



CASE STUDY

SQUAMOUS CELL CARCINOMA MIMICKING CYSTIC LESION. A DIAGNOSTIC DILEMMA?

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ARTICLE INFO

Article History:

Received 28th September, 2016
Received in revised form
22nd October, 2016
Accepted 09th November, 2016
Published online 30th December, 2016

Key words:

Squamous cell carcinoma, Chemotherapy,
Radiation therapy.

ABSTRACT

The incidence of head and neck cancer in India is variable. One of the major roles of the oral and maxillofacial surgeon is that of diagnostician. Maxillofacial surgeons are called upon to evaluate and diagnose a wide variety of conditions affecting the oral cavity, jaws and head and neck. This case report emphasizes on the need for early diagnosis and role of chemotherapy and radiation therapy on advance lesions.

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Citation: Dr. Shaliki Wadhera, Dr. Shreyas Mohile, Dr. Pushkar P. Waknis, Dr. Prathamesh V. Bhujbal, Dr. Aditi Saha and Dr. Sharvika Aher, 2016. "Squamous cell carcinoma mimicking cystic lesion. A diagnostic dilemma?", *International Journal of Current Research*, 8, (12), 44373-44375.

INTRODUCTION

Oral cancer is the sixth most common cancer worldwide. In India 4 in 10 of all cancers are oral cancers. Annually 130,000 people succumb to oral cancer which translates into approximately 14 deaths per hour. Approximately 90% of oral cancers are squamous cell carcinoma. (Syamsundar, 2012) Thus, a complete examination of the head and neck is performed to assess the precise location and extent of the primary tumor, identify regionally metastatic disease and to rule out multiple primary malignancies.

Case report

A 42 year old female patient reported to the Department of Oral & Maxillofacial Surgery at D.Y. Patil Dental College, Pune in October 2014 with a chief complaint of pain and swelling in lower right back region of jaw since 6 days which was dull aching. Swelling of approximately 4x5 cm over right side of the face which was diffused and fluctuant, extending antero-posteriorly 2 cm away from the corner of lip till the earlobe. She was diagnosed with submandibular space infection. Incision and drainage done and offending 46

removed. A cheesy material was sent for histopathology. HP report was "infected" aspirate and patient was relieved and send to home. After 3 months patient came with a swelling on same side which doesn't look like a cyst or an odontogenic infection. (Figure 1a &b) An incisional biopsy and computed tomography was taken. (Figure 2) Biopsy reveals well-differentiated squamous cell carcinoma (T4N2bM0 staging).

Treatment

All necessary blood and radiologic investigations were done. Patient was taken under general anesthesia with nasoendotracheal intubation. Primary scrubbing, painting and draping done. Local anesthesia (lignocaine with adrenaline 1:200000) administered at the site of incision. Incision was made. Modified radical neck dissection was done followed by removal of primary tumor. Reconstruction was done with pectoralis major myocutaneous flap. (Figure 3, 4, 5, 6) The post-operative histopathologic report indicated of poor prognosis. Even through all the surgical margins are negative, there was lympho-vascular invasion of level I, III and III group of lymph nodes. There was extracapsular invasion of level I and II nodes. Patient was send for post-operative chemotherapy and radiation therapy within a month after healing. (Figure 7) Six months later patient came with an ulcerato-proliferative growth as a second primary at the infra-temporal fossa region. (Figure 8) And, later succumbed to it.

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1(a)



1(b)

Figure 1a & b. Extra-oral examination



Figure 3. Incision



Figure 4. Modified Radical Neck Dissection

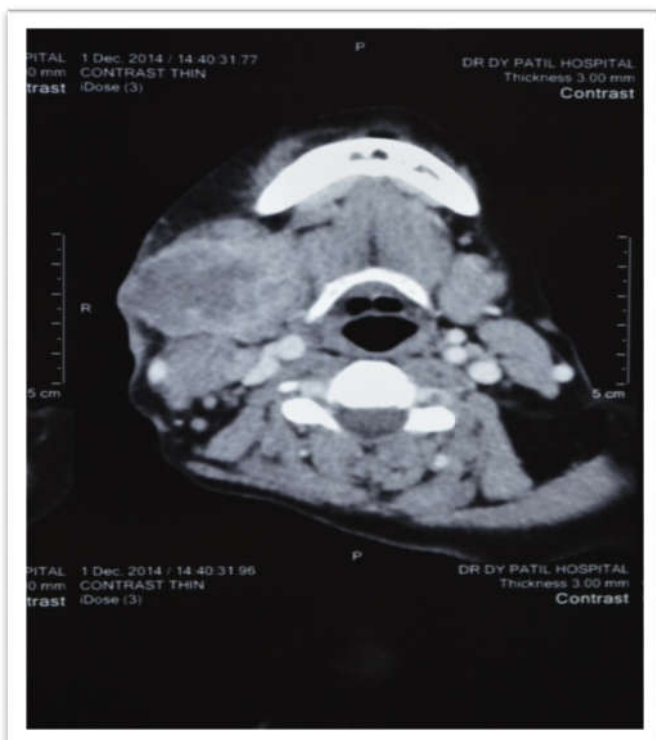


Figure 2. Computered tomography



Figure 5. PMMC flap marked



Figure 6. Flap in position with closure



Figure 7. 3 weeks post-operatively



Figure 8. 6 months post-operatively

DISCUSSION

Treatment of OSCC includes single modality surgery, radiotherapy [external beam radiotherapy (EBRT) and/ or brachytherapy], or various combinations of these modalities with or without systemic therapy (chemotherapy and/or target agents). The selection of treatment is based on considerations of disease control, anticipated functional and cosmetic outcomes, and availability of resources and expertise (Shao-Hui Huang, 2013). The standard indications for postoperative radiotherapy for SCC are close or positive margins, perineural invasion, two or more positive nodes, extracapsular spread and nodes greater than 3 cm in size. (Stell and Maran, 2012) The main reasons for the failure of the treatment were delay in diagnosis and poor awareness of OSCC. Since positive positive nodes and extracapsular is an indication for radiation therapy. Lack of knowledge and poor economic status led to the demise of the patient. Squamous cell carcinoma arising from infected cyst or from odontogenic infection is very rare (Shao-Hui Huang, 2013). Ward and Cohen pointed to three possible mechanisms: 1) a pre-existing cyst becomes secondarily involved in a carcinoma of unrelated origin arising either from an adjacent epithelial structure or as a distant primary tumor; 2) the lesion is a carcinoma from the outset, a part of which has undergone cystic transformation; 3) the initial lesion is a cyst, and malignant changes have subsequently taken place in the epithelial lining (Ward TG, 1963). The possible etiology for this patient could be infection or poor nutritional status. Since this patient had no history any deleterious habits or family history. Several studies suggest high fruit and vegetable intake is associated with a decreased risk of head and neck cancer. This may be due to increased intake of the antioxidants or free radical scavenging vitamins A, C and E. (Stell and Maran, 2012).

Conclusion

Early diagnosis with early surgical intervention should be the foremost in the treatment of OSCC. Lack of education and awareness of oral cancer leads to delay in diagnosis. Early chemotherapy and radiation therapy is required in extracapsular spread, perineural invasion and positive or close surgical margins.

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