

Editorial

Postoperative Care in Oral Cancer

Oral cancer is a life-threatening and potentially disfiguring condition accounting to about 5% of total body cancers.¹ Current treatment for head and neck cancers involves a multidisciplinary approach, and the principle behind these approaches involves obtaining a disease-free-period post-treatment, maximizing the quality of life by preservation of form and functions. Currently, surgical reconstruction forms an integral part of multidisciplinary cancer therapy.

Wide surgical excision can not only cause disfigurement it but also can lead to functional disabilities affecting patients self image and social adaptability. Adequate reconstruction after tumor excision is, therefore, the first step to rehabilitation.

Postoperative care often requires a dental team intervening as a part of the multidisciplinary approach. Prior to treatment, dental intervention involves a pretreatment evaluation for dental conditions which include comprehensive clinical and radiological screening to eliminate dental infections.

Post-treatment prosthetic rehabilitation in the form of obturator is often required to maintain speech and swallowing following maxillary resection of tumors that create defects of the maxilla, palate, or adjacent soft tissue.^{2,3}

All types of cancer therapies can greatly influence oral functional abilities like speech and swallowing, which may necessitate a speech therapy and other procedures to maintain orofacial functions. Sensory neural impairment like olfaction and gustation is often compromised following a wide surgical excision and rarely from chemoradiotherapy. Amifostine and zinc supplementation have greatly made way in cancer therapy by preventing gustatory loss.⁴

Pain in cancer patients may be caused by the tumor or by cancer therapy or may be unrelated to cancer. Pain is influenced by an emotional response caused by fear of cancer. The management of cancer pain requires attention to the potential multiple causes of pain. Dental and periodontal disease that causes pain may be controlled with analgesics and antibiotics; however, definitive dental management is needed. Neurologic pain states, including neuropathic pain and neuralgia-like pain, may require the use of antidepressants and anticonvulsants respectively.

Failure to understand the psychological component of pain and lack of attention to the emotional and social aspects has led to failure of pain therapy. It is often indicated to use both the analgesics and adjuvant medications in order to obtain pain control.⁵

Maintenance of oral hygiene involves the removal of dental plaque from teeth and the associated oral structures along with the removal of retained food due to impaired swallowing mechanisms. Inadequate oral hygiene can increase discomfort and predisposes to complications, such as infection of surgical wounds, inflammation and infection of the surrounding oral tissues, leading to gingivitis or mucositis.⁶

The facial musculature performs a variety of orofacial functions, such as mastication, speech and deglutition. Orofacial myofunctional exercises help the patient regain tone of the orofacial musculature. Components of myofunctional therapy include tongue and facial exercises in order to promote tongue position, mastication and deglutition and improved breathing.⁷

Oral and dental care is important in all phases of the diagnosis and treatment of the patient with head and neck cancer. Prevention of the oral complications that arises during or after therapy, and management of the complications when they occur, require the involvement of a knowledgeable practitioner. Dental providers are a part of the health-care team and must be involved in the care of the head and neck cancer patient.

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