

Review of the Literature on Oral Cancer: Epidemiology, Management and Evidence-based Traditional Medicine Treatment

Abstract

Oral cavity cancers are part of the upper aerodigestive tract cancers and represent a significant burden worldwide. Its epidemiology varies from country to country with high frequencies in South East Asian countries. Tobacco and alcohol are the main risk factors. Survival of oral cancer is low i.e., less than 40% in the advanced stage (stage III and IV), diagnosis of oral cavity cancer is based on a complete clinical examination of the oral cavity complete with biopsy, bio-markers are an adjunct to screening and diagnosis of oral cavity cancers, surgery, radiotherapy, chemotherapy and immunotherapy are part of the therapeutic armamentarium of oral cancer but also have limitations. Traditional medicine is an important and proven alternative in the treatment and support of patients with oral cavity cancer. Prevention of oral cavity cancers includes not only early detection of precancerous and cancerous lesions but also control of risk factors and education of the population. Surgery, radiotherapy, chemotherapy and immunotherapy are part of the therapeutic strategy of oral cancer treatment but also have limitations. Traditional Medicine is an important and proven alternative in the treatment and support of patients with oral cavity cancer. It is thus desirable to scientifically validate phytochemicals in order to integrate alternative medicine as part of national cancer management strategy. *In silico* advanced studies on secondary metabolites of medicinal plants traditionally used to treat oral cancer are in progress.

Keywords: Oral cavity cancer, Upper Aerodigestive Tract, Evidence-based Medicine, Phytochemicals, Medicinal plants, Alternative/Traditional Medicine

1. Introduction

Cancers of the Oral Cavity (COC) are part of the cancers of the Upper Aerodigestive Tract (UADT) and share the same epidemiological characteristics [1, 2]. Cancer of the UADT is the sixth most common clinical form of cancer in the world [3, 4, 5]. Oral cavity cancers (OCCs) account for between 30 and 40% of VADS cancers [6, 7]. It often presents as an ulcerated lesion with an indurated base [8, 9]. Squamous cell carcinoma is the most common histological subtype and accounts for over 90% of OCCs [6, 7, 10]. Other types of cancers (salivary gland cancers, sarcomas, lymphomas,

melanomas) account for less than 10% of OCCs and about 1% are metastatic cancers from the lung, breast, prostate and kidney [11,12].

The development of OCC depends on epigenetic and genetic factors. This tumor process takes place in several stages, starting with some changes in the oral mucosa, followed by the development of invasive cancer until the appearance of metastases [13]. The aim of this literature review is to discuss the epidemiology of OCC, some risk factors and means of diagnosis and treatment as well as prevention of OCC. The articles selected for this literature review were in English and French after selection on Google scholar, PubMed search engines from 2010 to 2021. All articles related to OCCs dealing with epidemiology, risk factors, treatment and prevention were included in this literature review.

2. Literature

2.1. Epidemiology

OCC accounts for 2% of all cancers, with an estimated 377,713 new cases in 2020 and 177,384 deaths worldwide [5,14]. The actual epidemiological data on OCC are not homogeneous.

They vary from one country to another, with high frequencies in South East Asian countries [5,14]. In developed countries, 75% of oral cancers are related to tobacco and alcohol consumption [3]. In contrast, in low-income countries, the high incidence of OCCs is due not only to tobacco and alcohol consumption, but also to betel nut consumption, especially in Southeast Asia [15,16] and nitrosamine-rich foods such as smoked and salted fish, infections, poor nutrition and exposure to carcinogenic foods [3].

India, Pakistan, Bangladesh and Sri Lanka have some of the highest numbers of diagnosed OCC in the world [17-19]. In Pakistan, OCC accounts for nearly 19.2% of all diagnosed cancers [20]. In India, it accounts for 30-50% of all cancers and is a major public health problem [19, 21]. In the Middle East, 8,928 cases of OCC are reported each year, representing 1.5% of all cancers, with a case fatality rate of 1% (3,573 cases) [22]. France is among the most affected countries in Europe with almost 12,080 new cases in 2017, 68% in men and 32% in women [23]. In the US, OCC accounted for nearly 2.9% of all diagnosed cancers and 1.6% of deaths in 2018 [24].

In Africa, data are scarce due to the lack of cancer registries in many countries. However, the few studies carried out across Africa have given an idea of the frequency of the disease. In Kenya, Onyango et al. [25] found in their study the frequency of OCC to be between 2 and 3.6% of VADS cancers. In the Democratic Republic of Congo (DRC), studies of OCC have reported a frequency of between 1.8% and 2.3% [26, 27].

2.2. Risk factors

OCC is a multifactorial disease [8], depending on a number of factors that may be unique to the individual and/or related to the environment, genetics and local and infectious factors [8, 28, 29].

2.2.1. Potential malignant lesions

Potentially malignant oral epithelial lesions or disorders include both clinical lesions and oral dysplasia which should be reserved specifically for lesions with histopathological proven foci of dysplasia [30]. They have a statically increased risk of progressing to cancer and are sufficient to cover pre-

cancerous lesions and pre-cancerous conditions according to the latest World Health Organization recommendations [31, 32].

70% of OCCs are preceded by a potentially malignant lesion [6]. Pre-cancerous lesions of the oral cavity mainly include leukoplakia, erythroplakia, submucosal fibrosis, lichen planus, lupus erythematosus, and actinic cheilitis [31-34]. Alcohol and tobacco are the main risk factors for precancerous lesions of the oral cavity [30, 34]. Treatment of these lesions consists of removal of the risk factors and regular monitoring of the lesions for early detection of possible transformation into cancer cells [32, 33]. However, Ganesh et al. reported in their study that surgery on these lesions does not reduce the rate of transformation of these lesions into oral cancer [35].

2.2.2. Tobacco and alcohol

Tobacco use is the leading cause of death in the world, accounting for over 7 million deaths each year, or 44% of all deaths from non-communicable diseases [36]. All forms of tobacco are carcinogenic [37]. 80 to 90% of OCC patients are smokers and the risk increases with the amount of tobacco smoked and its duration [2, 38 – 40]. The use of one pack of tobacco per day for 20 years or two packs per day favors the development of oral cancer [39, 41]. This can be explained by the fact that tobacco contains several chemical substances, in particular nicotine, which diffuses rapidly into the brain and leads to a strong dependency [2, 42]. In addition, tobacco contains polycyclic hydrocarbons and nitrosamines which are carcinogenic, and irritants which interfere with host DNA and eventually lead to oral cancer [42-45].

Alcohol is classified as a carcinogen by International Agency for Research on Cancer (IARC) [46]. 75% of individuals with bluetongue are alcohol consumers [40]. According to the WHO, more than 3 million people died from alcohol abuse in 2016, i.e., one in twenty deaths worldwide is due to alcohol [47]. Alcohol consumption is an important risk factor for some chronic non-communicable diseases such as cardiovascular disease, diabetes and some cancers [47, 48]. It is involved in DNA hypomethylation. This leads to loss of control of proto-oncogene expression, increased mucosal permeability, liver damage and decreased immunity and salivary flow [13, 38, 39, 41]. Alcohol and tobacco have a synergistic effect in the occurrence of oral cancers [39-43]. Unfortunately, alcohol and tobacco consumption are increasing rapidly in Africa [49].

2.2.3. Oral hygiene

Poor oral health and hygiene are often associated with OCC [50, 51]. Poor oral hygiene promotes the development of oral cancers as a result of the increase in oral flora by bacteria that will increase the amount of acetaldehyde following the breakdown of ingested alcohol [51-54].

2.2.4. Viruses

There are over 200 HPV stereotypes, six of which are implicated in cancer, including HPV16 and 18 [53, 54] and are more commonly found in normal tissues [54, 55]. HPV16 and 18 express the E6 and E7 oncoproteins which inhibit tumor suppressor proteins encoded by the P53 and Rb genes respectively which led to disruption of cell regulation [4, 32, 56]. Multiple sexual partners and oral sex with more than 6 partners may contribute to the development of OCC due to HPV [57]. The carcinogenic role of the HIV/AIDS virus has also been suggested by a decrease in the immunity of

affected individuals, leading to the development of certain HIV-associated tumors in the oral cavity such as lymphomas and Kaposi's sarcoma [57-59]. Epstein-Barr virus (EBV) interferes with host DNA and can cause oral leukoplakia and adenocarcinomas [31, 51].

2.2.5. Trauma

Chronic trauma to the oral mucosa is the repetitive result of mechanical action caused by injury from an irritant [60]. This irritating agent can be a defective tooth (fractured, badly positioned); a bad dental filling [13, 60]. Chronic trauma, especially from ill-fitting dentures in the mouth, can be an activator of the carcinogenic process, especially if other risk factors are added [1, 29, 61]. These chronic microtraumas modify the mucous membrane leading to keratinization.

2.2.6. Nutritional factors

A diet rich in vegetables and fruit is linked to a reduced risk of oral cancers because fruits and vegetables contain vitamins, particularly A, C, D and E, which are antioxidants that reduce the risk of cancers of the upper aerodigestive tract [59, 62, 63]. However, a diet rich in meat, salted and smoked fish increases the risk of developing OCCs due to the presence of nitrosamines which are carcinogenic [3].

2.2.7. Genetic predispositions

Not everyone who is exposed to carcinogenic factors can develop cancer; only a proportion develop it as a result of factors intrinsic to the individual [29, 43]. The deleterious effect of a particular carcinogen varies from one person to another, from one region to another [29]. The P53 protein is a tumor suppressor gene that prevents carcinogenesis by triggering cell cycle arrest and 40-70% of OCCs have mutations in the P53 gene, leading to the formation of a non-functional product [64]. 90% of these mutations are located between exons 5 and 8 of TP53 which is a region where most mutations occur including R175, G245, R248, R249, R273 and R282 on the DNA binding domain [65, 66]. Thus, people with syndromes caused by the mutation of certain genes have an increased risk of developing OCC as in Fanconi anaemia where this risk is 100 times higher than in the normal population [67, 68].

2.2.8. Gender and age

OCCs are more common in men than in women [69-71]. The use of alcohol and tobacco is thought to be at the root of this male predominance of OCCs. Although a female ascendancy has been noted following an increase in tobacco and alcohol consumption in women [29, 72], according to a study by Luo et al. [73] the high levels of hormones, particularly oestrogens, in women play a protective role against OCC compared with men. Age around 50 has been found in the majority of studies [74-76]. However, due to the increased use of tobacco and alcohol among young people, several cases of cancer have been observed before the age of 50 [77]. HPV infection and genetic predisposition are thought to be the basis of this infection in young people following risky sexual behaviour such as oral sex [77, 78].

2.2.9. Exposure to the sun's UV rays

Exposure to UV radiation from the sun is a risk factor for lip cancer. The lower lip is the most exposed to this disease [79, 80]. The people most affected by this cancer are outdoor workers such as

farmers, fishermen, masons, etc. [80, 81]. This lesion often appears between the fifth and seventh decade as a result of accumulated exposure to UV radiation from the sun [80, 82].

2.3. Other factors

Marijuana use, betel nut addition, people with low social status, mouthwash containing alcohol, chronic candidiasis and aging [13,15-17, 24, 29-35].

2.4. Location

The tongue is the site most affected by OCC [83, 84, 85]. This can be explained by the central position of this organ in the oral cavity. It plays a very important role in mastication, phonation and swallowing [85] and is continuously exposed to carcinogenic substances such as tobacco and alcohol [85, 86]. Cancer of the tongue occurs most frequently in men aged 60-70 years (85-87). Other common sites of OCC are the lips due to sun exposure and smoking, the gums, the floor of the mouth and the inner cheeks due to certain habits such as alcohol and chewing tobacco consumption [88-89].

2.5. Inflammation and Oral Cancer

Inflammation is the main feature of cancer [90]. About 15% of cancers are due to inflammatory processes [91]. Chronic inflammation plays an important role in the development of VADS cancers [90-94]. Several inflammatory mediators are involved in OCC carcinogenesis including nuclear factor kappa B (NK-KB), vascular endothelial growth factor (VEGF), p53, nitric oxide (NO), reactive oxygen species (ROS), nitrogen species, specific micro RNAs (miRNAs), cytokines [tumor necrosis factor alpha (TNF- α), interleukins (IL-1, IL-6, IL-8)], prostaglandins, COX-2 [91-97]. The expression of these mediators is largely responsible for a pro- or anti-tumorigenic inflammatory response through changes in cell proliferation, cell death, cell senescence, DNA mutation, DNA methylation [91, 95]. These inflammatory mediators are involved in angiogenesis, tumor growth and proliferation of tumor metastases [91-100]. NO plays an active role in free radical and tumor biology [101], overexpression of COX-2 is found in 80% of potentially malignant lesions and cancers of the VADS and this overexpression is associated with lymphatic metastasis [97-100].

2.6. Biopsia

Several tests are used for the diagnosis of OCC such as oral cytology, toluidine blue test, oral cytobrush, light-based tests [102-105]. Clinical examination of the oral cavity supplemented by biopsy followed by histopathological examination remains the diagnostic reference examination, as other techniques have limitations such as false positives, lack of structural analysis, superficial samples [103-106]. Biopsy remains the only examination that accurately determines the exact limit, benignity or malignancy of a lesion, its dysplastic character and the in situ or invasive evolution of a cancerous lesion [102,107].

2.7. Biomarkers

Biomarkers are normal biological indicators of pathogenic processes or responses to exposure or intervention [108]. The use of biomarkers from biological fluids (blood, urine, saliva) facilitates the early diagnosis of cancers [109]. Saliva contains factors such as cytokines, DNA and RNA molecules, circulating cells, tissue derivatives, and extracellular vesicles that can be used as biomarkers in OCCs [110]. Salivary biomarkers are proposed as important adjuncts in the diagnosis and screening of OCCs and potentially malignant lesions [111]. More than 100 salivary molecules have been identified

as potential biomarkers of OCCs [112]. Protein biomarkers (IL1 β , IL6, IL8) are useful for the early detection and screening of OCCs and MPLs [113] as they are involved in the pathogenesis of OCCs and in the transformation of MPLs [113-115].

2.8. Oral cancer treatment

Several treatment protocols for oral cancer exist and depend on the nature of the cancer, the age of the patient and the TNM stage [116-118]. The treatment plan for OCC is decided in a collegial manner in an interdisciplinary meeting after clinical, radiological and endoscopic assessment [102, 114]. Surgery remains the main treatment for OCC but is associated with massive disfigurement, inability to perform normal oral functions, psychosocial stress and extensive rehabilitation [10, 117-119].

Radiotherapy, chemotherapy, or immunotherapy is also part of the therapeutic armamentarium, and palliative treatment is indicated for non-operable cases [10, 116, 119]. Radiotherapy and chemotherapy also have limitations in terms of significant toxicities or resistance to treatment, all of which compromise patients' quality of life and well-being [117-119]. In addition, recurrence and/or metastasis are found in more than half of patients after several years of primary cancer treatment (80% after the first two years), leading to recurrent cancer growth [116-120].

2.9. Evidence-based Traditional Medicine in the treatment of oral cancer

More than 80% of the world's population uses traditional medicine and for cultural, economic or accessibility reasons [121]. Several studies worldwide have confirmed the importance of this medicine in the treatment of cancers in general and those of the oral cavity in particular [122-124]. It is currently recognized that modern cancer therapies have demonstrated their limitations in terms of their inability to completely eliminate tumor cells, drug resistance and other adverse effects [122-123]. Given these drawbacks, there is a growing interest in traditional medicine, particularly herbal medicine, which is used by 80% of the population in developing countries for the treatment of various diseases including cancer [122-124]. There is evidence that this medicine improves the effectiveness of chemotherapy, radiotherapy, targeted therapy and immunotherapy [123]. It is believed to act on cancer by inhibiting tumor progression and improving the immune system [123]. Medicinal plants have been widely used as a natural source of remedy to cure multiple diseases including cancer [125]. Among the most widely used herbs are: green tea extract contains large amounts of polyphenols including epigallocatechin 3-gallate (EGCG) has anti-cancer and anti-inflammatory properties and induces cell cycle arrest and apoptosis by activating p53 and targeting p21 and Bax [126, 127]. Ginger contains gingerol, paradol and zingerone, has antioxidant, anti-inflammatory, anti-ulcerogenic, anti-carcinogenic properties [128], turmeric is a spice derived from turmeric *curcuma longa*, has anti-carcinogenic properties in DCS cancers as a result of its anti-inflammatory effects in decreasing NF-KB and pro-apoptotic regulation. Turmeric has a phagocytic action on free radicals, inhibits lipid peroxidation and decreases tumor cell proliferation by suppressing angiogenesis and reduces tumor growth and metastasis and by activating p53 and p21 [13, 128, 129], According to the study by Wang et al, coffee consumption reduces the risk of oral cavity cancer [130], garlic, honey, polyphenols, flavonoids, anthocyanins, saffron, lycopene, raspberry also have anti-cancer properties against OCC [13, 128, 129, 131].

2.10. Survival and prevention

The five-year survival rate of OCC has not improved despite progress in treatment, it is about 40% when diagnosed at advanced stage III and IV and 80% when diagnosed at early stage I and II [132, 133]. The prevention of oral cancer is multisectoral at the level of government, civil society and oral practitioners. The fight against social inequalities, awareness campaigns against the production, advertising and consumption of tobacco and alcohol [136].

Educate the population to have a healthy lifestyle, good oral health and good sexual health [136]. Thus, OCC screening should be an essential component of the routine head and neck examination performed in primary dental care practices [6].

3. Conclusion and suggestions

This review of the literature has shown the different facets of OCC in terms of both epidemiology and management. OCC is a multifactorial disease involving several endogenous and exogenous risk factors. Knowledge of the epidemiology, the different risk factors, the crucial role of inflammation and genetics in the development of OCC, as well as the different diagnostic and treatment techniques are necessary for the screening and management of cancer patients.

Surgery, radiotherapy, chemotherapy and immunotherapy are part of the therapeutic strategy of oral cancer treatment but also have limitations. Traditional medicine is an important and proven alternative in the treatment and support of patients with oral cavity cancer. It is thus desirable to scientifically validate phytochemicals in order to integrate alternative medicine as part of national cancer management strategy. *In silico* advanced studies on secondary metabolites of medicinal plants traditionally used to treat oral cancer are in progress.

In memoriam

We are indebted to you Dear Professor Pakasa Muyulu Nestor, for initiating the present research project. Here are today the fruits of your effort which you do not consume. We will keep your wise counsel and good manners. May your soul rest in peace and may the land of our ancestors be sweet and light to you.

COMPETING INTERESTS DISCLAIMER:

Authors have declared that no competing interests exist. The products used for this research are commonly and predominantly use products in our area of research and country. There is absolutely no conflict of interest between the authors and producers of the products because we do not intend to use these products as an avenue for any litigation but for the advancement of knowledge. Also, the research was not funded by the producing company rather it was funded by personal efforts of the authors.

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