



Complicanze ed effetti collaterali al cavo orale e orofaringeo nei pazienti trattati con radioterapia e chemioterapia: indicazioni per una corretta gestione clinica.

(a cura di A. Testolin, Belluno)

Sono recentemente apparsi in letteratura due “voluminosi” lavori relativi alla gestione clinica delle complicanze e degli effetti collaterali a livello del cavo orale e orofaringeo conseguenti a trattamenti radianti e/o chemioterapici.

Il primo è una dettagliata revisione della letteratura apparsa su CA Cancer Journal for Clinicians (disponibile in rete al seguente indirizzo: <http://onlinelibrary.wiley.com/doi/10.3322/caac.v62.6/issuetoc>).

Il lavoro non è incentrato esclusivamente sulle modalità di prevenzione o cura delle complicanze ma pone l'accento anche sulla biologia/patogenesi delle alterazioni acute e croniche, sui fattori di rischio correlati con la loro insorgenza e sulle modalità per misurare e graduare la tossicità.

Oral Complications of Cancer and Cancer Therapy From Cancer Treatment to Survivorship

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Oral complications resulting from cancer and cancer therapies cause acute and late toxicities that may be underreported, underrecognized, and undertreated. Recent advances in cancer treatment have led to changes in the incidence, nature, and severity of oral complications. As the number of survivors increases, it is becoming increasingly recognized that the aggressive management of oral toxicities is needed to ensure optimal long-term oral health and general well-being. Advances in care have had an impact on previously recognized oral complications and are leading to newly recognized adverse effects. Here, the authors briefly review advances in cancer therapy, including recent advances in surgery, oral care, radiation therapy, hematopoietic cell transplantation, and medical oncology; describe how these advances affect oral health; and discuss the frequent and/or severe oral health complications associated with cancer and cancer treatment and their effect upon long-term health. Although some of the acute oral toxicities of cancer therapies may be reduced, they remain essentially unavoidable. The significant impact of long-term complications requires increased awareness and recognition to promote prevention and appropriate intervention. It is therefore important for the primary oncologist to be aware of these complications so that appropriate measures can be implemented in a timely manner. Prevention and management is best provided via multidisciplinary health care teams, which must be integrated and communicate effectively in order to provide the best patient care in a coordinated manner at the appropriate time. *CA Cancer J Clin* 2012;62:400-422. © 2012 American Cancer Society.

Il secondo illustra le linee guida redatte dal “Royal College of Surgeon of England” e dalla “British Society for Disability and Oral Health” (disponibile in rete al seguente indirizzo: <http://onlinelibrary.wiley.com/doi/10.3322/caac.v62.6/issuetoc>).

Le linee guida prevedono specifiche raccomandazioni per la gestione delle complicanze orali, prevedendo un percorso di valutazione e cura che si articola in azioni da intraprendere prima, durante e dopo il trattamento oncologico.

Le linee guida sono inoltre corredate di sezioni rivolte all'assistenza infermieristica ("Nursing Oral Care Action) ed ai pazienti (Patient Information Leaflet).

**The Oral Management of Oncology Patients
Requiring
Radiotherapy, Chemotherapy
and / or Bone Marrow
Transplantation**

Clinical Guidelines

Updated 2012

**The Royal College of Surgeons of England /
The British Society for Disability and Oral
Health**

Entrambi i lavori non contengono novità eclatanti tuttavia, vista anche la loro facile reperibilità, possono costituire un utile strumento di consultazione.

In APPENDICE viene riportato un sunto delle linee guida Inglesi.

Da ultimo segnalo i risultati di uno studio randomizzato sull'utilizzo della doxepina (antidepressivo) nel trattamento del dolore secondario alla mucosite del cavo orale nei pazienti irradiati.

**N09C6 (Alliance) - A Phase 3, Randomized Double-Blind Study of
Doxepin Rinse Versus Placebo in the Treatment of Acute Oral
Mucositis Pain in Patients Receiving Head and Neck Radiation
Therapy With or Without Chemotherapy**

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biology • physics

Sciacqui orali con 25 mg di doxepina in 5 ml di acqua paiono ridurre significativamente il dolore legato alla presenza di mucosite. Gli autori concludono affermando che lo studio indica un nuovo standard terapeutico nel trattamento del dolore al cavo orale dovuto alla mucosite radioindotta.

PRIOR TO CANCER THERAPY

2.1. Prior to Cancer Therapy - at initial diagnosis

- 2.1.1. Oral care information is provided as an integral component of the general care philosophy.⁵ Oral care should be seen as a contribution to total patient care and implemented in conjunction with the care priorities agreed with the oncology team.³
- 2.1.2. Realistic simple preventive advice is given emphasising its value in maintaining oral comfort during therapy.

2.2. Prior to Cancer Therapy - oral/dental care

- 2.2.1. A comprehensive oral assessment is undertaken.^{4,17} This will help:
 - i. Identify existing oral disease and potential risk of oral disease.
 - ii. Remove infectious dental/oral foci before the start of cancer therapy.
 - iii. Prepare the patient for expected side effects of cancer therapy.
 - iv. Establish an adequate standard of oral hygiene to meet the increased challenge.
 - v. Develop a plan for maintaining oral hygiene, providing preventive care, completing oral rehabilitation, and follow-up.
 - vi. Establish the necessary multidisciplinary collaboration within the cancer centre to reduce/alleviate oral symptoms and sequelae before, during and after cancer therapy.Each centre should have a multidisciplinary team to accomplish these goals; the exact methods used may vary between cancer centres.¹⁸
- 2.2.2. Detailed oral hygiene instruction with reinforcement and elaboration of diet advice is provided in cooperation with the dietician.⁴
- 2.2.3. Oral hygiene practices are supplemented with the use of an alcohol free chlorhexidine mouthwash or dental gel, if there is gingival disease diagnosed.¹⁹
- 2.2.4. Impressions of the mouth are taken for study casts to construct applicator trays and where appropriate for obturator planning.
- 2.2.5. Carious teeth that can be restored are stabilised with appropriate restorations.
- 2.2.6. All sharp teeth and restorations are suitably adjusted and polished.
- 2.2.7. The patient is counselled about denture wear during therapy. If a removable prosthesis is worn, it is important to ensure that it is clean and well adapted to the tissue. The patient should be instructed not to wear the prosthesis during cancer therapy treatment, if possible; or at least, not to wear it at night.²⁰
- 2.2.8. Wherever possible, teeth with a dubious prognosis are removed no less than ten days prior to cancer therapy.²¹
- 2.2.9. Orthodontic treatment is discontinued.²²

DURING CANCER THERAPY

2.3. During Cancer Therapy

- 2.3.1. The patient receives appropriate support from a dental hygienist.
- 2.3.2. A high standard of oral hygiene is encouraged, including denture hygiene.
- 2.3.3. The use of an alcohol free chlorhexidine mouthwash is recommended if toothbrushing is likely to be inadequate for plaque removal; it can be used in addition or as a short-term alternative to tooth brushing
- 2.3.4. Those patients receiving radiotherapy, or total body irradiation prior to bone marrow transplantation are at high risk of dental caries and should receive dietary advice and fluoride supplements appropriate to their age.^{25 - 26}
- 2.3.5. Children and adults receiving bone marrow transplants often receive aciclovir as a prophylaxis if there is a high risk of viral infections. This is usually prescribed by the oncology team.^{27,28,29}
- 2.3.6. Antifungal medication is used following detection of oral candida. For children this may be used routinely as a prophylaxis in some cancer centres.
- 2.3.7. Every effort is made to reduce the severity of the mucositis.
- 2.3.8. Every effort is made to reduce the effect of the xerostomia for quality of life and prevention of oral disease.
- 2.3.9. Patients are advised that removable prostheses may become difficult to wear and may be left out. If there is any discomfort they should be examined by a member of the dental team and adjusted to ensure they are atraumatic.
- 2.3.10. If the mouth is too painful for cleaning with a soft toothbrush, the tissues can be cleaned with oral sponges if available or gauze moistened with alcohol-free chlorhexidine mouthwash.
- 2.3.11. Certain food, drinks and mouthwashes, which irritate the oral mucosa, should be avoided to maintain oral comfort.
- 2.3.12. Dental treatment is avoided wherever possible during therapy.

FOLLOWING CANCER THERAPY

2.4. Following Cancer Therapy – Prevention and Monitoring

- 2.4.1. Growth and development should be closely monitored. For children there should be a dental review at least every six months. For patients with xerostomia, trismus, severe graft-versus-host disease or severe mucositis a three month review is recommended.
- 2.4.2. Regular and appropriate oral healthcare monitoring is provided by the designated member of dental staff. This should include regular radiographs, oral health advice and preventive regime reinforcement.
- 2.4.3. Strategies for dealing with xerostomia continue.
- 2.4.4. Fluoride supplements appropriate to age should be used.
- 2.4.5. Chlorhexidine gel can be applied with applicators every three months.
- 2.4.6. In the event of trismus, jaw exercises are implemented.
- 2.4.7. Orthodontic considerations – orthodontic treatment can start once the patient has been free of cancer for one year. Any developmental disturbances that may have occurred due to their medical treatment must be assessed to decide on their suitability for orthodontics. Where extensive root damage/lack of root development has occurred, serious consideration must be given to not providing orthodontic treatment. Bisphosphonate treatment is not necessarily a contraindication to orthodontic treatment.

2.5. Following Cancer Therapy – General Considerations

- 2.5.1. In the event of uncontrolled periodontal disease, vigorous treatment is initiated. This may involve identification of atypical pathogens.
- 2.5.2. Herpes labialis can be a chronic problem. Topical aciclovir is effective.
- 2.5.3. Restorations are kept simple ensuring acceptable aesthetics and function.
- 2.5.4. Dental extractions, if essential, must be performed with appropriate precautions.
- 2.5.5. Dentures should be avoided wherever possible.
- 2.5.6. Implant stabilisation of prostheses and obturators may be feasible in some patients.

2.6. Following Cancer Therapy – Requirements for Denture Wearers

- 2.6.1. Removable prostheses are left out at night.
- 2.6.2. Glandosane saliva substitute should be used for edentate patients only.
- 2.6.3. Antifungals are used if a candidal infection is diagnosed.
- 2.6.4. Appliance wear is discontinued if the mouth becomes painful. Advice must be sought.
- 2.6.5. Obturators are reviewed regularly. They may require frequent attention with adjustment or remake.

2.7. The Management of Osteoradionecrosis

- 2.7.1. Establish the diagnosis of osteoradionecrosis (ORN) and stage, ensuring that the bony changes are not due to malignancy. Following a

diagnosis of ORN it is recommended that:

- 2.7.2. Oral trauma is minimised, and a high standard of oral hygiene is established.
- 2.7.3. Local measures are employed to relieve symptoms including topical/systemic analgesia.
- 2.7.4. New therapeutic use of Antioxidant medications may be beneficial in ORN lesions identified early.
- 2.7.5. High dose systemic antibiotics are prescribed.
- 2.7.6. Localised surgical excision of exposed necrosed bone with primary mucosal closure may become necessary.
- 2.7.7. Evidence suggests that ultrasound may be useful as an adjunct to healing.
- 2.7.8. In severe cases the use of hyperbaric oxygen therapy (HBOT) may be necessary.
- 2.7.9. In advanced chronic cases the extent of involvement of bone necrosis must be established followed by radical ablative surgery to remove necrotic bone and soft tissue, and reconstruction with either a pedical or microvascular free flap.