

Oral Cancer Survivors and Quality of Life

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Introduction

Surgical therapy for oral cancer has a significant impact on quality of life (QOL), which is defined as the perceived gap between the patient's current situation and his or her desired standards [1]. The patient's self-perception and capacity to function are always altered as a result of surgical incision and cancer excision, which is frequently combined with radiation. Body scars and changes may be readily handled in public and typically remain hidden during social activities in scenarios such as mastectomy or vascular shunt for dialysis; however, oral cancer patients cannot disguise their post-treatment state. Despite the media's exaggeration of cancer treatment advancements, it still fits into one of three categories: surgery, radiation, or chemotherapy. Oncological outcomes have improved as a result of better surgical and reconstructive procedures, as well as more effective chemoradiotherapy protocols, but a growing number of patients are experiencing long-term severe side effects from these necessary therapeutic measures. When deciding on the optimal treatment regimen for a patient, head and neck oncologists frequently confront the challenging task of balancing cancer cure and patient survival with preservation of function, aesthetics, and QOL. Oral cancer survivors' lives are constrained not only by the dread of dying from the disease, but also by abnormalities produced by the tumour and the disease's impact on their everyday functions.

Oral cancer is most prevalent in people in their forties and fifties, however a worrisome number of cases have been reported in younger adults in recent years [2,3]. Oral cancer can be classified into three groups based on epidemiology and clinic pathology: carcinomas of the oral cavity proper, carcinomas of the lip vermilion, and carcinomas originating in the mouth. Men are more likely than women to develop intraoral and oropharyngeal tumours, with a male to female ratio of over 2: 1.2 [4,5]. However, the male-to-female ratio has narrowed over the last half-century, owing to women's equal exposure to recognised mouth carcinogens including cigarettes and alcohol [2,5].

The tongue is the most prevalent location for intraoral carcinoma, accounting for around 40% of all occurrences in the oral cavity. The second most prevalent intraoral site is the bottom of the mouth. The gingiva, buccal mucosa, soft palate, and hard palate are some of the less common locations [5,6]. The horseshoe-shaped region of the oral mucosa formed by the lateral tongue and floor of the mouth (with extension back to the lateral soft palate and tonsillar area) is the most vulnerable to cancer development [7]. There are two key elements that might explain why this area is so vulnerable: To begin with, any carcinogens will combine with saliva, pool in the bottom of the mouth, and continually wash these locations; second, these areas of the mouth are covered by a thinner, nonkeratinized mucosa, which provides less protection against carcinogens [7]. Squamous cell carcinoma (SCC) is the most common form of oral cancer, accounting for more than 95 percent of all oral cancers [1].

Oral cancer is preceded by a number of oral diseases and disorders, the most frequent of which are leukoplakia and erythroplakia. The yearly transition rate of oral leukoplakia into oral SCC has recently been reported to be less than 1% [2]. Erythroplakia is an uncommon condition that mostly affects people over the age of 60 [2].

The oral cavity is defined by the line drawn by the circumvallate papilla posterior–inferiorly from the vermilion–cutaneous junction of the lips to the junction of the hard and soft palate posterior–superiorly. The anterior faucial pillars represent the limits from the front to the back. The oral cavity has been classified into seven different anatomic sites from which primary lesions may originate [3] by the American Joint Committee on Cancer (AJCC). The clinical examination, which is the first line of defence in the identification of oral cancer, is used to make the diagnosis. Almost half of all oral cancers are not discovered until they have progressed to an advanced stage. The identification of oral and oropharyngeal SCC during nonsymptom-driven exams was linked with a lower stage at diagnosis, according to a research by Holmes et al. [4].

Following oral cancer surgery, a typical symptom is limited mouth opening. Fibrosis and scar contraction, as well as tightness of the masticatory muscles, are the major causes of the patient's inability to open his mouth [4,5]. Trismus has been linked to a variety of health issues, including decreased nutrition due to poor mastication, difficulties speaking, and even death [5]. Jaw opening limitations have been observed in 6-86% of individuals who underwent radiation to the temporomandibular joint and/or masseter/pterygoid muscles, with varying degrees of frequency and severity.

In cancer patients, health-related quality of life (HRQOL) is now thought to be a significant predictor of mortality and morbidity [6]. Health practitioners can use HRQOL to analyse the physical, mental, and social effects of treatments and enhance their ability to predict a patient's prognosis. QOL surveys offer the benefit of gathering and rating the most frequent issues faced by patients in a systematic manner. Various formats were employed prior to the introduction of controlled questionnaires with a specific number of graded questions [7]. Validity (the degree to which the questionnaire measures what it claims to measure), reproducibility (required in subsequent repeats), consistency, reliability, and change sensitivity are the most important criteria they must possess [8]. Patients with oral cancer nowadays choose a multidisciplinary approach that includes an integrated treatment plan. Future research should focus on not just reducing oral cancer but also improving functional and aesthetic outcomes following therapy. Since a result, before choosing on an oral cancer therapy, one must be aware of the long-term problems and side effects in terms of QOL, as an increase in a patient's survival does not always imply an increase in QOL.

Summary

Patients who had adjuvant radiation had poorer scores in function parameters and more symptoms [9], and their QOL deteriorated as a result of secondary effects as well as psychological impairment, according to QOL transversal and longitudinal investigations [8].

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