



## GINGIVAL SCC WITH LYMPH NODE METASTASIS

## Oral Medicine

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## ABSTRACT

**Background:** Squamous cell carcinoma is a malignant epithelial neoplasm characterized by variable clinical manifestations. When located in the gingiva, this neoplasm may mimic common inflammatory lesions. The aim of this article was to report a case of atypical squamous cell carcinoma, in which the patient had no risk factors for the development of this neoplasm.

**Methods:** A 49 year old female patient with a history of enlarged lymph nodes without any local causative factors for a duration of 2 years underwent all possible investigations and finally got diagnosed with SCC at unusual sites.

**Results:** The diagnosis of squamous cell carcinoma was made and after incisional biopsy, the patient was referred for treatment consisting of surgical excision of the tumour. A removable partial denture was fabricated for rehabilitation, one month after surgery of the maxilla; the patient was submitted to dissection of the regional lymph nodes and radiotherapy for an additional 3 months.

**Conclusion:** Gingival squamous cell carcinoma is a condition which chance of cure is higher when carcinomatous lesions are diagnosed and treated early. In this instance dentists play an important role in early detection of gingival squamous cell carcinoma.

## KEYWORDS

## INTRODUCTION:

SCC of head and neck affecting different areas have different invasion and exophytic characteristics. SCC can mimic different oral lesion and gingival enlargements, which does not have clinical appearance of malignant neoplasms<sup>[1]</sup>. Due to this reason, these lesions can be misdiagnosed as inflammatory lesion of periodontium. Pathak *et al.* reported GSCC has high risk for metastasis<sup>[2]</sup>.

## CASE REPORT:

A 48 year old female patient visited the department of oral medicine and radiology with a chief complaint of swelling in the lower third of face on left side since 2 years. Patient was asymptomatic 2 years ago and noticed swelling which gradually increased to present size and which is associated with pain and multiple sinus openings since 2 months.

On extra oral examination on lymph node examination Level III lymph nodes were palpable on left side.

On clinical examination a solitary swelling approximately of size 3x3 cm is seen over submandibular region on left side extending anteroposteriorly 1cm away from chin and 0.5cm from angle of mandible. Superoinferiorly from lower border of mandible to 2cm away from submandibular region. Surface is seen with multiple sinus openings surrounded by erythematous areas.

On palpation the swelling is tender, non compressible and firm to hard in consistency with discharge from sinus openings. Furcation involvement is seen 16,26,27,46.[Figure 1]

A provisional diagnosis of Cervical lymphadenopathy and Differential diagnosis of Tuberculous lymphadenitis, Actinomycosis and Carcinoma of lymph node was given. A set of diagnostic investigations were performed including radiological and serological.

On examination of OPG generalized inter dental bone loss was noticed and missing teeth were noticed 36,37.[Figure 2] Ultrasonography of the swelling showing group of hypodense areas with irregular borders and loss of hilum.[Figure 3] On CT examination impression was given as enlarged hypodense level IB lymph node on left side was seen.

Multiple matted and necrotic nodes were seen in the level IB and II, III level nodes are seen suggestive of Tuberculous lymphadenitis.[Figure 4,5]

On serological investigations ZN staining showed no acid fast bacilli and fungal examination was non reactive. PCR was done to rule out tuberculosis which was negative. Biopsy was done from alveolus of 36,37 and lymph node. Histopathology report was given as **well differentiated squamous cell carcinoma**.

## DISCUSSION:

SCC of the gingiva frequently involves the mandible than the maxilla [3] and is mainly observed in female and mostly affects people older than 50 years [4,5]. However, some investigators have reported a higher incidence in male [6].

SCC affects different sites in the oral cavity; the most affected sites are lower lip, lateral border of tongue, retromolar region, floor of mouth, and gingiva. Gingival SCC (GSCC) arise from keratinized mucosa, which destroys bone structure and causes tooth mobility.[7]

Risk factors for GSCC are tobacco usage, alcohol consumption, candida infection, iron deficiency, virus, and immunosuppression.[8] According to Yoon *et al.*[9] and Meleti *et al.*,[10] GSCC does not show a strong association with classical risk factors such as actinic radiation, tobacco use, either smoked or chewed in its various forms, especially when associated with excessive consumption of alcohol. In the present case, the patient did not give any history of having any of the above habits.

As the GSCC resembles other oral enlargements, it is often misdiagnosed. Due to the misdiagnosis, the operator might worsen the prognosis by doing invasive procedures such as simple oral prophylaxis or curettage or extraction. It has been hypothesized by Peterson (1993) that invasive procedures can embed the cancer cells into the circulation and further increase chance of metastasis.[11]

In the present case the patient did not present with any lesion clinically and in radiographs the lesion was presented as classical periodontitis. Metastatic lymph nodes were appreciated in computed tomography

and USG. Biopsy has confirmed the suspicious lesion as malignant. Hemi-maxillectomy along with radical neck dissection followed by radiotherapy was given to the patient. Prognosis was good and recovery was faster.



Figure : 1



Figure 2:



Figure : 3

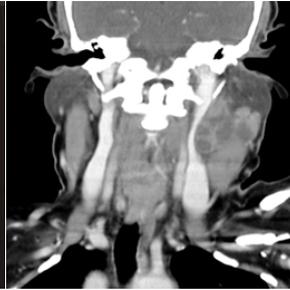


Figure :4



Figure : 5

### CONCLUSION:

Gingival and lymph node squamous cell carcinoma is a condition which chance of cure is higher when carcinomatous lesions are diagnosed and treated early. In this instance dentists play an important role in early detection of gingival squamous cell carcinoma.

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