

Head and neck cancer in Bihar

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Abstract

Head and neck cancer in Bihar has distinct demographic profiles, risk factor, food habits and personal family history. The term head and neck cancer refers to a group of biological similar cancers originating from the upper aerodigestive tract, including lip, oral cavity, nasal cavity, paranasal sinuses, pharynx and larynx. Head and neck cancers can cause varying degree of structural deformities and functional handicaps, depending on site, size and patterns of spread, thereby compromising well being and self esteem.

Keywords: Head, Neck.

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Received Date: 20/02/2016 Revised Date: 12/03/2016 Accepted Date: 06/04/2016

Access this article online	
Quick Response Code:	Website: www.statperson.com
	Volume 6 Issue 2

INTRODUCTION

Head and neck cancer is one of the most common carcinoma. Head and neck cancer are emerging as major public health problem, which are lifestyle related, having a lengthy latent period and need dedicated infrastructure and human resources for treatment.^{2,3} The term head and neck cancer refers to a group of biological similar cancers originating from the upper aerodigestive tract, including lip, oral cavity, nasal cavity, paranasal sinuses, pharynx and larynx. Head and neck cancers can cause varying degree of structural deformities and functional handicaps, depending on site, size and patterns of spread, thereby compromising well being and self esteem. The morbidity and mortality associated with head and cancer is of grave concern of the patients, their relatives and the population at large. Most of the head and neck cancer are squamous cell carcinoma, originating from the mucosal lining of these.

ETIOLOGY

Most head and neck cancer cases and death are due to both individual predisposition linked to certain genetic characteristics and exposure to carcinogens caused by lifestyle behaviors such as tobacco smoking in the form of cigarettes, bidis, cigars, hookas, water pipes or oral use of tobacco like khaini, pan massala, ghutka etc.⁴ Around 57% of all men and 11% of women in India between the age group of 15-49 years of age use some form of tobacco. Results from the global youth tobacco survey in India shows that about 10-20% of student in 8-10 grades (13-15yr) currently use tobacco in some form. Various studies shows that the risk of developing oral cancer is five to nine times greater for smokers than for non smokers. Alcohol consumption regularly is associated with an increased risk of oral cancer. Regular consumption of 4-5 drinks daily, the risk of oral cancer is 2-3 fold higher than among non smokers. Intake of alcohol along with tobacco in any form further increases the risk of oral cancer. The strong association of cancer of the pharynx and oral cavity with the tobacco use is well recognized. About one fourth of oral cancer cases are attributable to cigarette smoking. Head and neck cancer risk markedly increases when smoking duration is more than twenty years and the daily frequency of smoked cigarettes is higher than twenty. Malignant neoplasm of the larynx is most commonly seen in elderly patients. 80% of all benign tumor of the larynx is papilloma. Recent evidences suggests that human papilloma virus may be linked with some oesophageal cancer. Intake of alcohol along with tobacco in any form further increases the risk of oral and esophageal cancer.

MATERIALS AND METHODS

The study was carried out in M.G.M MEDICAL COLLEGE and L.S.K HOSPITAL KISHANGANJ, Bihar, department of E.N.T in the time period from 2012-15. It was a retrospective, descriptive study and included biopsy proven cases of carcinoma from head and neck region seen by histopathology section of department pathology. The study was carried out to know the incidence rates based on age, sex and site of lesion. Out of 490, biopsy taken 455 were neoplastic. 241 were benign while 214 were malignant. The most common age group for all malignant biopsies was 7th decade for males and the 5th decade for females. Malignant cases were commoner in males than female with the male female ratio was 3:1. Oropharynx was most common site of lesion followed by oral cavity, larynx, nose and pars nasal sinus, esophagus, nasopharynx, ear.

Number of suspected cases for biopsy -490

Result of biopsy - 455 were neoplastic

Benign cases- 241

Malignant cases- 214

Sites of lesion

1. Oropharynx -110
2. Oral cavity-102
3. Larynx-95
4. Nose and PNS-70
5. ESOPHAGUS-50
6. Nasopharynx-23
7. Ear-5

MANAGEMENT

The problem of managing head and neck cancer in Bihar is somewhat different as compare to the other part of India.

The major shortcoming is to cope up with the loss of follow up, which makes the task of conducting and reporting the end results of clinical trials awfully difficult. Diagnostic infrastructure in many parts of Bihar is scare. The service of a pathologist or pathology \cytology centres which are crucial for diagnosing cancer are not available in many district of Bihar. Treatment facilities are also mostly restricted to urban area. The management of head and neck cancers has evolved dramatically over the decades with Surgery, chemotherapy and radiation (diagnostic and therapeutic) techniques for patients with head and neck cancer. The addition of systemic therapy has also resulted in improved outcomes, principally through the use of chemotherapy concurrently with radiation. Laser surgery has given a new era in the treatment of early cases of

head and neck cancer (specially oral and laryngeal) where structural and functional integrity is very nicely maintained.⁶ Bihar falls into a high risk head and neck cancer geographical zone, presentation is late and treatment is not optimal. Lack of national tumour registry in India is one of the main reason for lack of accurate data about prevalence and incidence of head and neck cancer as well as other cancer. Recently government of Bihar has banned alcohol and pan masala ghutka. This step will help in decrease in head and neck cancer in Bihar.

PRIMARY PREVENTION OF HEAD AND NECK CANCER

The most effective prevention strategy is reduction in consumption of tobacco in all forms. These cancers can be prevented to a larger extent through a comprehensive tobacco control program which includes education, awareness, legislation, community participation and tobacco cessation service especially targeted at teenage.⁷ Although illiteracy and poverty are the often cited reason for our neglect toward extent of quality of life in head and neck cancer patients, it is actually the lack of physician awareness, and the nonavailability of valid tools that are responsible for the paucity of quality of life. Awareness of the people about cancer and delayed follow up also responsible for poor prognosis of cancer in Bihar as well as in India.

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Source of Support: None Declared
Conflict of Interest: None Declared