

# Oral Cancer Pathology and Prophylaxis

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## Editorial

The highest rates of oral cancer incidence and death are seen in a few developing nations, such as India, Pakistan, and Bangladesh, where this is the most frequent kind of cancer, as well as Hong Kong, Singapore, and the Philippines. Oral cancer rates vary widely across Europe, with significant variances even regions within the same nation. In affluent nations, alcohol and tobacco are the two most well-known risk factors for oral cancer, accounting for more than 75% of oral malignancies in males in the United States, France, and Italy. Other factors, on the other hand, appear to have a significant impact in the world's most dangerous places.

This study provides an overview of the descriptive epidemiology of oral cancer, as well as the most well-known risk factors, with an emphasis on prevention strategies. Squamous cell carcinoma of the mouth is a well-known cancer that accounts for more than 90% of all oral malignancies. In the previous few years, the overall 5-year survival rate in OSCC has not increased appreciably. The overall survival rate is 56%, and the disease-free survival rate is 58%. The most crucial objective is to make an early diagnosis while the illness is still in its early stages. Pain is a prevalent symptom in people with oral cancer, accounting for 30–40% of their major complaints.

Pain was described in 12 distinct ways, and it was linked to TNM staging in the tongue and the tongue/mouth floor. Although pain is the most common symptom, it generally appears only after the lesions have grown to a significant size, at which point the patient seeks medical help. As a result of their asymptomatic nature, early carcinomas frequently go unreported. Symptoms can range from minor discomfort to severe pain, especially on the tongue, in later and bigger lesions. Other symptoms include ear discomfort, bleeding, tooth movement, breathing issues, trouble speaking, dysphagia, prosthesis problems, trismus, and paraesthesia. Pain can develop early in specific areas, such as the tongue or the floor of the mouth.

The movement of the tongue against the teeth causes increased discomfort in the case of OSCC of the tongue. Carcinomas of the lip and buccal mucosa, on the other hand, only cause severe discomfort when they are advanced. Patients with cervical lymphadenopathy may appear with no additional symptoms on rare occasions. Patients may develop skin fistulas, bleeding, severe anaemia, and cachexia as the disease progresses. In the 342 (52.6%) OSCC patients evaluated, swelling and/or discomfort were the earliest indications or symptoms. The most common symptoms, according to

other authors, were ulceration and swelling, followed by discomfort, bleeding, restricted tongue movement, dysphagia, and paraesthesia.

A study of individuals with OSCC of the tongue discovered that the most common symptom was tongue discomfort (66.5%), with % having a lump on the tongue. Ear discomfort, speech alterations, dysphagia, and cervical tumours were all more prevalent in tumours near the root of the tongue. OSCC may arise in any region, however it is more frequent in particular locations. The tongue and the floor of the mouth<sup>12–16</sup> are the most common sites, mostly in Western countries, where it occurs in over 50% of cases. Buccal mucosa, retromolar region, gingiva, soft palate, and, less commonly, the rear of the tongue and hard palate are also involved. In particular geographical places, the lip is more commonly affected.

A study of 478 oral cavity carcinomas conducted between 1947 and 1970 discovered that, excluding the lip, 40% of tumours were identified on the tongue and 33% on the floor of the mouth. The lateral and ventral sides of the tongue, followed by the floor of the mouth, were the most common areas in an examination of 92 instances [1–5].

## Conflict of interest

None

## References

1. Freeman, John A., David Esrig, John P. Stein, and Donald G. Skinner. "Management of the patient with bladder cancer: urethral recurrence." *Urol Clin North Am* 21 (1994): 645-651.
2. Bono, A.V., C. Benvenuti, G. Damiano, and J. Lovisolo. "Results of transurethral resection and intravesical doxorubicin prophylaxis in patients with T1 G3 bladder cancer." *Urol* 44 (1994): 329-334.
3. Gofrit, O.N., A. Shapiro, D. Pode, and A. Sidi, et al. "Combined local bladder hyperthermia and intravesical chemotherapy for the treatment of high-grade superficial bladder cancer." *Urol* 63 (2004): 466-471.
4. Ozono, Seiichiro, Shiro Hinotsu, Shoichi Tabata, and Kenji Takashima, et al. "Treated natural history of superficial bladder cancer." *Jpn J Clin Oncol* 31 (2001): 536-540.
5. Adolphs, H.D., and H.P. Bastian. "Chemioimmune prophylaxis of superficial bladder cancer." *J Uro* 129 (1983): 29-31.

**How to cite this article:** Smith, Olivia. "Oral Cancer Pathology and Prophylaxis." *Oral Health Case Rep* 8 (2022): 46.

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**Received:** 17 February, 2022, Manuscript No. ohcr-22-66014; **Editor Assigned:** 20 February, 2022, PreQC No. P-66014; **Reviewed:** 25 February, 2022, QC No. Q-66014; **Revised:** 04 March, 2022; Manuscript No R-66014; **Published:** 08 March, 2022; DOI: 10.37421/2471-8726.2022.8.46