

Tongue Cancer

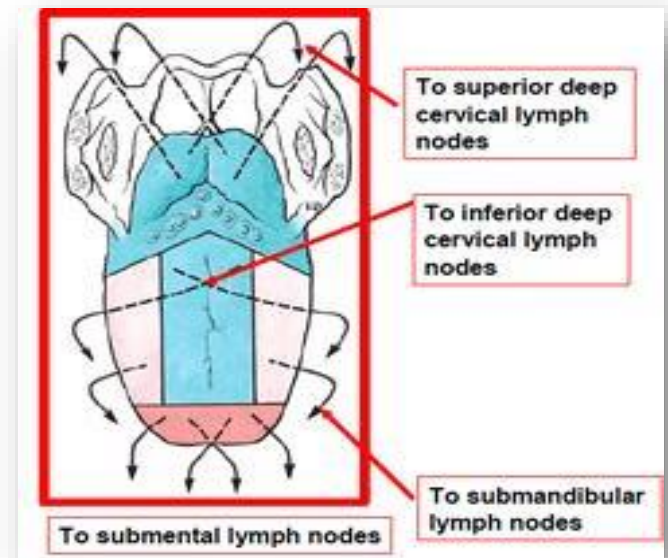
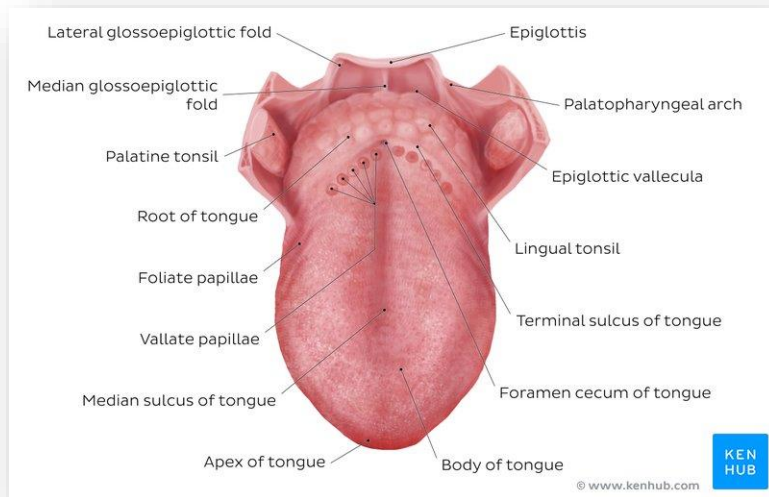


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Anatomy of the Tongue



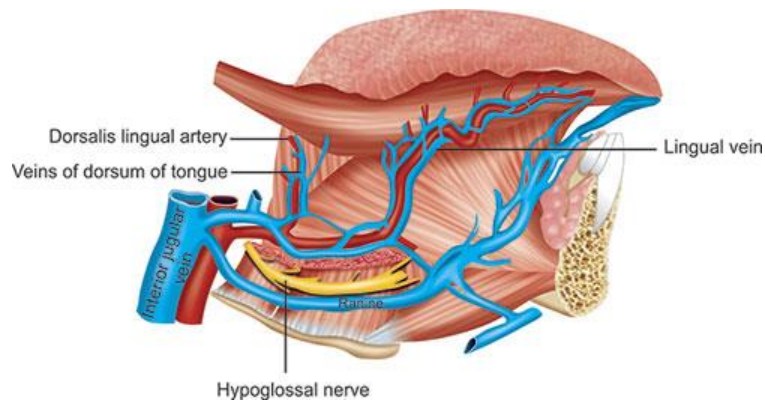
Lymphatic drainage of tongue



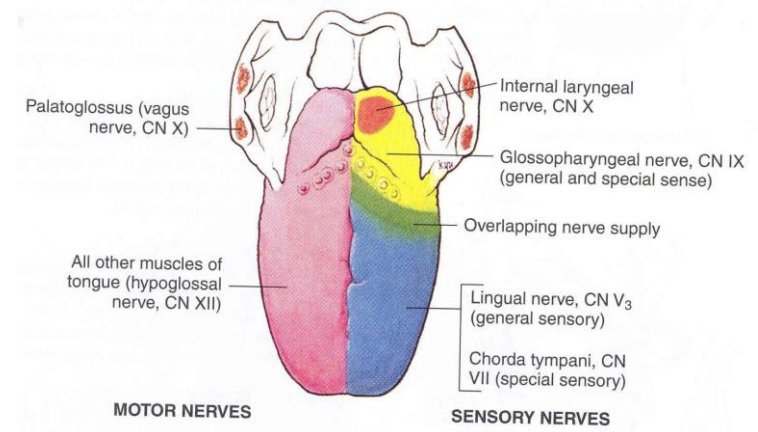
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Blood supply to the tongue



Nerve supply to the tongue



Oropharangeal Carcinoma

- The incidence is greater in men than in women
- It is predominantly a disease of the elderly (those over 60 years of age).



Risk Factors

- Tobacco
- Alcohol
- Areca nut/pan masala
- Human papillomavirus
- Epstein–Barr virus
- Plummer–Vinson syndrome
- Poor nutrition



Pathology

- Histology- Squamous cell carcinoma is the predominant histology.
- Tumors mainly arise from the mucosal epithelium.
- Chronic exposure of the mucosal surface to carcinogenic substances can produce multiple subclinical sites of carcinoma.



Premalignant Lesions

Low-risk/equivocal-risk lesions

- Oral lichen planus
- Discoid lupus erythematosus
- Discoid keratosis congenita

Medium-risk lesions

- Oral submucous fibrosis
- Syphilitic glossitis
- Sideropenic dysphagia (Paterson–Kelly syndrome)

High-risk lesions

- Erythroplakia
- Speckled erythroplakia
- Chronic hyperplastic candidiasis





Speckled leukoplakia on the lateral border of



Erythroplakia of the left soft palate and





**Metachronous tumour in the
right mandibular alveolus**

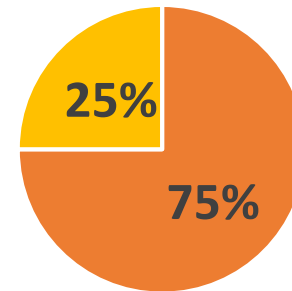


**Chronic hyperplastic
candidiasis of the left buccal
mucosa**



Tongue Cancer

- Main histological type is squamous cell carcinoma.
- Three morphological types
 - 1) Exophytic
 - 2) Ulcerative
 - 3) Infiltrative



■ Anterior tongue cancer

■ Posterior tongue cancer



Clinical Features

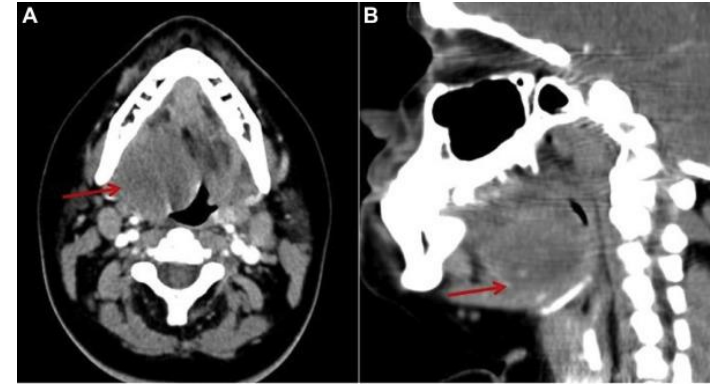
- Chronic ulcer
 - ➔ Painless
 - ➔ Painful
- Neck lump (due to cervical lymph node enlargement)
- Dysphagia – In posterior tongue cancer



Investigations

To diagnose

- Incisional biopsy



To stage the tumor

- MRI – Do before diagnostic biopsy
- CT neck, thorax, abdomen
- Radioisotope bone scan of the facial skeleton
- FNAC of enlarge cervical lymph nodes



Classification & Staging

Primary tumour (T)

TX Primary tumour cannot be assessed

T0 No evidence of primary tumour

Tis Carcinoma in situ

T1 Tumour <2 cm in greatest dimension

T2 Tumour >2 but <4 cm

T3 Tumour >4 cm but <6 cm

T4 Tumour invades adjacent structures, e.g. mandible, skin



Regional lymph nodes (N)

NX Regional lymph nodes cannot be assessed

N0 No regional lymph node metastasis

N1 Metastasis in a single ipsilateral lymph node <3 cm in greatest dimension

N2a Metastasis in a single ipsilateral lymph node >3 cm but not more than 6 cm

N2b Metastasis in multiple ipsilateral lymph nodes, none >6 cm in greatest dimension

N2c Metastasis in bilateral or contralateral lymph nodes, none >6 cm in greatest dimension

N3 Metastasis in any lymph node >6 cm

Distant metastasis(M)

M0 No evidence of distant metastasis

M1 Evidence of distant metastasis



Stage

0	-	Tis N0 M0
I	-	T1 N0 M0
II	-	T2 N0 M0
III	-	T3 N0 M0
		T1, T2, T3 N1 M0
IV	-	T4 N0 M0
		Any T N2 M0
		Any T N3 M0
		Any T Any N M1



Prognosis

- Posterior tongue cancer- poor prognosis
- HPV positive- good prognosis
- HPV negative- bad prognosis
- Positive margins, perineural invasion, lymphovascular invasion, and positive lymph nodes - bad prognosis



Treatment

Depend on,

- Site of disease
- Stage
- Histology
- Concomitant medical disease
- Social factors

Multidisciplinary team approach



1.Surgery

- Wide local excision
- Partial glossectomy
- Hemiglossectomy
- Reconstruction

2.Radiotherapy

3.Chemotherapy



Prevention

- HPV vaccination
- Avoid carcinogens- Cessation of smoking, reduction in alcohol consumption
- Treat to premalignant conditions



Management of premalignant conditions

- Elimination of associated aetiological factors
- All erythroplakia and speckled leukoplakia -urgent incisional biopsy
- Severe epithelial dysplasia and carcinoma in situ -ablated by surgical excision or laser vaporization
- Small lesions -surgical excision and primary closure
- Larger defects- laser vaporization and allowed to epithelialize spontaneously

