

Editorial 2

Postsurgical Rehabilitation of Oral Cancer Patients and Vital Role of a Prosthodontist

Oral cancer may affect up to 2,75,000 new patients per year worldwide.¹ Frequently, the presence of oral cancer necessitates the surgical removal of all or parts of the maxilla, leaving the patient with a defect that compromises the integrity and functions of the oral cavity.² Many of these will be disfigured by the destruction of tissues within the face and the head area. Large orofacial defects result from cancer treatment consequences in serious functional as well as cosmetic deformities. Acceptable cosmetic results usually can be obtained with a facial prosthesis.³ The rehabilitation phase for more compromised conditions, such as edentulous alveolar ridge, radiation therapy and tongue cancer, soft palate or mandible requires special care. Although techniques for reconstructive surgery and prosthodontic rehabilitation have advanced, more than 50% of head and neck cancer patients who have undergone reconstruction still report impaired masticatory function.⁴ I think this is unfortunate, though it was mentioned way back in 1978 by Olson and Shedd,⁴ the scenario has not been changed much so far in recent years. Still so many oral cancer patients are surgically made cancer free but become oral handicap due to lack of careful surgical or prosthetic rehabilitation procedures. Community based surveys identifying the prevalence of these issues are highly recommended.



The immediate postoperative restoration of esthetics, deglutition, and speech shortens recovery time in the hospital and expedites the patient's return to the community as a functioning member. Immediate obturators support soft tissues after surgery and minimize scar contracture and disfigurement, providing a positive effect on the patient's psychology.² Depending upon the healing stages of the wound, patients are advised to modulate the consistency of the food. An immediate surgical obturator is placed during surgery and the patients are advised to take only liquid diet. A delayed/interim surgical obturator is placed 6 to 10 days after surgery and the patients are advised to take liquid and semisolid diet. A definitive obturator is placed 3 to 4 months after surgery and the patients are advised to take conventional semisolid and solid food.² Midfacial defects may affect speech, mastication, quality of life, psychology, and social behavior. Large defects that result from cancer treatment are rarely rehabilitated by surgical reconstruction alone, they usually require a facial prosthesis to restore the function and appearance.⁵ In addition, an intraoral prosthesis, such as an obturator is often needed to restore speech and deglutition. Recent advancements in maxillofacial reconstructive surgery and osseointegrated dental implants provide a treatment modality that may adequately rehabilitate patients with oral cancer so that they can return to a healthy and productive life.

Maxillofacial prosthodontics can play a vital role in restoring the normal appearance and functions of such patients. The maxillofacial prosthodontist, as a member of the surgical team, is able to aid in the recovery of the oral cancer patients by careful presurgical planning of prosthetic rehabilitation. Presurgical records in the form of oral impressions, photographs and facial measurements are important parameters that can simplify the nature of complex rehabilitation procedures. This paper highlights the scope and the vital role of the maxillofacial prosthodontist in the team of doctors treating oral cancer patients including pathologist, maxillofacial surgeon, oncology surgeon, radiologist and nutritionist, etc. And thus oral cancer patient, even if he/she becomes cancer free, may become oral handicap due to lack of postsurgical rehabilitation.

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