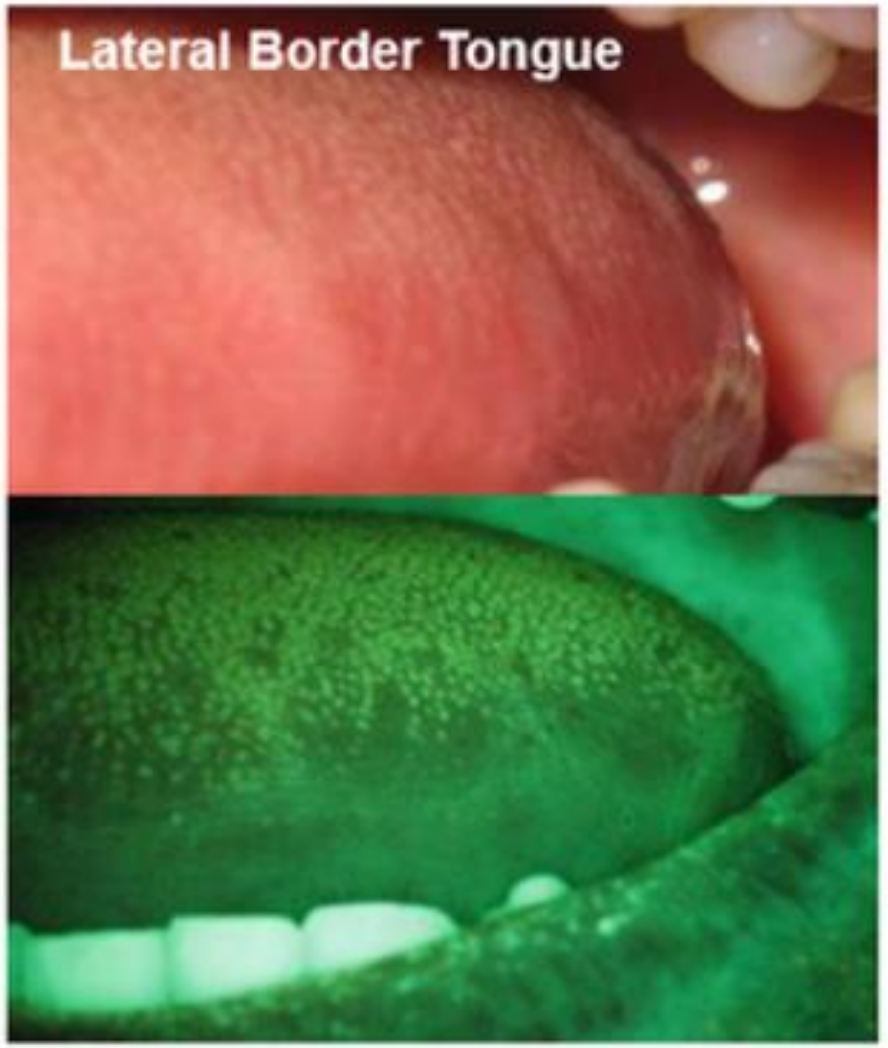
Nuclear back-scattering ↑
Fluorophores excited ↓

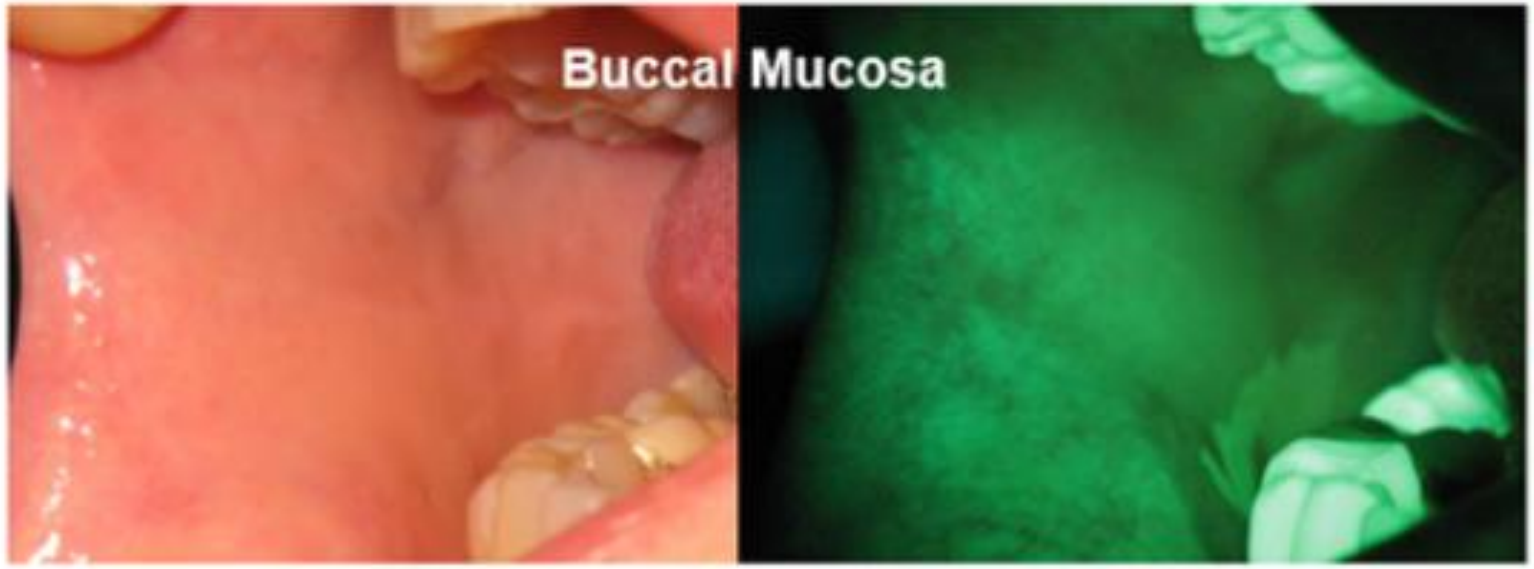
Fluorescence ↓

Florescence intensity decreases with dysplastic progression

ENHANCED TECHNOLOGY

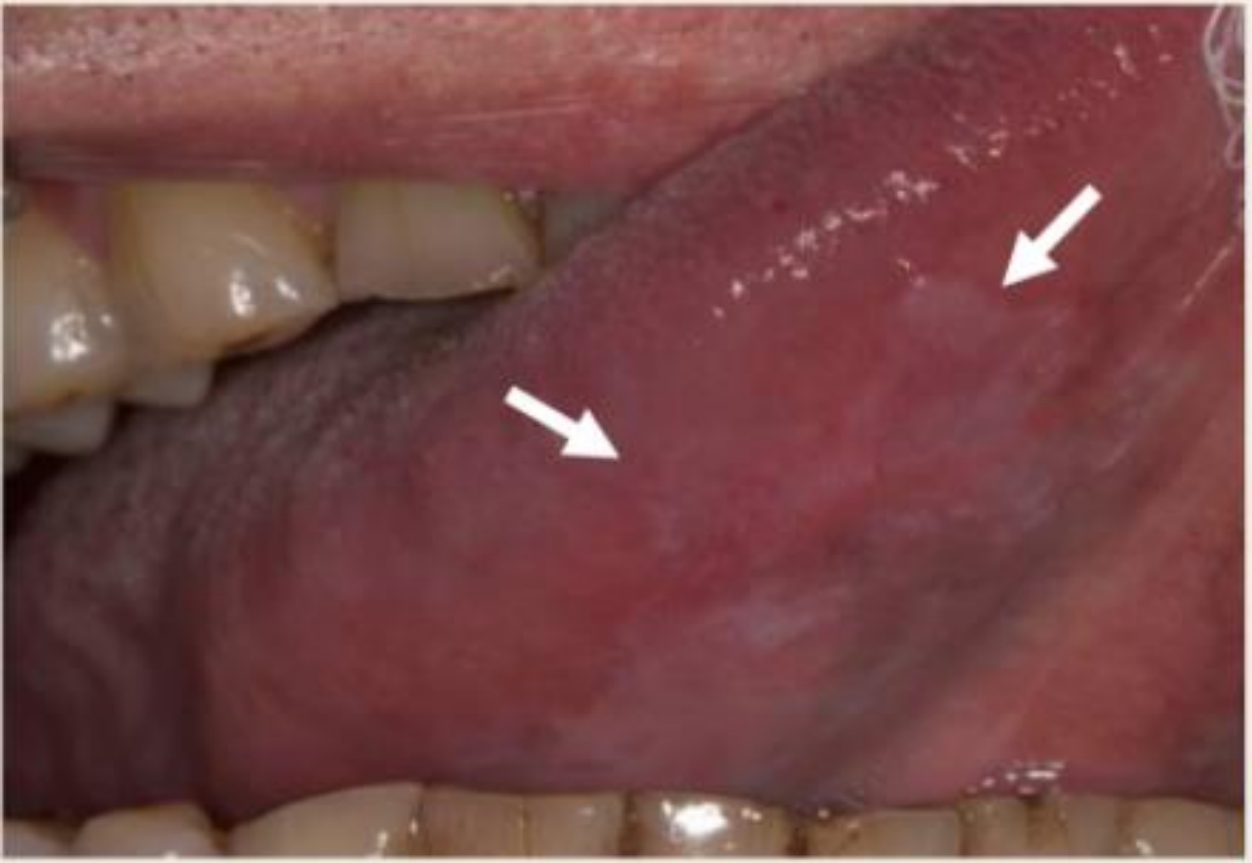


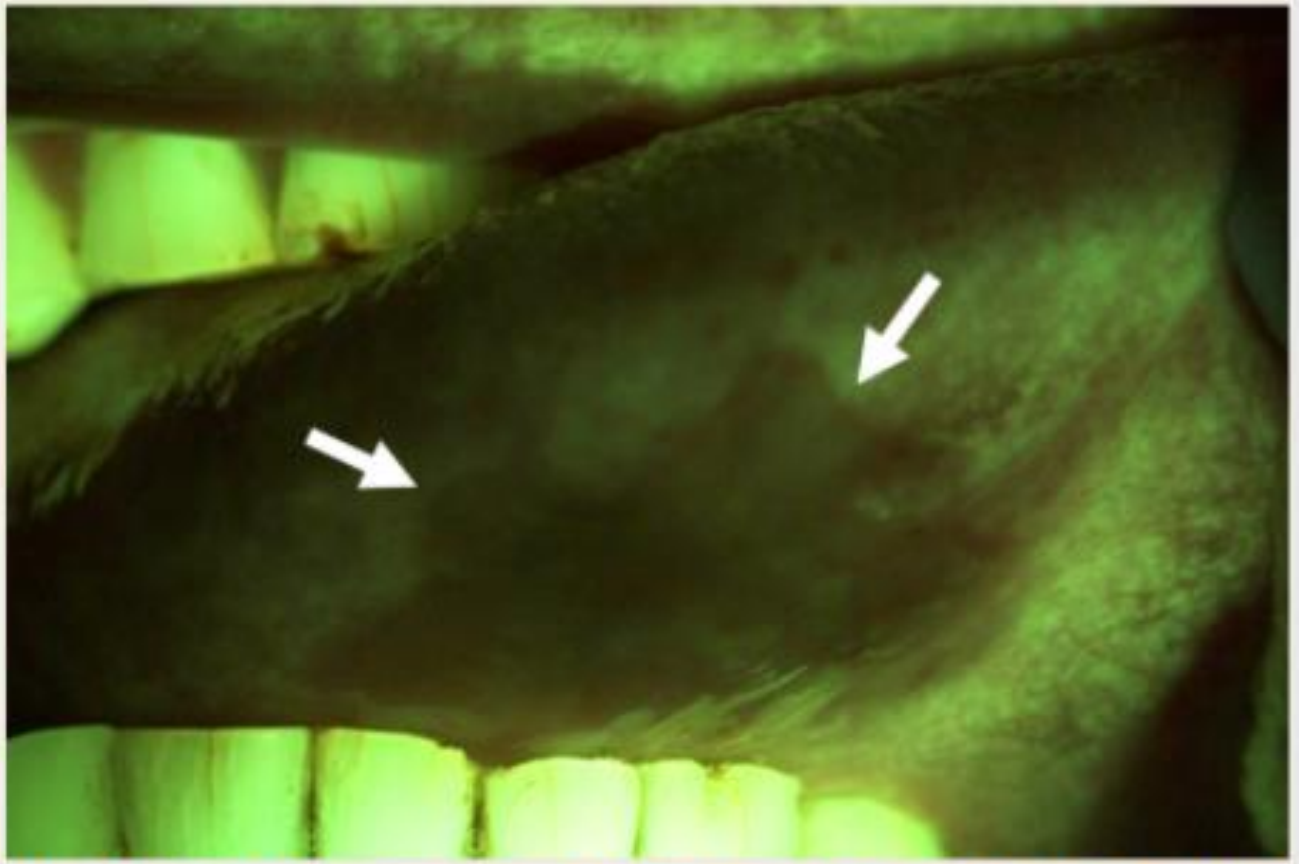




VELscope Vx
Enhanced Oral Assessment

ENHANCED TECHNOLOGY





EXCISIONAL BIOPSY: SEVERE DYSPLASIA

ORAL LESION MAY SHOW AS IRREGULAR, DARK AREAS

Images courtesy of the British Columbia Oral Cancer Prevention Program

DIAGNOSIS

F A PHYSICAL EXAM REVEALS A POSSIBLE CANCER LESION, THE NEXT STEPS WOULD

- BIOPSY
  - INCISIONAL VS EXCISIONAL
    - BLADE, PUNCH, BRUSH
      - RESULTS MUST CORRELATE WITH PHYSICAL FINDINGS *
- IMAGING
  - PLAIN FILMS
  - CT SCAN WITH CONTRAST
  - PET SCAN

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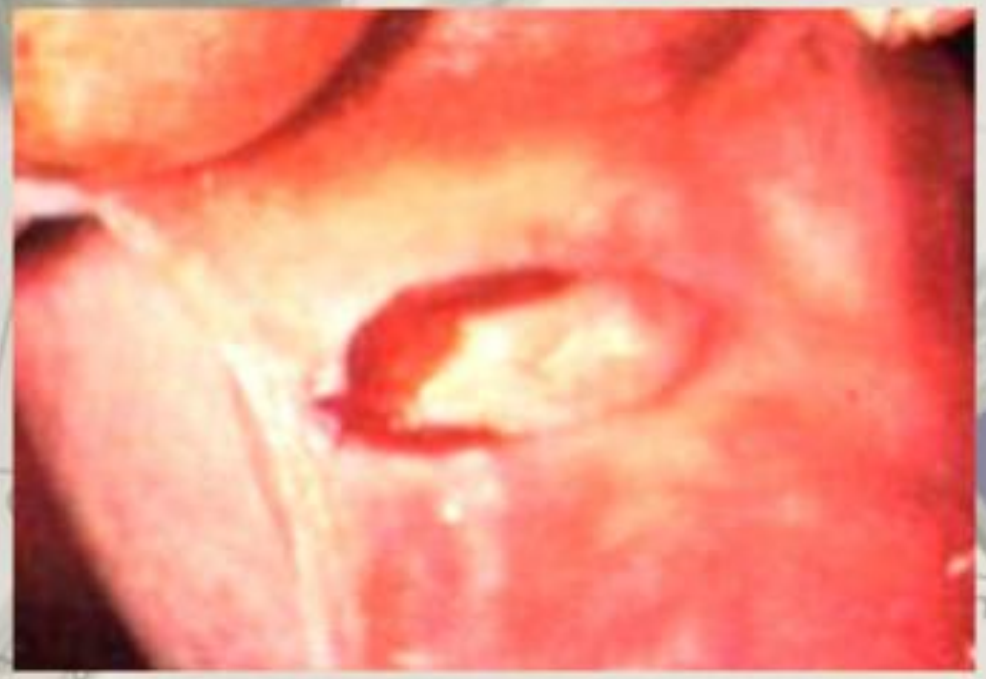
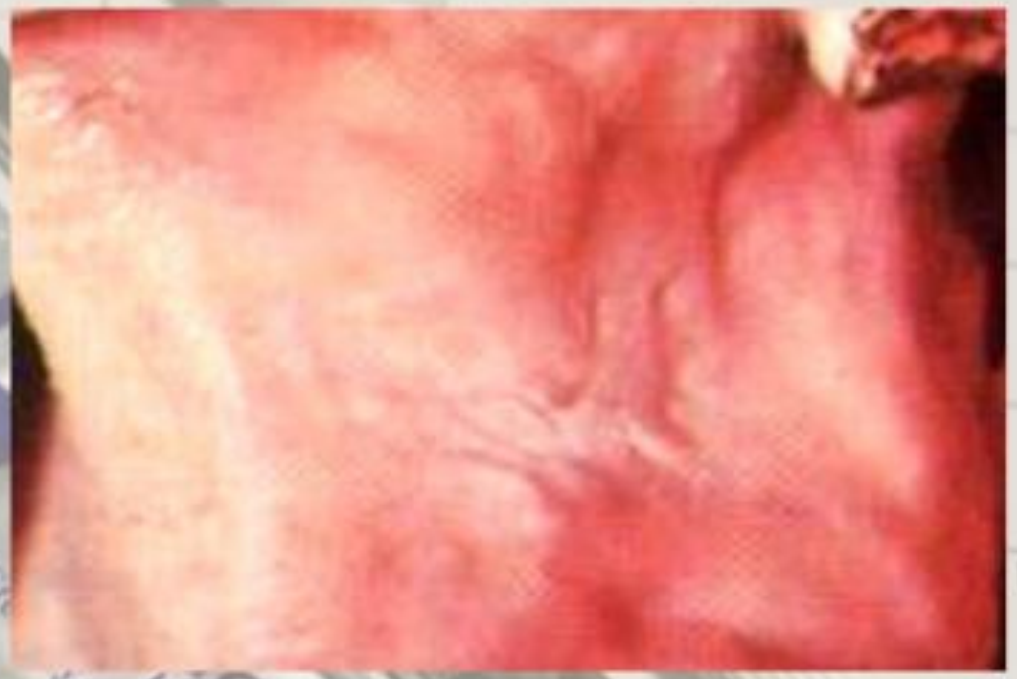
BIOPSY





Adenoma

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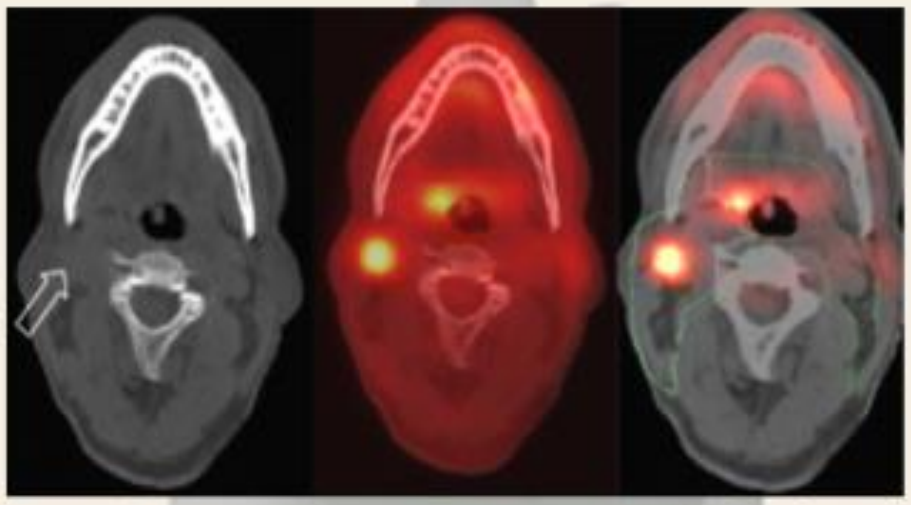
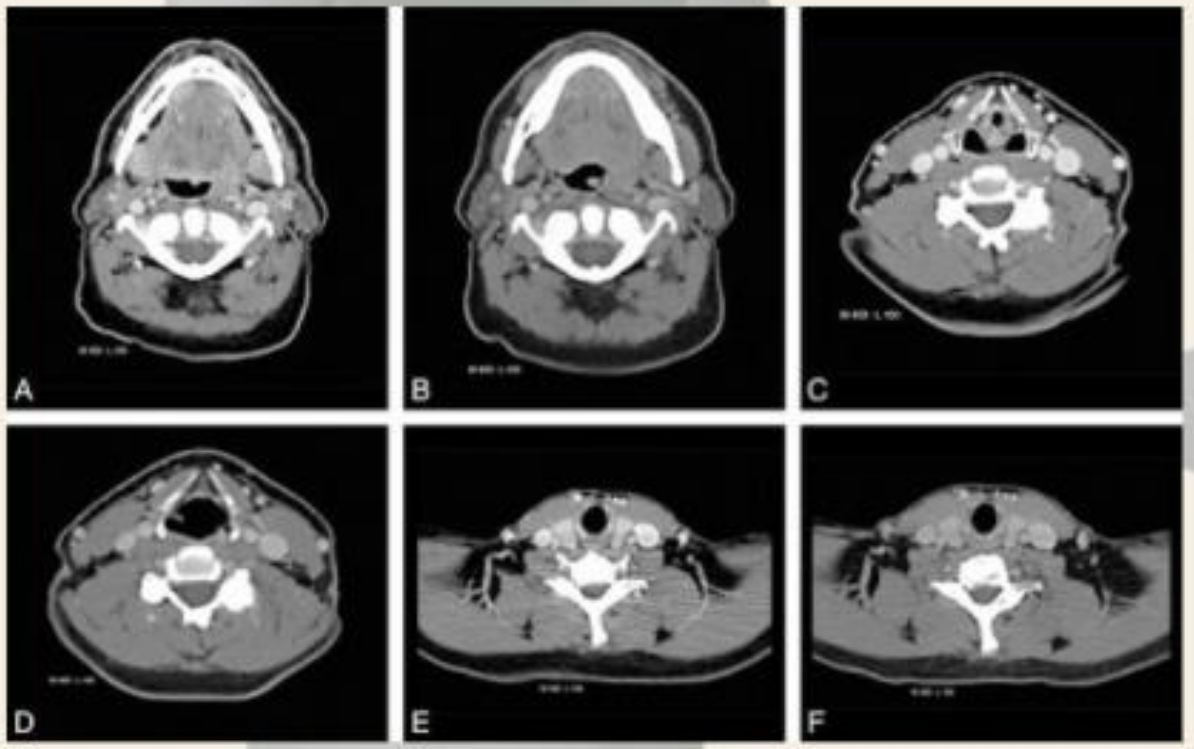
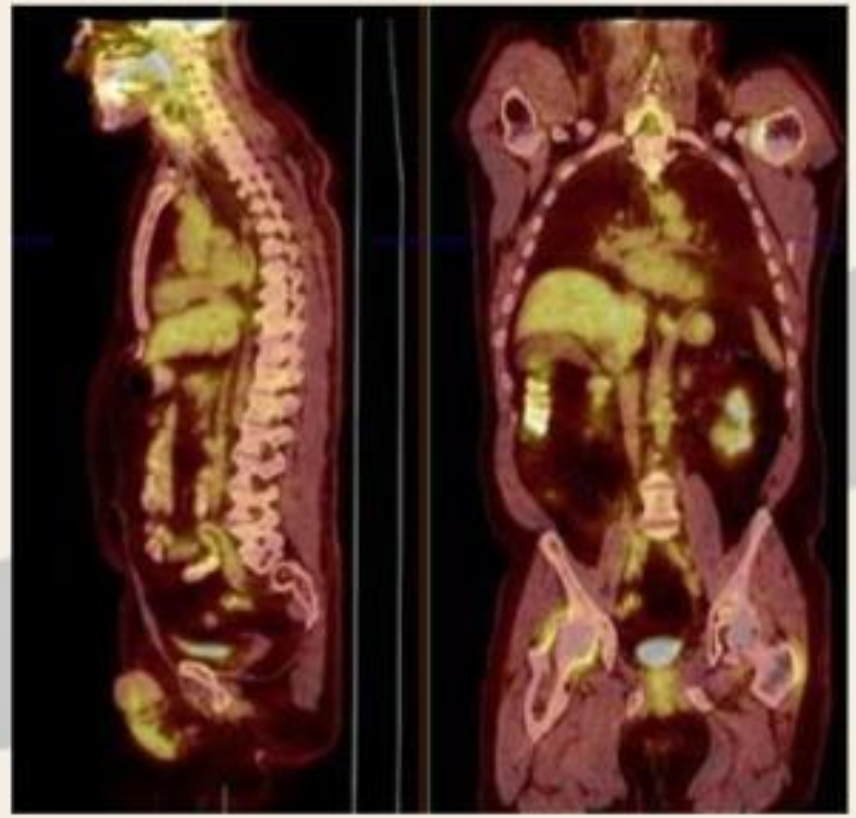
IMAGING







PDA STUDY CLUBS

STAGING - TNM

T=TUMOR

- TX=UNABLE TO ASSESS
- T0=NO TUMOR
- T1=<2 CM
- T2=>2 CM/<4 CM
- T3=>4 CM
- T4= INVADES BONE, MUSCLE, SKIN

PDA STUDY CLUBS

STAGING - TNM

N=REGIONAL LYMPH NODE OF THE NECK ON THE CT SCAN

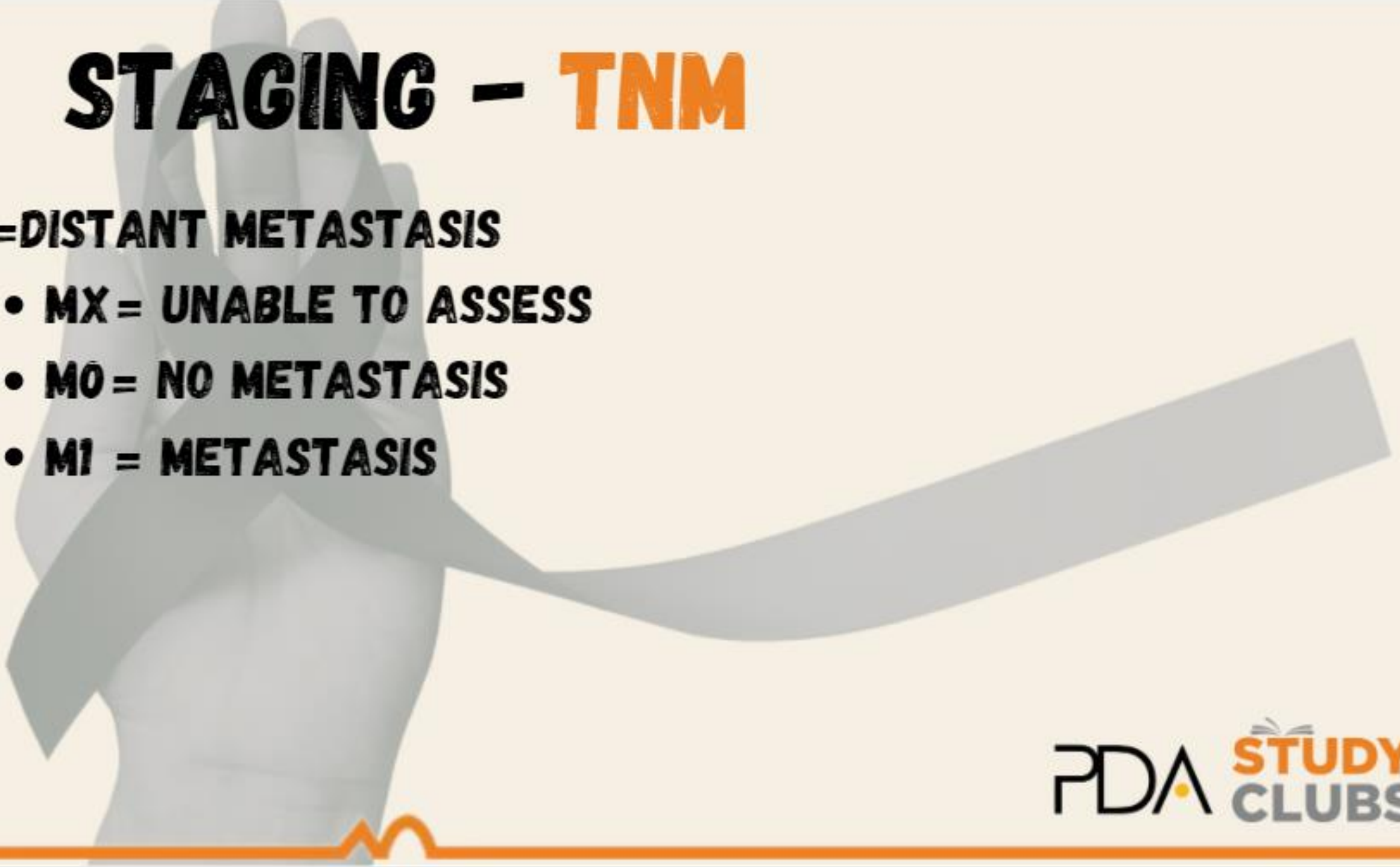
- NX=UNABLE TO ASSESS
- N0=NO NODES
- N1=SINGLE <3 CM (SAME SIDE)
- N2=SINGLE 3-6 CM (SAME/OPPOSITE SIDE)
- N3=>6 CM (SAME/OPPOSITE)

PDA STUDY CLUBS

STAGING - TNM

M=DISTANT METASTASIS

- MX= UNABLE TO ASSESS
- M0= NO METASTASIS
- M1 = METASTASIS



PDA STUDY CLUBS

PROGNOSIS:

TMN STAGING:

- DIRECT CORRELATION TO OUTCOME

GRADING:

- WELL DIFFERENTIATED
- MODERATELY WELL DIFFERENTIATED
- POORLY DIFFERENTIATED

PROGNOSIS:

TMN STAGING:

- DIRECT CORRELATION TO OUTCOME

GRADING:

- WELL DIFFERENTIATED
- MODERATELY WELL DIFFERENTIATED
- POORLY DIFFERENTIATED

PDA STUDY CLUBS

TREATMENT:

TUMOR BOARD

SURGICAL RESECTION:

- NO RECONSTRUCTION
- RECONSTRUCTION

NECK DISSECTION

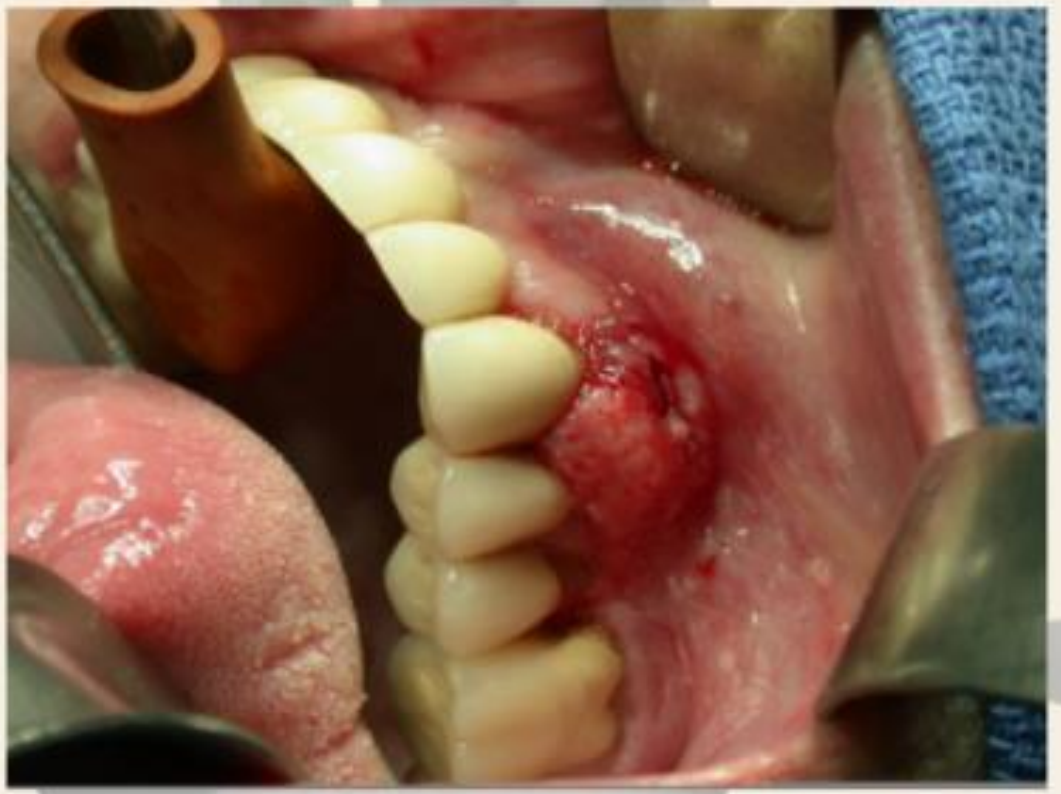
RADIATION:

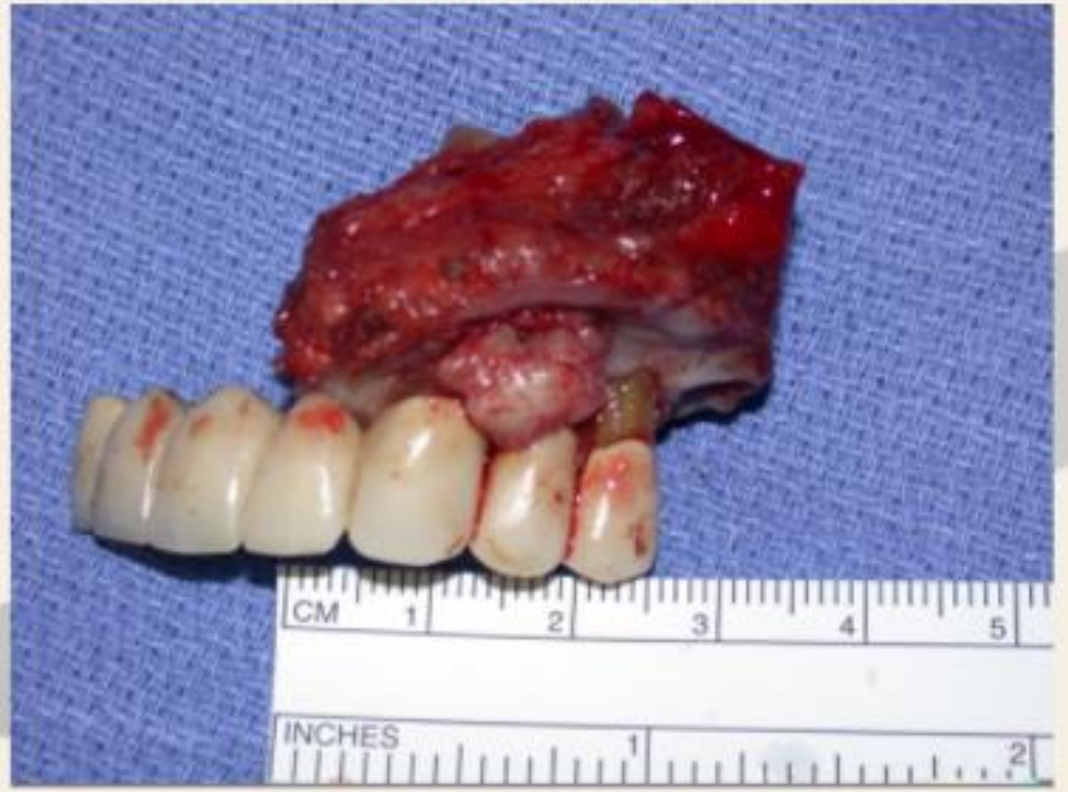
- T1 LESION NO SURGERY
- SURGERY AND RADIATION

CHEMOTHERAPY:

- NO ROLE

SURGICAL RESECTION





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RECONSTRUCTION

IMMEDIATE BONE GRAFT

- VASCULARIZED
- FREE GRAFT

DELAYED BONE GRAFT

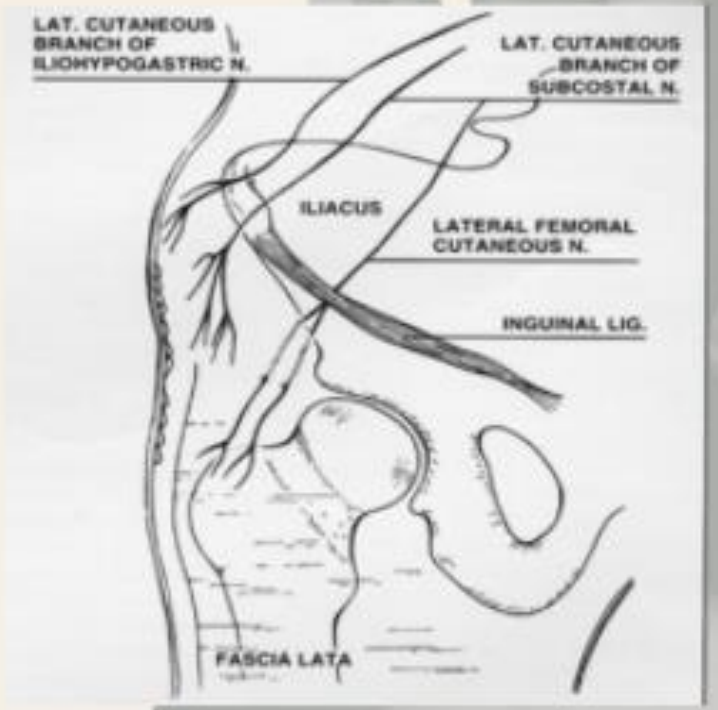
- STABILIZE WITH RECONSTRUCTION PLATE

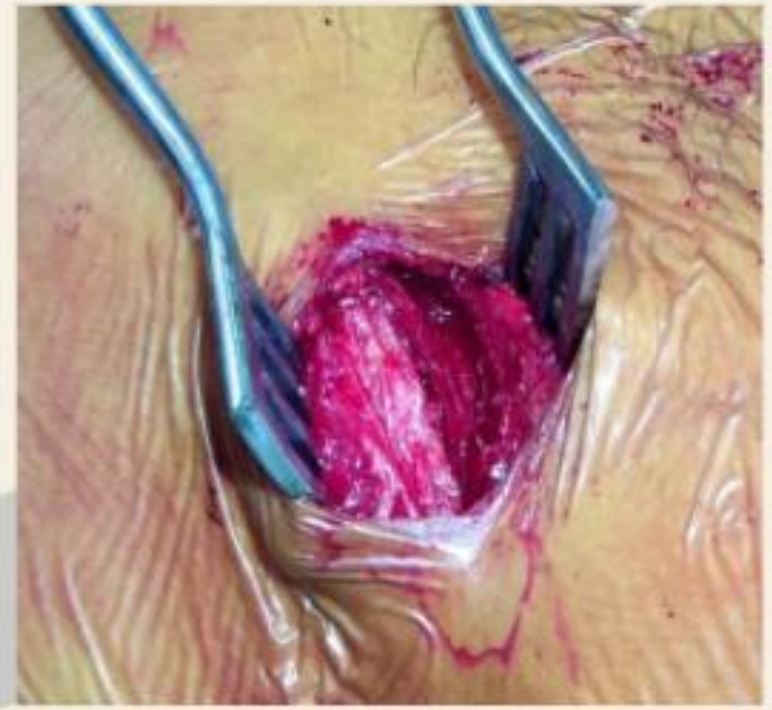
NO RECONSTRUCTION

- PECTORALIS FLAP (NO BONE GRAFT)

OBTURATOR

GRAFT HARVEST





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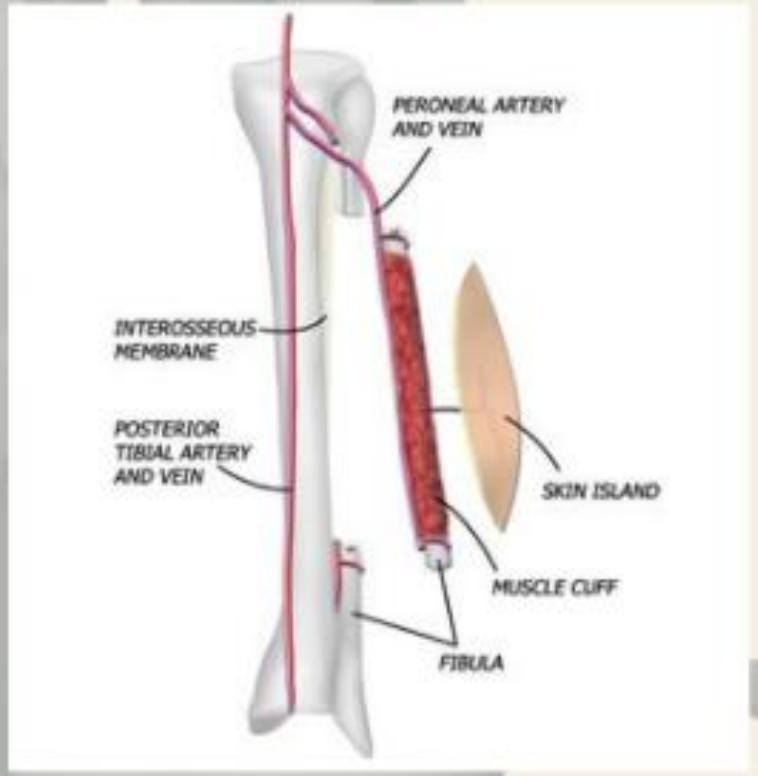
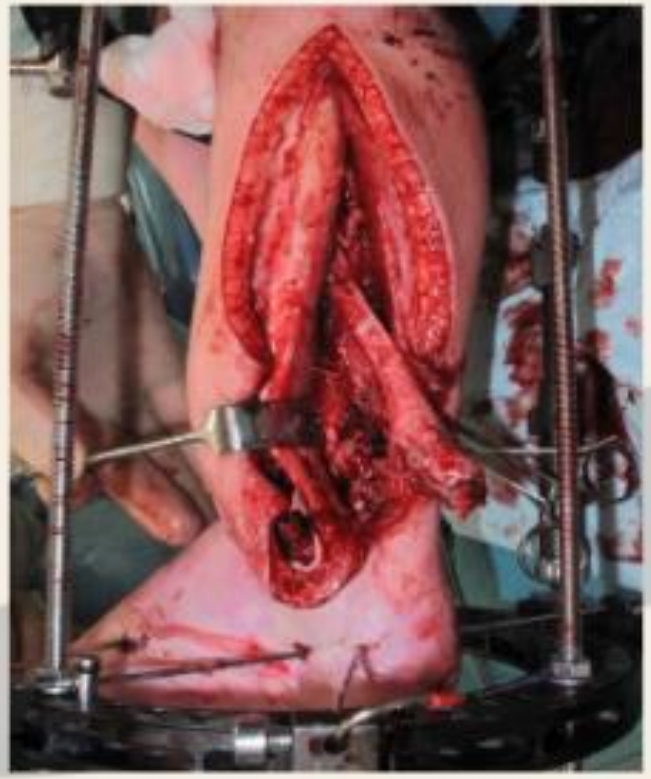
GRAFT HARVEST





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RADIATION THERAPY

DAMAGES ACTIVELY DIVIDING CELLS

EXTERNAL BEAM

IMPLANTS

MEASURED IN RADS OR GREYS

- 100 RADS = 1 GREY

MAXIMUM DOSE:

- 7500 RADS OR 75GY

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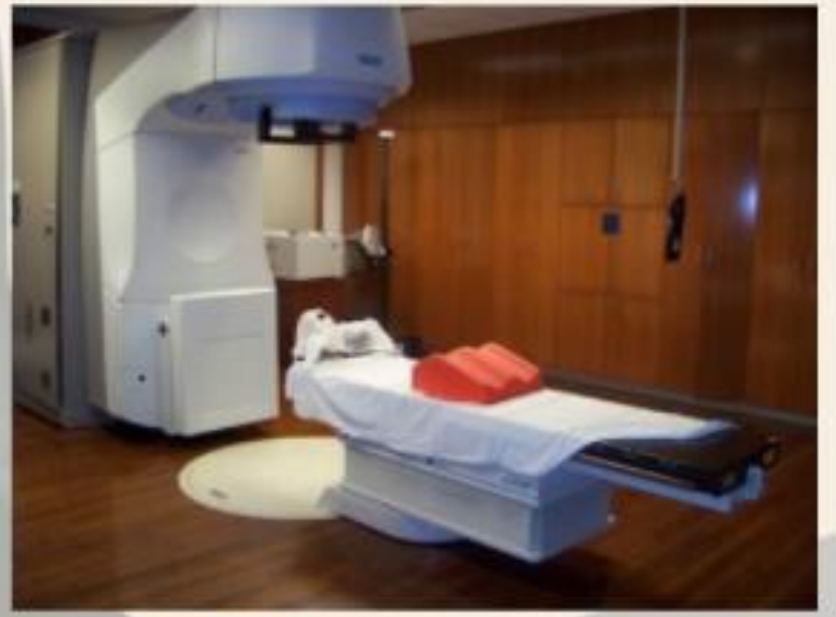
RADIATION THERAPY



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POST-RADIATION THERAPY

MUCOSITIS

- LASTS 2-3 WEEKS

XEROSTOMIA

- 3 MOS POST RADIATION
- CERVICAL DECAY

OSTEORADIONECROSIS

- DECREASED BLOOD SUPPLY

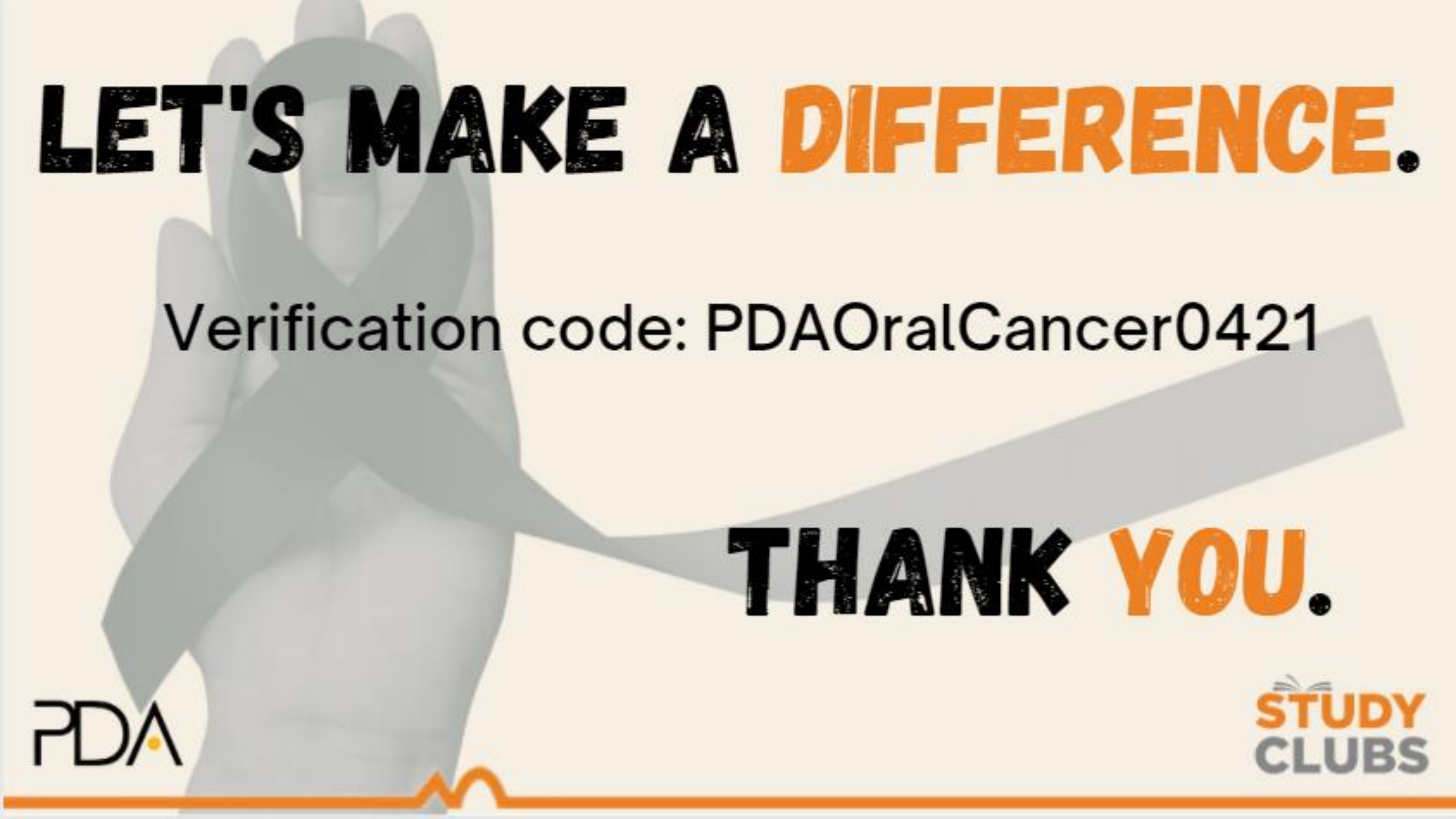
PDA STUDY CLUBS

HYGIENE HUB-EPISODE 7:

PUTTING IT ALL TOGETHER: CONSISTENT BEHAVIORS THAT DRIVE BEST IN CLASS CARE

MAY 19TH @ 12:15 PM EST

MAY 21 @ 1:15 PM EST


LET'S MAKE A DIFFERENCE.
Verification code: PDAOralCancer0421
THANK YOU.
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