LEUKOPLAKIA → White patch that isn't any other disease. - strictly a clinical term.

→ From thickened keratin.
→ Considered Pre-malignant, but has only 4% malignant transformation potential.
→ Most common pre-cancer but not the highest transformation risk.
→ MALES, SMOKERS — 80% of Leukoplakias are in smokers., Can disappear when smoking stops.
- ALCOHOL NOT ASSOCIATED. SANGUINARIA usage = Maxillary alveolar Leukoplakia.
- UV Radiation causes Lower Lip Leukoplakia. → along w/ actinic cheilosis.
- Treponema (dorsal tongue), Candida, HPV Also assoc.
- Nicotine Stomatitis (pipe smokers palate), Frictional keratosis are trauma/irritations that create hyperkeratosis but Not considered Leukopl. b/c it isn't pre-malignant.

- Age 40+
- Mostly on Lip vermillion, buccal mucosa + Gingiva - sinister locations are floor of mouth, Ventral tongue + Vermillion of Lip. (show dysplasia).

smooth/thin → Thick/fissured → Granular/verruciform → Erythroleukoplakia
——— more MALIGNANT transformation ———→

PROLIFERATIVE VERRUCOUS LEUKOPLAKIA → a High Risk form. has rough surface projections
- Spreads slowly, transforms into SCC. STRONG FEMALE Assoc. (overall Leukoplakias more in men)

- Leukoplakia Histo: Epithelium has teardrop-shaped Rete-ridges, loss of polarity, keratin pearls
- Tx: Biopsy - remove if dysplastic, check every 6 mo. if not., tell pt to stop smoking

ERYTHROPLAKIA - Red patch that isn't any other condition.

- Significant epithelial dysplasia, Carcinoma in situ, or invasive SCC.
- Tougher to see than Leukoplakia, much more dangerous.
- Older males.
- Floor of mouth, tongue, palate.
- well demarcated erythematous macule or plaque w/ soft velvety texture
- 90% are either severe dysplasia, Ca. in. Situ., or superficial ~~see~~ invasive SCC.
- Lack of keratin.
- Biopsy, long-term follow up.

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* Malignant transformation potential of Pre-cancerous lesions:
① Proliferative Verrucous Leukoplakia
② Nicotine Palatinus (reverse smoking)
③ Erythroplakia
⋮
Thick leukoplakia
Thin leukoplakia

PLUMMER-VINSON SYNDROME - assoc. w/ Iron deficiency anemia (* this is pre-cancerous)
- Thin epithelium, high freq. of oral + esoph. SCC.
- Burning tongue, red tongue, smooth angular cheilitis
- dysphagia from esophageal webs, spoon-shaped nails, fatigue, SOB, weak

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Oral Cancer — Smoking is major cause. Alcohol alone = nothing alcohol+Smoking = more cancer
- Phenols, Radiation (UV and therapeutic), Iron deficiency (Plummer-Vinson) -all are causative.
- Vitamin A protects against cancer (deficient pts at risk)

Squamous Cell Carcinoma

- Can be exophytic, endophytic, Leuko/Erythroplakic
- Underlying bone may be invaded = MOTH-EATEN pattern

CARCINOMA OF THE LIP vermillion

- Seen in light-skinned individuals w/ long UV exposure
- LOWER LIP, Slow growth

INTRAORAL CARCINOMA: ① LATERAL TONGUE, ② Floor of mouth.

- Floor of Mouth region starts as leukoplakia/erythroplakia in midline near frenum.
- Gingival carcinomas invade/destroy underlying bone, least assoc. w/ tobacco use.

OROPHARYNGEAL CARCINOMA: Most in tonsillar area, soft palate, the rest @ base of tongue.

- Pain + dysphagia. Metastasis likely (pt. unaware until late). goes via lymph (- HARD NODES - Fixed (for all metastases))

STAGING - TNM system. best indicator of prognosis (better than grading).
Grading - how much the tumor resembles parent tissue - differentiated = I anaplastic = III/IV

ORAL SCC - 58% 5yr survival rate [illegible].

- Tx = excision. Lower lip carcinoma much better prognosis than upper lip.

ORAL Squamous Papilloma - occurs all over oral cavity. Roughened texture.

- painless exophytic to cauliflower-like.
- most due to papillomavirus.
- * No known Malignant potential