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Pallative Oral Care - A Healing Hand: An Overview

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Abstract: Oral cancer is the 6" most common malignancy, is a major cause of cancer morbidity and mortality worldwide. The International Agency for Research on Cancer GLOBOCAN project aspredicted that India's cancer burden will nearly double in the next 20 years. The mostcommon intra oral subtype is Squamous Cell Carcinoma [WHO). Palliative care is a multidisciplinary approach that relives and prevents the suffering of terminally-ill patients. Itcovers the physical, emotional, spiritual and social aspects of problems arising in such patients. WHO defined palliative care as "The active total care of the patient who have life threateningdisease and unable to respond to curative treatment". The goal of oral medicine of palliative care is to prevent or treat as early as possible symptoms, side effects in response totreatment of disease. Oral medicine specialist may be the first person to diagnose the case of oral cancer and an early definitive intervention improves both prognosis and survival of the patient. The common oral problems faced are pain, discomfort, xerostomia, dysphagia, stomatitis, mucositis, candidiasis and speech that can significantly hamper the quality of life. At present the treatment method include surgery. radiotherapy and chemotherapy. Along with cure of disease in such patient it is also necessary to prevent or to alleviate symptoms and sufferings.In this paper a brief attempt is made to list a few areas in which an oral medicine specialist can help the other members of palliative care team and also the patient in leading a better life.

Keywords: *Oral Cancer, Radiotherapy, Palliative Care.*

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I. INTRODUCTION

Palliative care is a specialized area of healthcare that focuses on relieving and preventing the suffering of patients. Even though the treatment of cancer are intended to improve the qualityof life in this patients, the complications associated with them are unavoidable. Oral cavity cancer is the sixth leading cause of cancer worldwide India is said tohave the major number of oral cancer patients due to large consumption of tobacco.

- *Aims of Oral Care*

Provide relief from pain Prevent suffering Honoring patient preferences Improving quality of life during illness Address emotional and spiritual concerns of patients

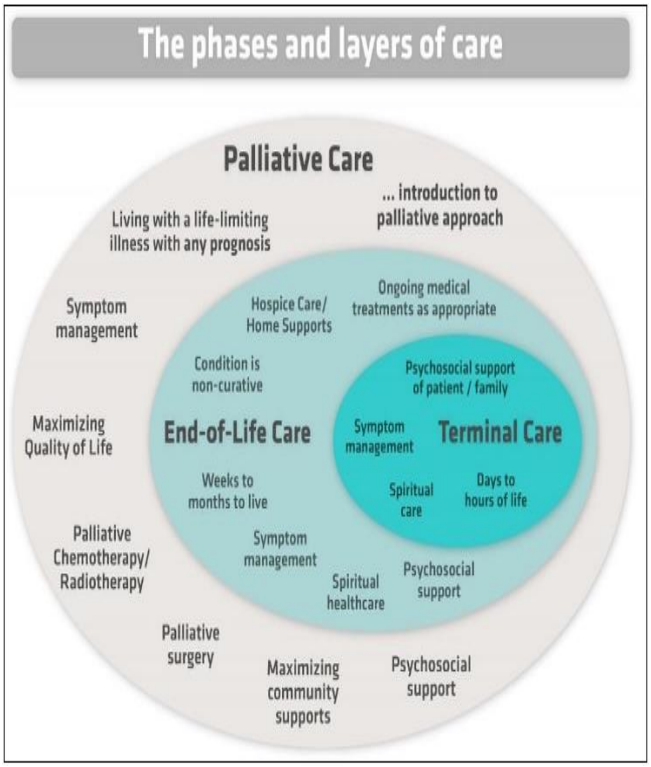

Fig 1 The Phases and Layers of Care

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➢ *Oral Cancer:*
Oral Problems due to disease per se:

- Problems due to treatment: Pain.
- Mucositis and stomatitis Trismus.
- Xerostomia Difficulty in Chewing.
- Candidiasis Difficulty in Swallowing.
- Taste loss Difficulty in Speaking
- Pain
- Osteoradionecrosis

➢ *Oral mucositis and stomatitis:*
Oral mucositis and stomatitis, commonly induced by chemotherapy and radiotherapy, significantly impede patient well-being, causingdebilitating symptoms such as:

- Severe oral pain
- Discomfort
- Dysphagia
- Difficulty in chewing (mastication).
- Increased risk of secondary infections.

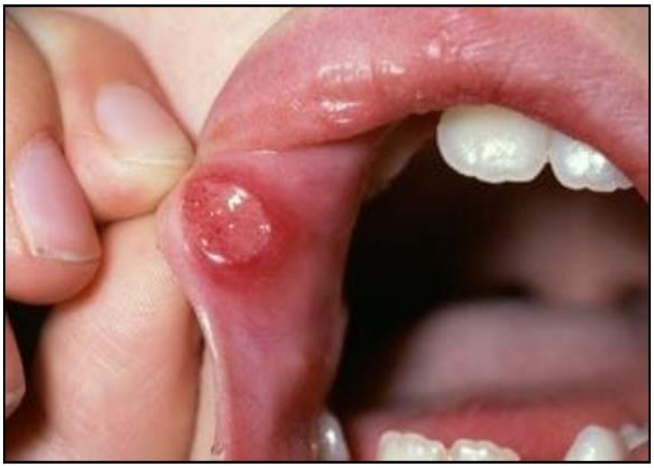
Fig 2 Oral Mucositis in patient who

➢ *Pathogenesis Undergone Radiotherapy*
Following Radiotherapy mucosa becomes hyperemic and oedematose, then becomes denuded, ulcerated and covered with fibrinous exudate leading to radiation induced mucositis.

➢ *Management:*

Diluting agents	Saline, frequent water rinse, Bicarbonates rinses, Ice chips.
Topical analgesics	Benzydamine Hcl, Tantum, Xylocaine Hcl, Dyclonine, Diphenhydramine Hcl.
Lip lubricants	Wax, Water based lubricants, Lanolin.
Magic Mouthwash	Diphenhydramine: 12.5 mg/5ml and lidocaine 2% mixed in equal proportion. 5 ml Swish and spit QID
Coating agents	Kaolin-pectin, Aluminium chloride, Aluminium and Magnesium Hydroxide.

➢ *Candidias:*
Occurs in about 70-85 % of the cases. It is a leading opportunistic infection in cancer patients. Predisposing factors are poor oral hygiene, xerostomia, immunosuppression, drugs like corticosteroids, Diabetes mellitus, denture wearers, poorly nourished.

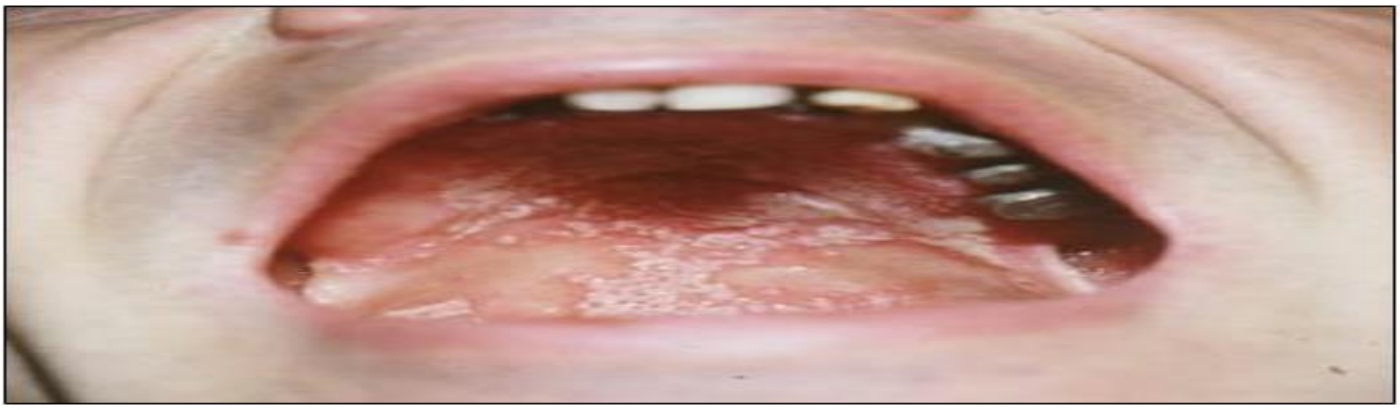
Fig 3 Oropharyngeal Candidiasis in head and neck cancer Patients Treated with Radiation

➢ *Pathogenesis:*
Following Chemotherapy and Radiotherapy there will a destruction of immune cells which in turn causes decreased immunity and mucositis causing Candidiasis.

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Table 1 Treatment modalities for Candidiasis

Topical	System
Clotrimazole troche, 10 mg, 5 times a day for 14days	Fluconazole 100 mg - 1st line of drug for 7-14days, oral
Nystatin suspension 200 000 - 500 000 IU swished and swallowed 3-5 times a day	Ketaconazole 200-400 mg for 7-14 days, oral
Nystatin popsicles for colling relief	Amphotericin B for refractory Candidiasis 0.25-1.5 mg\mg a day i.v

➢ *Xerostomia:*

Dryness of mouth common in radiotherapy receiving patients. It increases the risk of dental caries, difficulty in chewing and swallowing, sleep disorders with impact on quality of life. Radiation exposure ∝ glandular damage If radiation dose is 10-16Gy it reduces salivary flow by 50-60% and increases the viscosity of saliva.

➢ *Management*

- *Symptomatic. Pharmacological*

✓ Frequent sips of water. Parasympathomimetic drugs like:
✓ Oral rinses or gels. - Pilocarpine (5mg t.i.d)
✓ Humidifier use at night- Cevimeline (30mg t.i.d)
✓ Minimal intake of caffeine and alcohol. Pilocarpine mouthwash (1 -2% solution)
✓ Sugar free sialagogues (chewing gums) Saliva substitutes

II. OSTEORADIONECROSIS

Radiation-induced osteomyelitis, or osteoradionecrosis, is a severe inflammatory condition affecting bones exposed to therapeutic radiation during treatment for malignancies in the head and neck region. Radiotherapy' with high doses on surrounding tissues, causing mucositis, xerostomia, and radiation caries, with bone's mineral composition making it susceptible to radiation-induced damage, leading to osteoradionecrosis.

➢ *Pathogenesis*

The primary cause of Osteoradionecrosis is damage to endothelium following radiation therapy which in turn intiates the sequence of destructive processes- Hypocellularity, inflammation, vessel obliteratation, tissue hypoxia and hypovascularity leading to Osteoradionecrosis and non-hraling wounds.

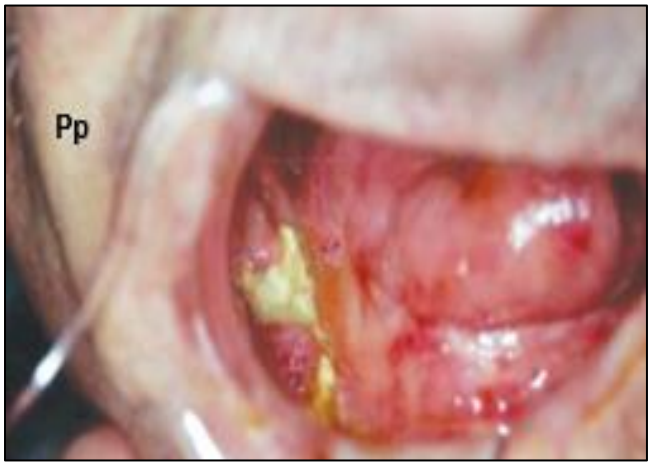

Fig 4 Clinical picture of showing Osteoradionecrosis

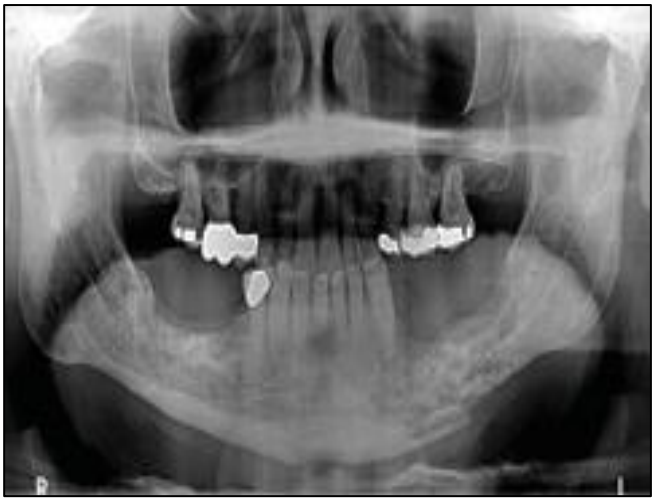
Fig 5 Panoramic radiograph showing Osteoradionecrosis

➢ *Management*

- Primary treatment - Hyperbaric oxygen
- Elimination of trauma
- Avoidance of removable dental prosthesis
- Adequate nutritional intake
- Discontinue Tobacco and Alcohol
- Topical antibiotic (tetracycline)

➢ *Pain:*

Most common and dreaded symptom. In 90% of the cases occurs due to tumor or its therapy, mainly due to mucositis and ulceration. Henceforth reducing pain is very much important in palliative care as it improves the quality of life of the patient.

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➢ *Management:*

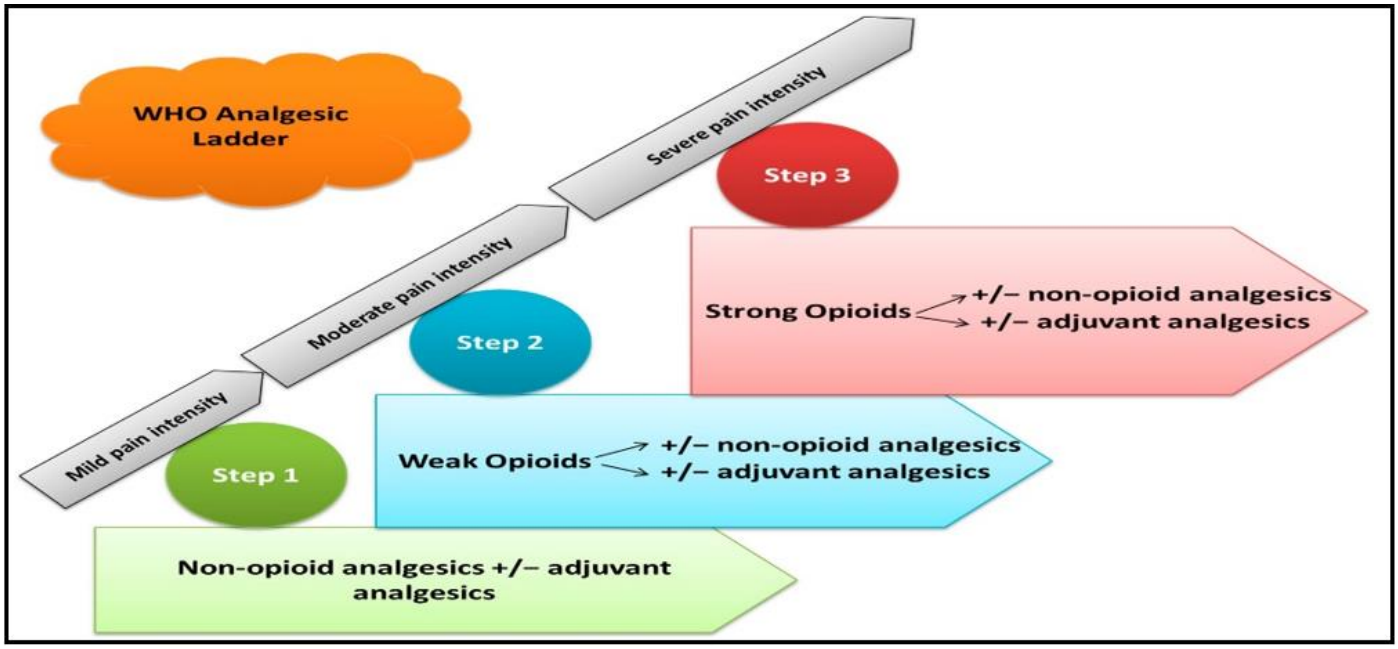

Fig 6 WHO Analgesic Ladder

➢ *Current Scenario of Palliative Care in India*

- Govt of Kerala declared palliative care as part of primary health care
- Kerala become the 1st state in India to announce palliative care policy
- Currently there are 1,084 primary palliative care units in Kerala
- Currently only 3 States Kerala, Karnataka & Maharashtra have a palliative care policy
- Only 1-2 % of the population who need palliative care have access to it in India compared to global average of 14%
- Many more states in India have to start adapting palliative care policy and service must be made easily and readily available for better quality of life

Fig 7 Palliative Care Policy Implementation in 2019

III. CONCLUSION

Palliative care dentistry is an evolving branch and gaining immense importance in this advancing world. The palliative doctor gives the 'touch of god' as they take care of the terminally ill patients. It is equally important as treating the disease. The oral medicine specialist can play an important role in alleviating both the physical and psychological pain of dying. The oral medicine specialist role is to improve the quality of life Aim is to add life intotheir days and just not days into their life. Providing comprehensive supportive service for family and patient. It should involve multidisciplinary approach that addresses physical, emotional, spiritual and social concern of the patient.

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