Strang Cancer Prevention Institute
Dedicated to Promote Cure by Early Detection and Research to Prevent Cancer since 1933

Prevention

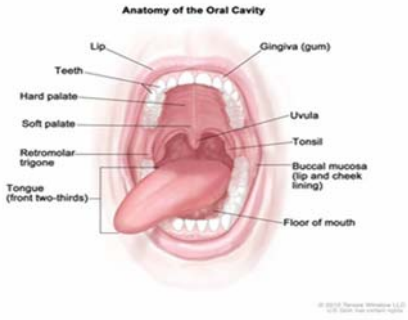
Head and Neck Cancer Awareness Month April 2017

HEAD AND NECK CANCER AWARENESS MONTH

General Information about Oral Cavity and Oropharyngeal Cancer

Oral cavity and oropharyngeal cancer are diseases in which malignant (cancer) cells form in the mouth and throat. The number of new cases of oral cavity and oropharyngeal cancer and the number of deaths from oral cavity and oropharyngeal cancer varies by race and gender. Different factors increase or decrease the risk of oral cavity and oropharyngeal cancer.

Oral Cavity and Oropharyngeal Cancer are Diseases in which Malignant (cancer) Cells Form in the Mouth and Throat.



Oral cavity cancer forms in any of these tissues of the oral cavity:
The front two thirds of the tongue.
The gingiva (gums).
The buccal mucosa (the lining of the inside of the cheeks).
The floor (bottom) of the mouth under the tongue.
The hard palate (the front of the roof of the mouth).
The retromolar trigone (the small area behind the wisdom teeth).

Oropharyngeal cancer forms in any of these tissues listed below of the oropharynx:
The middle part of the pharynx (throat) behind the mouth.
The back one third of the tongue.
The soft palate (the back of the roof of the mouth).
The side and back walls of the throat.
The tonsils.
Most oral cavity and oropharyngeal cancers start in squamous cells, the thin, flat cells that line the lips, oral cavity, and oropharynx. Cancer that forms in squamous cells is called squamous cell carcinoma.

Oral cavity and oropharyngeal cancer and the number of deaths from oral cavity and oropharyngeal cancer vary by race and gender.

Over the past ten years, the number of new cases and deaths from oral cavity and oropharyngeal cancer slightly increased in white men, but remained the same for white women. The number slightly decreased for both black men and black women.

Oral cavity and oropharyngeal cancer is more common in men than in women. Although oral cavity and oropharyngeal cancer may occur in all adults, it occurs more often in older adults who are 65 years and older.

France, Brazil, and parts of Asia have much higher rates of oral cavity and oropharyngeal cancer than most other countries.

The number of new cases of oropharyngeal cancer caused by certain types of human papillomavirus (HPV) infection has increased. One kind of HPV, called HPV 16, is often passed from one person to another during sexual activity.

ORAL CAVITY AND OROPHARYNGEAL CANCER SCREENING

There is No Standard or Routine Screening Test for Oral Cavity and Oropharyngeal Cancer

Screening for oral cavity and oropharyngeal cancer may be done during a routine check-up by a dentist or medical doctor. The exam will include looking for lesions, including areas of leukoplakia (an abnormal white patch of cells) and erythroplakia (an abnormal red patch of cells). Leukoplakia and erythroplakia lesions on the mucous membranes may become cancerous.

If lesions are seen in the mouth, the following procedures may be used to find abnormal tissue that might become oral cavity or oropharyngeal cancer:

Toluidine blue stain: A procedure in which lesions in the mouth are coated with a blue dye. Areas that stain darker are more likely to be cancer or become cancer.

Fluorescence staining: A procedure in which lesions in the mouth are viewed using a special light. After the patient uses a fluorescent mouth rinse, normal tissue looks different from abnormal tissue when seen under the light.

Exfoliative cytology: A procedure to collect cells from the lip or oral cavity. A piece of cotton, a brush, or a small wooden stick is used to gently scrape cells from the lips, tongue, mouth, or throat. The cells are viewed under a microscope to find out if they are abnormal.

Brush biopsy: The removal of cells using a brush that is designed to collect cells from all layers of a lesion. The cells are viewed under a microscope to find out if they are abnormal.

More than half of oral and oropharyngeal cancers have already spread to lymph nodes or other areas by the time they are found. No studies have shown that screening would decrease the risk of dying from this disease.

The Risks of Oral Cavity and Oropharyngeal Cancer Screening Include the Following:

Finding oral cavity or oropharyngeal cancer may not improve health or help a person live longer.

Screening may find oral cavity and oropharyngeal cancers that have already spread and cannot be cured. When these cancers are found, treatment may cause serious side effects and not help a person live longer.

False-negative test results can occur.
Screening test results may appear to be normal even though oral cavity and oropharyngeal cancer is present. A person who receives a false-negative test result (one that shows there is no cancer when there really is) may delay seeking medical care even if there are symptoms.

False-positive test results can occur.
Screening test results may appear to be abnormal even though no cancer is present. A false-positive test result(one that shows there is cancer when there really isn't) can cause anxiety and is usually followed by more tests and procedures (such as biopsy). which also have risks.

Misdiagnosis can occur.
A biopsy is needed to diagnose oral and oropharyngeal cancer. Cells or tissues are removed from the oral cavity or oropharynx and viewed under a microscope by a pathologist to check for signs of cancer. When the cells are cancer and the pathologist reports them as not being cancer, the cancer is misdiagnosed. Cancer is also misdiagnosed when the cells are not cancer and the pathologist reports there is cancer. When cancer is misdiagnosed, treatment that is needed may not be given or treatment may be given that is not needed.

Author: Michael P. Osborne MD, MSurg, FRCS, FACS President, Strang Cancer Prevention Institute

SOURCE: National Institutes of Health National Cancer Institute

For further information please visit www.strang.org

The Strang Cancer Prevention Cookbook

Root Vegetable Lasagna

Reduce your Risk for Cancer by Eating a Healthy Diet!

Serve as a colorful nutritious entrée or a vegetable side dish

Use a mandolin to produce uniform thin slices of the root vegetables

6 Servings

2 ancho chiles
1 ½ cups vegetable stock or low-sodium canned broth
1 teaspoon olive oil
2 large baking potatoes (about 1 pound), peeled and sliced lengthwise 1/8 inch thick
2 medium sweet potatoes (about 14 ounces), peeled and sliced lengthwise 1/8 inch thick
2 medium parsnips (about ½ pound), peeled and sliced lengthwise 1/8 inch thick
3 medium turnips (about ¾ pound), peeled and sliced 1/8 inch thick
salt
¾ cup diced roasted peppers, drained if jarred
2 cups shredded low-fat cheddar or Monterey Jack-cheese (abut ½ pound)

Preheat the oven to 375 F

In a small saucepan, simmer the ancho chilies in the stock for 10 minutes. Turn off heat and let steep while you prepare the lasagna. Rub a casserole or baking pan (about 3-quart) with the olive oil. Arrange the root vegetable slices in the pan stating with a layer of slightly overlapping potatoes, followed by sweet potatoes, parsnip, and turnips; repeat the sequence.

Season each layer with salt to taste and sprinkle with diced roasted pepper and shredded cheese, reserving about 1/3 cup of shredded cheese. Strain the stock, discarding the chiles, and pour evenly over the casserole. Cover with foil and bake for 50 minutes. Remove the foil, sprinkle with the reserved cheese, and bake for 15 more minutes. Let cool for 15 minutes before serving.

High in Fiber-20 percent of the daily requirement
Calories 285
Protein 13 g
Carbohydrates 41g
Fat 8 g
Cholesterol 0 mg
Dietary Fiber 5 g
Saturated Fat 1 g

Recipe by Laura Pensiero, R.D. Owner Gigi Trattoria, Rinebeck, New York

THIS NEWSLETTER IS DEDICATED TO FRANCIS OSBORNE

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Strang Cancer Prevention Institute
575 Madison Avenue 10th Floor
New York, NY 10022
Tel: (212) 501-2111 www.strang.org

Editor
Merle K. Barash MA AEd, MA Psya