

Geriatric Care for Cancer Patients with Oral Health ProblemDr. Anindya Bhalla^{1*}, Dr. Asmita Jain², Dr. Sujata Bhalla³¹Public Health Dentistry SR Preventive Oncology, Delhi state cancer institutes, Delhi, India²Radiation Oncology SR Clinical Oncology Delhi state cancer institutes, Delhi, India³Senior Oral Health Consultant, Delhi, India Delhi Smile Dental and Medical Centre, India**Review Article*****Corresponding author**

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Abstract: The incidence of cancer increases with advanced age and as the world population ages, clinicians will be faced with a growing number of older patients with cancer as cancer patient's ages, they are put at risk for various medical conditions which not only affect their well-being but may also be problematic for their dental health. The dentist's contribution in the treatment of such patients before, throughout and after antineoplastic therapy. The oral cavity is a usual site of discomfort and pain caused by chemotherapy and radiotherapy, making the dentist's contribution to the patient's relief imperative [6, 8].

Key words: Dental, geriatric oral care, cancer patients.

INTRODUCTION

Older people are increasingly retaining their natural teeth but at higher risk of oral disease with resultant impact on their quality of life. Socially deprived people are more at risk of oral disease and yet less likely to take up care [1]. Most important risk factor in the development of cancer is age. Approximately 50% of newly diagnosed cases occur in people over 65 years and that percentage is expected to increase to 70% by 2030 [6]. The incidence of cancer is between 12 and 36 times higher in adults aged over 65 compared to younger people. This is compounded by the fact that the cancer-related mortality in older populations is higher, close to 70% per year [7].

Barriers to dental care

The results of this study suggest that there are five key areas which act as barriers to older people utilizing dental care, when a need to do so was perceived.

One further issue identified was a lack of perception of need, particularly amongst people with complete dentures. Each of the barriers was identified as a factor which would cause participants to either forgo dental treatment altogether or delay it until they felt it was absolutely necessary (symptomatic attendance). Starting with 'cost' and taking each of the barriers in turn we examine the implications of the barriers themselves and suggestions made for removing these barriers by older people[2-5].

Oral side effects in cancer patients

- Oral mucositis: it is a painful inflammatory reaction of the oral mucosa. OM is Stomatological Disease and Chemotherapy: oral complications and dental interventions 37 characterized by infiltration of the inflammatory cells followed by epithelial disruption and ulceration. It arises 4-7 days after the initiation of a high dose course and disappears 2-4 weeks after the treatment is completed [8].
- Osteonecrosis of the jaws:-Osteonecrosis impairs the function of osteoclasts and osteoblasts which

are the main types of cells that are closely related to bone health and repair. It appears after temporary or permanent impairment of the bone blood supply [9].

- Fungal:- The persistence of neutropenia, due to chemotherapy, favors the development of fungal infections. The most common fungi are Candida and Aspergillus species. The persistence of neutropenia, due to chemotherapy, favors the development of fungal infections. The most common fungi are Candida and Aspergillus species. Zygomycetes and endemic fungi, such as Histoplasma capsulatum, should also be considered as well as Fusarium species. Candida albicans is widely detected in such infections [10, 8].
- Viral: Periodontal disease due to chemotherapy Viruses replicate inside a host cell, multiply and invade other cells causing infection. The herpetic infections with the most favorable HSV-1 subtype are common in chemotherapy patients [11].
- Lichenoid reactions:-A lichenoid reaction (LR) is a pathologic entity involving cutaneous or mucosal

areas, or both of them simultaneously. The clinical appearance of oral lichen planus (OLP) with characteristic lesions of whitish reticular papules and erythematous erosions [11] and plaques in a reticular form accompanied by radiating striate may be present [12].

- Hyposaliva and xerostomia: - Chemotherapy usually impairs salivary gland function. This disturbance is temporary and reversible. However, it causes discomfort, affects the speech, and difficulties with chewing.
- Taste changes:-Taste changes& Taste disturbances are widely detected in patients undergoing chemotherapy. Although they are not lethal, taste disturbances may cause a great deal of discomfort.
- Steven-Johnson syndrome: - toxic epidermal necrolysis Toxic epidermal necrolysis (TEN) and Steven Johnson syndrome (SJS) are different forms of the same pathologic entity.
- Neurotoxicity:-Agents such as vinblastine and vincristine are associated with neurotoxicity. This neurotoxicity can present as severe deep pain in the mandible [12].

DENTAL INTERVENTIONS

- Treatment before chemotherapy and radiation: - The role of the dentist in the care of a patient before, during, and after the chemotherapy course is crucial. Before any procedure takes place, the oncologist should inform the dentist of the patient's current health status, the characteristics of the pathologic entity, and the antineoplastic therapy to be prescribed [13]. A thorough examination which consists of a dental history, a radiographic baseline (including periapical, bitewing and panoramic radiographs), a periodontal and endodontic evaluation, and a prognosis of the existing restorations is completed [15].
- Dental treatment during chemotherapy and radiation:-Dental treatment during chemotherapy should be avoided unless it is urgently necessary. Extractions and other invasive procedures should be postponed. Throughout chemotherapy, the dentist must be aware of the degree of immunosuppression of the patient. Dental hygiene must be preserved at a satisfying level, and cariogenic food must be avoided [14].
- Dental treatment during chemotherapy and radiation:-After chemotherapy and radiation, dental treatment is planned by consulting the oncologist. The treatment is designed to remove the remaining foci of infection and to restore esthetic and any functional impairment [13].

CONCLUSION

Complications arising from chemotherapy & radiation must be managed in the most effective fashion. The patient should be regularly checked by their dentist, especially in the first few months [14].

Extractions and other invasive procedures should be avoided for at least 1 year. Several preventive measures are taken in order to limit their expression. Nevertheless, most cancer patients experience difficult situations. The oral cavity is a usual site of discomfort and pain caused by chemotherapy and radiotherapy, making dentist's contribution to patient's relief extremely important [8].

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