Low-Grade Adocarcinoma, Soft Palate

therapy and were suffering from extensive dental caries will be presented. Dental caries cause remarkable difficulties for tooth restoration.

Purpose:

Background:

Confrontation of dental pain and caries lesions. Treatment must be simple and direct rather than indirect restorations. Teeth with questionable or bad prognosis must be extracted. In cases with pulp involvement always endo treatments. Use of fluoride products not differentiated compared to pre-antineoplasmatic treatment.

Case I

• Patient 26 yrs old, Squamous Cell Carcinoma, right Maxilla
• Total radiation 67.2 Gy and 33 radiation therapies
• Surgical resection of tumor and maxillary sinus
• Removal of caries maxillary and cast posts at severely damaged teeth
• Endo treatments, composite resin restorations
• Provisional restorations with glass-ionomer cement, that will be replaced by composite resin

Preventive Program

- Use of fluoride products not differentiated compared to pre-antineoplasmatic treatment
- Frequent rinses of mouth with water in case of xerostomia
- Use of mouthrinses 0.05% NaF twice daily or 0.2% NaF once daily
- Use of soft toothbrush or gauze for teeth cleaning
- Avoid use of mouthrinses containing alcohol, may be irritant for oral mucosa

Case II

• Woman, 52 yrs old, Squamous Cell Carcinoma, Mandible
• Total radiation 68 Gy
• Surgical resection of tumor and maxillary sinus
• Maximum mouth opening 12 cm
• Postgraduate Students of Operative Dentistry, ** Professor at the Department of Operative Dentistry - Dental School of Athens

Protocols

BEFORE ANTINEOPLASMATIC THERAPY

- Toothpaste 500ppm Cuf n twice daily
- Mouthrinse 0.05% NaF twice daily or 0.2% NaF once daily
- Fluoride gel 0.05% of Cuf-ApC in trays 5min before night sleep
- Chlorhexidine 0.12%-0.2%
- Use of interdental brushes or dental floss

TREATMENT PLANNING

- Treatment plan must be simple but more aggressive compared to health population
- Early caries conservative restorations
- Larger caries direct rather than indirect restorations
- In cases with pulp involvement always endo treatments
- Teeth with questionable or bad prognosis must be extracted

RECALL SESSIONS

- About chemotherapy there are not specific recommendations
- About radiation therapy monitoring every 4-8 weeks

AFTER ANTINEOPLASMATIC THERAPY

- Saliva check
- Fluoride toothpaste 500ppm twice daily
- Mouthrinse 0.05% NaF twice daily or 0.2% NaF once daily
- Relief from xerostomia with frequent rinses with water and other humectants, depending on the severity of xerostomia
- Renovation of the lesions of dental tissues, after radiation of the oral environment
- Upon oral hygiene is satisfactory, even complicated and extended prostheses can be performed

RECALL SESSIONS

- The recall frequency is determined by the degree of xerostomia
- The first 2 years after antineoplasmatic therapy the recalls must be carried out every 4 months and subsequently every 6 months.


Fig. I-1: Intraoral clinical examination
Fig. I-2: X-ray examination
Fig. I-3: Removal of caries mandibulary
Fig. I-4: Removal of caries maxillary
Fig. I-5: Removal of caries maxillary and cast posts at severely damaged teeth
Fig. I-6: Endo treatments, composite resin restorations
Fig. I-7: Provisional restorations
Fig. I-8: Removal of caries maxillary
Fig. I-9: Final all ceramic and resin restorations
Fig. I-10: Final metal-ceramic and resin restorations
Fig. II-1: Intraoral clinical examination
Fig. II-2: X-ray examination
Fig. II-3a: Initial examination #15-17
Fig. II-3b: X-ray examination
Fig. II-3c: Composite resin restoration #28, endo treatment #24,25
Fig. II-4a: Removal of caries
Fig. II-4b: Endo treatment, fiber post #15, composite resin restorations
Fig. II-4c: Composite resin restoration #28, endo treatment #24,25
Fig. II-5a: Initial examination #15-17
Fig. II-5b: X-ray examination
Fig. II-5c: Composite resin restoration #28, endo treatment #24,25
Fig. II-5d: Initial examination #15-17
Fig. II-5e: Removal of caries
Fig. II-5f: Composite resin restorations

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