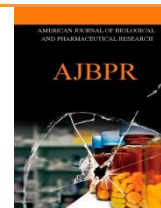




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SQUAMOUS CELL CARCINOMA - A CASE REPORT

Faisal Mohd^{1*}, Sreedhar Bala Sundari², Natarajan S³, Khan Sameera⁴,
Riaz Akhtar⁵, Malay K⁴

¹Post Graduate student, ²Professor and HOD, ³Professor, ⁴Senior Lecturer, ⁵Reader, Dept. of Oral Pathology, Career Post-Graduate Institute of Dental Sciences, Lucknow, Uttar Pradesh, India.

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ABSTRACT

Cancer is the second leading cause of death in globally. In 2004, more than one million people died of cancer. For early diagnosis, the standard-of-care must include thorough examination of every intraoral mucosal surface and of the extraoral head and neck tissues including lymph nodes. Any mucosal abnormality requires some action plan; whether the plan involves treatment, biopsy, referral, or recall examination depends on the nature of the lesion. Odontoma, complex type is an agglomerate of all the dental tissues that are characterized by normal histodifferentiation but abnormal morphodifferentiation producing little or no resemblance to normal tooth form. They are usually asymptomatic but often associated with eruption disturbances. An interesting case of unusually large complex odontoma that was associated with pain and an impacted as well as missing molar is reported. An interesting case of unusually large squamous cell carcinoma of maxilla that was associated with pain is reported here.

INTRODUCTION

Oral cavity is the most common site for cancer [1,2]. More than 90% of these oral-pharyngeal cancers are squamous cell carcinomas. The 5-year survival rate from these carcinomas has not significantly improved in the past 30 years and remains at approximately 50% [3]. The ratio of males to females diagnosed with oral cancer is 2:1 over lifetime. Approximately 96% of oral cancer is diagnosed in persons older than 40 years, and more than 50% of all cancers occur in persons over the age of 65 years. The average age at the time of diagnosis is 63 years. Recently, however, evidence has emerged indicating that oral cancers are occurring more frequently in younger persons (less than 40 years) [4]. This article presents a case report of squamous cell carcinoma of maxilla.

ETIOLOGY AND RISK FACTORS: The etiology of oral cancer is almost certainly multifactorial and involves many alterations in host immunity and metabolism, angiogenesis, and exposure to chronic inflammation in a genetically susceptible individual [4]. The carcinogenic changes may be influenced by oncogenes, carcinogens, and mutations caused by chemicals, viruses, irradiation, drugs (tobacco and alcohol), hormones, nutrients, or physical irritants [5].

CASE REPORT: A female patient aged 40 yrs. reported to the Dept. of Oral medicine & Radiology, Career Post Graduate Institute of Dental Sciences, Lucknow with a chief complaint of swelling in her left midfacial region since 4 years and also complains of non healing wound in upper left back region of jaw since 01 yr.

History of presenting illness revealed that the patient was asymptomatic before 4 years than complaint started with extraction of posterior most two teeth on upper

Corresponding Author

Mohd. Faisal

Email:- faisalali010@gmail.com



left side 4 years back because of mobility and pain. Then after few days, swelling appeared in that region. This swelling was not associated with pain or paraesthesia. The size of the swelling was that of pea size initially. Patient neglected this condition and didn't take any treatment for 3 years. Then after 3 years patient again got extracted a tooth of that region due to mobility and pain. Meanwhile the size of the swelling remained same and there was also a tooth socket which was not healing in this area. Again patient took no treatment for swelling and non healing socket. Two weeks back there was bleeding with non healing socket for which patient visited local dentist who referred her to CPGIDS&H.

Past dental history revealed that extraction of the two teeth in the upper left back tooth region was done 04 years back due to pain and mobility. Extraction of other teeth in same region due to same reasons, but the socket did not heal.

EXTRAORAL EXAMINATION:

Inspection: Swelling is seen on left midfacial region which is diffuse. Extent is from ala of nose to 4 cm anterior to tragus of ear. The size is around 4x6 cm. surface is smooth. Surrounding skin is normal. Overlying skin is not stretched and presence of foul smell.



Palpation: Inspectory findings are confirmed. Consistency is soft. The swelling is non fluctuant and non compressible. Fixed to underlying structure and swelling is non-tender.

INTRAORAL EXAMINATION

Inspection - Swelling is seen intraorally extending from distal aspect of 24 to the retromolar region. Mediolaterally from midpalatal suture area to 3cm beyond alveolar ridge. Shape is oval. Size is about 5x8 cm. overlying mucosa is stretched. Surrounding mucosa is normal. Colour is pinkish and presence of an unhealed socket in 27



Palpation - Inspectory findings are confirmed. Temperature is not raised, consistency is soft, fixed to

underlying structures. Swelling is non tender and compressibility is present. Non healing socket is seen with 27 and is associated with bleeding on probing.

Provisional Diagnosis: Malignant tumor of maxilla/minor salivary gland.

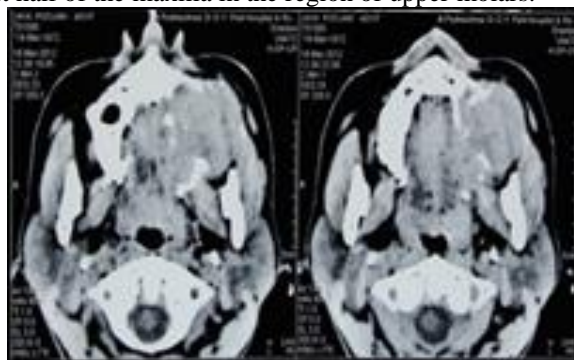
Differential Diagnosis: Ameloblastoma with 26, 27, 28 region, Lymphoma and squamous cell carcinoma of maxilla on left side

Investigations: Maxillary true occlusal radiograph and OPG were taken CT scan of the paranasal sinuses region was also advised [6,7]



Maxillary occlusal interpretation revealed that presence of a massive expansion of bone in the zygoma region on left side. Internal aspect is radiopaque. Nasolacrimal canal is also involved. OPG interpretation revealed that 16,26,27,28 are missing. The floor and posterior walls of maxillary sinus are destroyed. Pterygo-maxillary fissure is obliterated. The hazy radioopacity is seen in left maxillary sinus and in the region of 26, 27 and 28.

CT scan report revealed that there is an abnormal well defined heterogeneously enhancing lobulated soft tissue lesion with necrosis measuring approximately 5.0x 6.5x 5.0 cms in left maxillary sinus. No calcification is seen in the lesion. The lesion is eroding the posterolateral wall of the left maxillary sinus, the alveolar cortex of the left half of the maxilla in the region of upper molars.

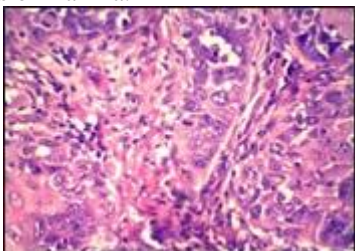


There is an expansion of the left maxillary antrum with attenuation of its medial and anterior walls and wall of the orbit. However no extension of the lesion into left orbital cavity is seen. Hypo-dense non enhancing mucosal thickening is seen in left maxillary sinus.



Radiographic Diagnosis: Primary maxillary squamous cell carcinoma.

Radiographic differential Diagnosis: Lymphoma and Osteomyelitis of maxilla.



Histopathology Report: The section shows several bits of tissue some of them composed of granulation tissue. One bit shows connective tissue infiltrated with

malignant epithelial cells having dysplastic features such as hyperchromatism, pleomorphism, abnormal mitotic figures and many keratin pearls.

Another bit shows a collection of bizarre cells probably of epithelial origin intermixed with loose myxoid tissue and extravasated blood element.

Final diagnosis: Squamous cell carcinoma of maxilla.

Treatment Plan: Chemotherapy and Radiotherapy [8,9].

Source of support: Nil

Conflict of Interest: None

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