Squamous Cell Carcinoma: A Case Report

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ABSTRACT:
Introduction
Squamous cell carcinoma is most common cancer accounts approximately 90% of all the oral cancers. It may affect almost all the site in the mouth, but most commonly the tongue, buccal mucosa and the floor of the mouth.
Case Presentation A painful lesion in the lower left posterior region of the jaw since the last six months of 55 years an unmarried female patient was seen.
Conclusion In this paper, we report an unusual clinical presentation of oral squamous cell carcinoma in buccal mucosa without any deleterious habits, which is very rare.

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Keywords: Buccal Mucosa, Squamous Cell Carcinoma, Unusual Clinical Appearance.

INTRODUCTION

Oral cancer is a type of neoplasm which is found on the lip, floor of the mouth, cheek lining, gingiva, palate or in the tongue. In India it is top three types of cancers.[1]
Approximately 95% of the oral cavity is of squamous cell type in nature. They causing a major health problem in developing countries, resulting in being the leading cause of death.[2, 3]
Major etiological and predisposing causes for Oral Squamous Cell Carcinoma (SCC) includes smoking, drinking habits and ultraviolet radiation (precisely for lip cancer), followed by several other factors such as human papilloma virus (HPV) and Candida infections, nutritional deficits and genetic predisposition.[4, 5]

CASE REPORT

An unmarried, 55 year old lady reported to the department of Oral Pathology of Burdwan Dental College and Hospital, West Bengal with the primary complaint of a pain and swelling in the lower left posterior region of the jaw since the last six months along with continuous trauma to cheek due to jagged teeth. It started with white patch 2 months ago followed by ulceration and now it is hard and swollen. The presence of jagged teeth on the left side for the past few years led to chronic cheek bites.
The patient's past medical history revealed that she was on antihypertensive drug since 5 years. She did not have any habit of chewing and/or smoking tobacco and did not consume alcohol either. She was practically on a soft diet. General physical examination showed that she was moderately built and nourished. All her vital signs were within normal limits. Extra-oral examination revealed an asymmetrical face with a concave profile and extra-oral swelling. Her submandibular lymph nodes were palpable. There was a 2 × 2cm (Figure-1), oval-shaped, single ulcer present on the posterior part of her left buccal mucosa. The ulcer had associated with irregular margins and undermined edges. Induration was also present. The base and borders was firm on palpation. The floor of the ulcer was granular and had normal color while growth was both exophytic and endophytic. (Figure-2). It was tender on palpation. Broken down teeth with sharp cuspal edges were present due to carious exposed lower left second molar and

retained root of lower second premolar and first molar. History of the extraction of the upper first and second molar was studied a few days back where in it was found that the oral hygiene was poor.

Based on the clinical findings, a provisional diagnosis of squamous cell carcinoma was made. A differential diagnosis of inflammatory hyperplasia, necrotizing sialometaplasia, tuberculous tested positive for the Mountoux test which was done to rule out.

Haematological investigations and incisional biopsy were the investigations advised.

Incistional biopsy was done with the extraction of lower left first, second and third molars.

The microscopic examination, the section showed ulcerated, atrophic epithelium invading into the underlying connective tissue (Figure 2). The dysplastic epithelial cells were arranged in islands of varying size. Numerous keratin pearls (Figures 3) and few mitotic figures with cellular and nuclear pleomorphism and hyperchromatism were also seen. Minimal chronic inflammatory cells were seen in the intervening stroma between the tumor islands, necrosis areas were also present. The deeper margins of the tissue section were found to be clear of dysplastic cells. A diagnosis of well-differentiated squamous cell carcinoma was given.

Figure 1: Asymmetrical face with a concave profile with extra-oral Swelling

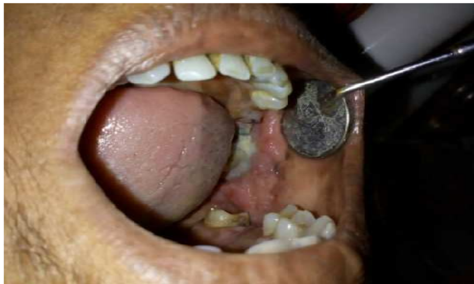

Figure 2: Intra-oral Photograph depicting ulcer with irregular margin and undermined edge

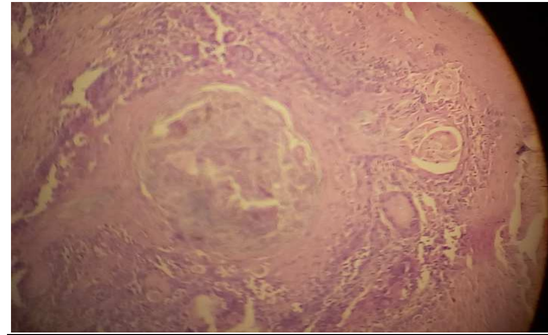

Figure 3: Pleomorphism, Hyperchromatism, and keratin formation

DISCUSSION

Head and neck is one of the most common sites for squamous cell carcinomas in Indias. SCC is predisposed by a white lesion which developed due to use of tobacco in different forms. Usually the SCC and lichen planaus are more common in buccal mucosa. Normally, the development of SCC is deliterious habit related precisely to tobacco consumption. The development of SCC in the oral cavity has also been reported without tobacco intake, especially in cases of middle aged women. In this present case report, there was no history of tobacco consumption. The patient had only malposed buccally placed upper molars in the affected area. The opposite buccal mucosa was free from any mucosal lesion. So it reveals that the continuous trauma from the malposed tooth was responsible for the development of SCC. The development of SCC from malposed tooth is the initiator for the formation of ulcer in the buccal mucosa which proceeds to the development of SCC. The final diagnosis was confirmed with both the clinical and the histological evaluation which is the only way to confirm the presence of any dysplastic changes.[6, 7]

The purpose of this article is to emphasize that development of SCC without any deleterious habits, SCC should be considered in differential diagnosis and this needs a careful examination and management by both medical and dental practitioners.

CONCLUSION

The use of tobacco and betel quid, heavy drinking of alcoholic beverages and a diet low

in fresh fruits and vegetables are the major risk factors for oral SCC. But present shows SCC can occur in the oral cavity without obvious habits. However, there should be further investigations to rule out the genetic and other external or internal causes.

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