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A rare case of carcinoma on hard palate

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ABSTRACT

Introduction: The hard palate is a thin horizontal bony plate made up of two facial skeleton bones that run across the roof of the mouth. The palatine process of the maxilla and the horizontal plate of palatine bone are the bones. The alveolar arch, formed by the alveolar process and holds the top teeth in place, has a complex palate that runs its length (when these are developed).

Clinical findings: Pain, difficulty in breathing, difficulty in mastication, difficulty in deglutition, balm application, change in voice, tooth exfoliation, lack of appetite Diagnostic evaluation: A male of 58 yrs old was brought by his son with a complaint of pain which is gradual in onset, dull aching, aggravates on chewing, difficulty in deglutition since two months, burning sensation on the consumption of spicy food since two months change in voice, nasal discharge, loss of appetite, weight loss, tooth exfoliation in the upper front region of jaw, and balm application (2-3 episodes, 15 days back).

Therapeutic investigation: X-ray, USG, MRI, CT scan, biopsy.

Outcome: After treatment, the patient shows excellent improvement.

Conclusion: A male of 58 years old was admitted on 28/9/2020 with a rare case of Wilms tumor. He was 45 kg, and his height was 158 cm. He was admitted to the hospital, where all investigations and treatments began. He improved dramatically after therapy and continued to do so until my last day of care.

Keywords: Carcinoma, Dull Aching, Weight Loss, Loss of Appetite.

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INTRODUCTION

The hard palate is a thin horizontal bony plate in the roof of the mouth made composed of two facial skeleton bones. The palatine process of the maxilla and the horizontal plate of palatine bone are the bones [1]. The hard palate runs the length of the alveolar arch created by the alveolar process and holds the upper teeth in place (when these are developed). The Mallinckrodt Institute of Radiology saw 13 individuals with primary hard palate cancer over eighteen years [2]. Adenoid cystic carcinoma was found in nine patients, squamous cell carcinoma in three, and mucoepidermoid carcinoma in one. The tumors were 3 cm in diameter on average. 1 Tumour = 1, Tumour2 = 5, Tumour3 = 3, Tumour4 = 4. The patients were clinically staged as follows: Tumour = 1, Tumour2 = 5, Tumour3 = 3, Tumour4 = 4. All of them were N0M0 [3]. Excision and postoperative irradiation were performed on ten individuals. The remaining three patients received definitive radiation treatment. The 10-year disease-free survival rate is 77 percent, with a 92 percent actuarial local control rate. Negative surgical margins resulted in better local control, and disease-free survival. The length of radiation therapy, the total tumor dose, or the histology of the tumor did not affect the outcome [4]. We conclude that combining surgery and irradiation affords patients with this disease good 10-year local control and disease-free survival rates. Unlike other head and neck cancers, hard palate cancers are usually visible or felt as an abnormality by a patient, a dentist, or a doctor [5].

Patient identification: A male patient of 58 years from admitted to the ENT ward, on 11/10/2021 with a rare case of complex palate carcinoma. His weight is 45 kg, and his height is 158 cm, and his BMI is 18.03.

History of illness: Patient complaint of painful nonhealing ulcer in the upper front region of the jaw. The patient was apparently alright months back when he experienced a painful nonhealing over the upper front region of the jaw over his left nostril area, which was initially small and gradually increased to present size.

Present medical history: A male patient of 58 yrs. Old was brought by his son with a complaint of pain which is gradual in onset, dull aching, aggravates on chewing, difficulty in deglutition since two months, burning sensation on the consumption of spicy food since two months change in voice, nasal discharge, loss of appetite, weight loss, tooth exfoliation in the upper front region of jaw, and balm application (2-3 episodes, 15 days back).

Previous treatment: The patient first visited a private hospital at Brahmapuri, where an Incisional Biopsy of the lesion was done under LA on 5/10/And CT PNS was done. The patient was then referred to other hospital, where slide ad-block review was done r/s/o "Moderately differentiated squamous cell carcinoma."

Associated illness: After testing Negative for COVID -19, the patient got admitted to the oral surgery ward for further management.

History: History of asthma in the last two years, patient is not on any medication for the same—no history of hypertension, diabetes, jaundice, TB, or bleeding disorder.

Family history: There are no allergies in his family. All others members of the family were not having any complaints about their health. No other member has any problem with hypertension, diabetes, or any other disease condition in his family.

Investigation and outcome: A male of 58 years was admitted to ENT ward, on 11/10/2021 with a rare case of hard palate carcinoma involving the upper labial sulcus. His weight is 45

kg, height is 158 cm, and his BMI is 18.03. He was admitted to the hospital, and all investigations and treatment were started. After getting treatment, she showed significant improvement, and the treatment was still going on till my last date of care.

Clinical findings: Pain, difficulty in breathing, difficulty in mastication, difficulty in deglutition, balm application, change in voice tooth exfoliation.

Physical examination: There are no abnormalities found in the head to foot examination; he is lean and thin and has a dull look, and is not active. He is weak and not cooperative.

Diagnostic assessment: Hb%-9,9 gm%, RBC-3.63 millions/cu.mm, WBC-8400/cu.mm, Platelets-2.05 lacs/cu.mm, MCV-76.7n, MCH 27.7 pico-gm, MCHC-35.6%, Monocytes-04%, Granulocytes-75%, Lymphocytes-20%, Eosinocytes-01%, Biasophiles-00%, Urea 15 mg%, Creatine 0.6 mgdl, Sodium 133 mEq/L, Potassium 2.8 mEq/L, Albumin2.3 gm/dl, Total bilirubin 0.5 mg/dl.

Medication: Inj. Tramadol 50 mg in 100 ml NS stat, Inj. Dexa 8 mg IV, Inj. Emset 4 mg BD, Inj. Neomol 1 mg IV BD×3days, Inj. Perinorm 10 mg IV BD×2 days, Inj. Ceftriaxone 1.5 gm IV BD×7 days, Inj. Metro 500 mg IV BD×5 days, Inj. Amikacin 500 mg IV BD×5 days, Inj. Pan 40 mg IV BD×7 days, Tab. Chymoral forte BD×7 days, Tab. Supradyn OD×7 days, Tab. Emcee 500 mg BD×15 days.

DISCUSSION

On 11/10/2021, a 58-year-old man was hospitalized to ENT ward with a rare instance of hard palate cancer. His BMI is 18.03, and he weighs 45 kg and stands 158 cm tall. All investigations and treatments were initiated after he was admitted to the hospital. He has made significant progress after receiving treatment, and the treatment is currently ongoing. It's important to remember that a patient may exhibit one or more of these symptoms without having complex palate cancer [6]. The identical symptoms can be caused by a variety of non-cancerous conditions. As a result, it's critical to get medical advice from a specialist. A clinician must determine the type of cancer, the grade of the tumor, and the

cancer stage after diagnosing a patient with complex palate cancer (cancer of the hard palate and the maxilla or upper jaw) using a biopsy or more commonly, pathology after surgery. It's crucial to remember that oral tumors might be challenging to detect. Suppose a doctor is having trouble distinguishing what form of cancer it is. In that case, they may seek a second opinion and send some of the tumor's components to a head and neck pathologist who is more familiar with these cancers. Squamous cell carcinoma is the most prevalent type of hard palate cancer. Squamous cell carcinoma accounts for more than 90% of oral malignancies. Squamous cell carcinoma is a type of cancer that develops from abnormal cells on the surface of the lips or in the mouth lining. When cancer is identified early on before it has spread beyond the deepest layer of the mouth lining, it is known as carcinoma in situ, and it has an excellent prognosis when removed. Verrucous carcinoma is a different subtype [6]. This subtype tends to grow slowly and is less likely to migrate to the lymph nodes in the neck or other body parts. Surgical excision of the tumor is nearly always the first treatment for hard palate cancer unless a doctor determines that surgery is not possible or safe. A soft tissue resection, a maxillectomy, or a neck dissection may be used to treat complex palate cancer.

The type of surgery recommended by a doctor will be determined by the location and extent of cancer and the stage [7]. The management of the maxilla and hard palate bones, lymph nodes, and other structures in the neck are important factors to consider when planning surgery for complex palate cancer [8].

Restoration of function to this region is vitally important since most cancer operations involving this region lead to an opening in the palate and a loss of some of the upper teeth [9]. Various forms of restoration of these types of defects have been employed and may include the use of prosthesis, known as a palatal obturator, or any of a variety of reconstructive techniques [10]. Patients and their care teams should talk about the different procedures that may be needed to treat their cancer. Adjuvant radiation is the most common type of radiation used to treat complex palate cancer. After surgery, adjuvant radiation is given to lessen the chances of the tumor returning [11].

Hard palate cancer is rarely treated with chemotherapy. It is sometimes used with radiation as an additional treatment after surgery. Chemotherapy is usually administered to adjuvant radiation therapy only if there is an extranidal extension from malignant lymph nodes in the neck or if cancer is left behind from surgery [12].

Doctors may choose to undergo a scan in the first six months after therapy. The first scan serves as a "baseline" study against which future studies can be compared. Cancer's nature and location will determine this. Imaging examinations can range from a simple chest X-ray to more in-depth procedures like a CT, MRI, or PET scan. A biopsy may be required if something abnormal is discovered.

CONCLUSION

Wilms tumor is a genetic condition in children; it is essential to detect it early so that the child may not cause complications. Wilms tumor is an uncommon kind of kidney cancer that primarily affects youngsters, but it's also necessary to take precautions. The alternative word for it is nephroblastoma. Wilms tumor, a malignant renal tumor, is the most frequent kidney neoplasm in children. It accounts for around 6% of all childhood tumors. In youngsters under 15, the frequency is 7.6 cases per million, with 75 percent of cases occurring before the age of five. While the condition usually is unilateral, it affects both kidneys in 5% to 10% of instances. It's sometimes referred to as nephroblastoma. It is most common between the ages of three and four, becoming much less common after that.

A male of 58 years from admitted to the ENT ward, on 11/10/2021 with a rare case of hard palate carcinoma. His weight is 45 kg, and his height is 158 cm, and BMI is 18.03. Admitted to hospital and all investigation and treatment were started. After getting treatment, she showed great improvement, and the treatment was still going on.

DECLARATION OF COMPETING INTEREST

All authors declare no conflicts of interest.

REFERENCES

1. Ogle OE, Weinstock RJ, Friedman E. Surgical anatomy of the nasal cavity and paranasal sinuses. Oral and Maxillofacial Surgery Clinics. 2012 May 1;24(2):155-66.

2. Lombardi D, McGurk M, Vander Poorten V, Guzzo M, Accorona R, Rampinelli V, Nicolai P. Surgical treatment of malignant salivary tumors. Oral oncology. 2017 Feb 1;65:102-13.

3. Stock RG, Chen AS, Seski J. A 30-year experience in managing primary carcinoma of the vagina: analysis of prognostic factors and treatment modalities. Gynecologic oncology. 1995 Jan 1;56(1):45-52.

4. Kauer-Dorner D, Pötter R, Resch A, Handl-Zeller L, Mag KK, Meyer-Schell K, Dörr W. Partial breast irradiation for locally recurrent breast cancer within a second breast conserving treatment: alternative to mastectomy? Results from a prospective trial. Radiotherapy and Oncology. 2012 Jan 1;102(1):96-101.

5. Pindborg JJ, Reichart PA, Smith CJ, Van der Waal I. Histological Typing of Cancer and Precancer of the Oral Mucosa: In Collaboration with LH Sobin and Pathologists in 9 Countries. Springer Science & Business Media; 2012 Dec 6.

6. Epstein JB, Gorsky M, Cabay RJ, Day T, Gonsalves W. Screening for and diagnosis of oral premalignant lesions and oropharyngeal squamous cell carcinoma: role of primary care physicians. Canadian family physician. 2008 Jun 1;54(6):870-5.

7. Speight PM, Farthing PM, Bouquot JE. The pathology of oral cancer and precancer. Current Diagnostic Pathology. 1996 Sep 1;3(3):165-76.

8. Yahalom J, Illidge T, Specht L, Hoppe RT, Li YX, Tsang R, Wirth A, Group IL. Modern radiation therapy for extranodal lymphomas: field and dose guidelines from the International Lymphoma Radiation Oncology Group. International Journal of Radiation Oncology* Biology* Physics. 2015 May 1;92(1):11-31.

9. Geiger JL, Adelstein DJ. Chemotherapy in the definitive management of oral cancers: Where do we stand today?. Oral oncology. 2020 Mar 1;102:104584.

10. Medina JE, Ferlito A, Pellitteri PK, Shaha AR, Khafif A, Devaney KO, Fisher SR, O'Brien CJ, Byers RM, Robbins KT, Pitman KT. Current management of mucosal melanoma of the head and neck. Journal of surgical oncology. 2003 Jun;83(2):116-22.

11. Zucca E, Roggero E, Bertoni F, Conconi A, Cavalli F. Primary extranodal non-Hodgkin's lymphomas. Part 2: Head and neck, central nervous system and other less common sites. Annals of Oncology. 1999 Sep 1;10(9):1023-34.

12. Lavertu P, Adelstein DJ, Saxton JP, Secic M, Wanamaker JR, Eliachar I, Wood BG, Strome M. Management of the neck in a randomized trial comparing concurrent chemotherapy and radiotherapy with radiotherapy alone in resectable stage III and IV squamous cell head and neck cancer. Head & Neck: Journal for the Sciences and Specialties of the Head and Neck. 1997 Oct;19(7):559-66.