



UNIVERSIDADE FEDERAL DE UBERLÂNDIA

FACULDADE DE ODONTOLOGIA



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**TRATAMENTO ODONTOLÓGICO EM PACIENTES COM
CÂNCER DE CABEÇA E PESCOÇO: REVISÃO DE
LITERATURA**

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LITERATURA**

Trabalho de conclusão de curso apresentado
a Faculdade de Odontologia da UFU, como
requisito parcial para obtenção do título de
Graduada em Odontologia

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RESUMO

Estabelecer protocolos clínicos odontológicos e discorrer sobre pontos de importância no atendimento clínico de pacientes que passaram por tratamento radioterápico, elucidando os possíveis efeitos da radiação ionizante na estrutura óssea da região irradiada e os possíveis efeitos colaterais decorrentes tais como a osteorradionecrose. As condutas clínicas serão abordadas e embasadas por meio de evidências científicas a fim de orientar o profissional no manejo do paciente após radioterapia em região de cabeça e pescoço na realização de procedimentos invasivos ou não invasivos. A base de dados usada foi o MEDLINE (PubMed) e foram selecionados trinta e três estudos originais e revisões. O idioma foi restrito ao inglês e não foi aplicada restrição do ano de publicação. Os termos utilizados para a busca foram os seguintes: radioterapia, osteorradionecrose, tratamento dentário. Os estudos selecionados envolviam manejo clínico com foco em protocolos em pacientes pós radioterapia. O tratamento odontológico em pacientes pós radioterapia pode ser realizado, porém deve ser priorizado ser menos invasivo possível. É necessário a realização por parte do profissional de um plano de manutenção de saúde bucal para o paciente antes, durante e depois do tratamento com radiação ionizante, a fim de evitar a necessidade de procedimentos de maior complexidade e mais invasivos.

Palavras-Chaves: Câncer de cabeça e pescoço; Radioterapia; Osteorradionecrose.

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Clinical dental management of the head and neck irradiated patient:

Topics of interest for clinicians

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Abstract

Background: To discuss important topics regarding the dental procedures performed in patients before, during and after the radiotherapy treatment. The biological effects of ionizing radiation on bone tissue focusing on clinical care will be described. The invasive and not invasive procedures after radiotherapy treatment in the head and neck region will be addressed using scientific evidences to determine the appropriate moment for tooth extractions, periodontal management, and preventive procedures for osteoradionecrosis.

Material and Methods: Thirty-three studies including original studies and reviews were selected in MEDLINE database (PubMed). No year of publication restriction was applied. Language was restricted to the English, and the following Medical Subject Heading terms were used: radiotherapy, osteoradionecrosis, dental management. Studies of osteoradionecrosis involving clinical management of irradiated patients, with an emphasis on updated guidelines and protocols were selected

Conclusions: The dental procedures should and can be performed before, during but also after radiotherapy. However, the clinical procedures should be less invasive as possible. A maintenance plan that reduces the necessity for major and more invasive treatments after radiotherapy is recommended.

Key words: Head and neck cancer. Radiotherapy. Osteoradionecrosis.

Introduction

Radiotherapy (RTX) treatment is widely used to treat various types of head and neck cancers¹. The purpose of RTX is to control the growth or elimination of the tumor¹, reducing the possibility of recurrence and improving the patient's quality of life¹. RTX treatment is indicated as a palliative protocol of incurable cancers¹. Despite of the benefits of this therapy, some patients frequently are involved with adverse effects caused by ionizing radiation^{2,3}. The main complications associated with RTX are: mucositis, xerostomia, changes in salivary quality and quantity, opportunistic infections, tissue fibrosis, sensory dysfunctions such as dysgeusia, increased periodontal disease progression, caries and osteoradionecrosis (ORN)⁴. These interurrences can have acute manifestation, during the treatment, or chronic manifestation after the completion of the treatment⁴.

The clinical characteristic of ORN is bone necrosis due to hypoxia, hypovascularization and hypocellularity⁵, with loss of mucosal integrity, associated or not with oral environment bone exposure². The ORN is the most serious adverse effect of RTX, compromising the tissue integrity and health of the oral structures. The ORN incidence ranges from 5 to 30% of patients who have undergone head and neck RTX³. The incidence of RTX has decreased with the use of the most modern radiation techniques³.

Several risk factors are associated with the development of the ORN, such as smoking, periodontal disease, alcohol abuse, intensity and duration of radiation².

Controlling the risk factors is important to minimize the development of ORN. The approaches proposed for the treatment of ORN involve non-invasive techniques such as maintaining the quality of oral hygiene, the use of antibiotic therapy, and also extensive surgical procedures to remove the necrotic bone². The high uncertainty rate of the infection control is a factor that must be considered for choosing the ideal treatment².

The knowledge about the manifestations caused by ionizing radiation in the oral cavity has great importance for clinicians. Many professionals still have doubts regarding the treatment planning and the management of patients involved with RTX. Therefore, this study aimed to describe and clarify the dental procedures performed by clinicians in cancer patients before, during and after RTX treatment.

Materials and methods

Thirty-three studies were included in this review. twenty-one these studies were original researches while twelve were reviews. These studies were searched in the MEDLINE databases (PubMed). All selected through the focus on the management of irradiated patients in the head and neck region. No publication year restriction was applied. The language was restricted to English, and the following Medical Subject Heading terms were used: radiotherapy, osteoradionecrosis, dental management. Studies on osteoradionecrosis involving clinical management of irradiated patients, with an emphasis on updated guidelines and protocols, were selected.

1. Dental procedures before and during RTX treatment

Before starting RXT, the professional must perform all necessary adequacy of the oral environment¹. Caries lesions treatment, subgingival scaling, endodontic treatments or tooth extraction that could be the focus of infection should be performed². These procedures should be performed at least two weeks before to start the RTX treatment². The prevention of ORN is based on elimination of the oral cavity infectious conditions at the pre-RXT phase, as well as to prevent the invasive procedures during and after RXT treatment⁶. Monitoring the quality of oral hygiene should be also always performed, since the development of ORN is also associated with poor oral hygiene⁶.

During the irradiation period, mucositis, opportunistic infections such as candidiasis, salivary gland dysfunctions such as xerostomia and taste alterations are

frequently reported by patients⁷. During the RTX, invasive dental procedures are not recommended². Prior monitoring the patient oral conditions should be performed², except in cases the occurrence of an emergency, then the invasive procedures are necessary for maintaining the patient's safety and health.

2. Dental procedures after RTX treatment

Post- RXT patients may have chronic complications such as ORN, xerostomia and trismus⁷. The irradiated patients may need dental care requiring the performance of various dental procedures, such as tooth restorations, endodontics, rehabilitation, among others^{8,9}. It is important that clinicians understand the consequences of RTX on the mucosa, bone tissue and dental tissue to prevent the installation of ORN and failure of clinical procedures¹⁰.

Ionizing radiation produces hypoxia, hypocellularity and hypovascularization that can alter the regenerative potential of the soft and hard tissues^{2, 11, 12}. Changes in tooth and bone structure can occur due to degradations in amine components that can mechanically alter enamel^{13, 14}, dentin¹⁰, and bones^{12, 13, 15}. The effect of ionizing radiation on the salivary flow and the xerostomia reduce the protection of this fluid against pathogens and enhance the friction on the mucosa during the oral chewing that could be the trigger for the occurrence of the mucositis lesions¹⁶.

2.1. Extractions

Post-RTX extraction is an important risk factors for the development of the ORN¹⁷, then this procedure should be avoided during this period³. A safety period for the development of the ORN is inconclusive^{3, 10}. The tooth extractions performed during post-RTX can result on ORN, due the invasive procedure in bone and mucosa tissues, which can compromise the microarchitecture and vascularization^{3, 5, 10, 17}.

A retrospective study evaluated 32 patients with tooth extraction after RTX and showed the ORN in 12.1% (9 patients)¹⁷. The patients with ORN received higher radiation dose (62.0 Gy vs. 37.4 Gy) and longer treatment time until extraction (41.2 months vs. 28.2 months) than the groups of patients without ORN. The recent systematic demonstrates that the presence of risk factors such as smoking, radiation dose and duration of treatment are more predictable aspects in decision-making when performing dental extractions than the time after RTX³.

The possibility of occurrence of ORN after tooth extraction is a possible and uncertain complication. If necessary, the extraction should be performed less traumatically possible, avoiding large flaps and osteotomies in order to improve the

healing process². Adjunct therapies, such as photobiomodulation, ozonotherapy, PENTOCLO protocol, hyperbaric chambers, may also be indicated, as early intervention may reduce the risk of ORN¹⁸.

2.2 Restorative treatment

In irradiated patients increased the risk of developing dental carious lesions due to multiple factors^{19, 20}. The development of carious lesions after RTX treatment can occur mainly from three months after irradiation and can lead to a severe oral health impact^{13, 20, 21}. These effects can occur due to the degradation of the organic components of dentin and enamel, which stimulate the increasing of its rigidity, making less efficient to support occlusal forces, which leads to the tooth wear^{21, 22}. The reduction or qualitative alteration of salivary flow turns the patients as a greater risk for developing dental caries due the limited pH buffering function promoted by saliva, as well as the dryness of the oral mucosa that makes oral hygiene procedures more uncomfortable^{16, 22}.

The rapid progression of the carious lesions on enamel and dentin and the structural substrate changes make the restorative protocols a major challenge due the poorly adhesive interaction with the dental substrate^{10, 22, 23}. It has been indicated the use of the neutral fluor application periodically^{21, 24}. In patients with xerostomia and high risk of radiation carious lesions and poor adherence to preventive fluoride therapy, the use of conventional and resin modified glass ionomer cement are more effective in protecting recurrent carious lesions⁸.

2.3 Surgical and non-surgical periodontal treatment

Periodontal disease occurs due to an imbalance between the periodontal microbiota and the host response, and the process of oral dysbiosis may be responsible in part for the disease progression⁶. RTX can be an important agent for periodontal microbiota dysbiosis due to reduced salivary flow, which is associated with less efficient oral hygiene²⁵. RTX induced fibrotic effects on connective tissues make periodontal tissues less competent in regenerative processes due to reduced oxygenation found especially in terminal-type circulation²⁶. These effects together increase the host's susceptibility to present more aggressive periodontal disease, increasing the risk of tooth loss after RTX treatment²⁷.

Due to the risks of ORN after tooth extraction, a personalized treatment and maintenance plan must be indicated considering the periodontal health status and systemic conditions pre-RXT⁶. The treatments must be completed as soon as

possible before RTX, being the full-mouth scaling technique is indicated^{25, 27}. Periodontal therapy for head and neck cancer implemented before, during and after treatments results in a significant improvement on periodontal health, but this therapy should be maintained, otherwise periodontal disease continues its progression^{6, 26}.

2.4 Endodontic treatment

Due to the increased carious lesions activity in patients after RTX, endodontic treatment should be necessary to avoid more aggressive procedures such as extraction^{9, 19}. However, some factors such as the reduction of the dental pulp oxygenation the structural tooth fragilization can complicate the diagnosis and reduce the endodontic treatment success^{9, 19}. Pulp oxygenation levels are reduced after 4-6 months, which can impair pulp diagnosis by promoting a negative sensitivity response in vital pulps and directing unnecessary endodontic interventions¹⁹. It is necessary to await at least 6 months after the radiotherapy to perform the sensibility pulp tests. The endodontic treatment associated with RTX, can increase the tooth structural weakening¹⁹. Resin composite restorations are recommended to direct restorative material for restoring the endodontically treated teeth, strongly avoiding the use of the amalgam²⁸. It is also important and recommended to replace amalgam restorations prior to RTX treatment²⁸.

2.5 Rehabilitation for edentulous regions using prostheses and implants

Most irradiated patients mainly seek treatment for edentulous regions, usually as a result of multiple tooth extractions performed before RTX treatment¹⁰. Oral rehabilitation is important to improve the patient's quality of life²⁹. It is essential that the clinicians understand the procedures that should be avoided in this post-radiation period³⁰. Treatments with partial or complete dentures must be carefully performed. The patient follow-up is essential so mismatched dentures can cause damage to the mucosa can generate trauma that predisposes ORN^{29, 31}.

It is not well established the safer rehabilitation procedure for post- RTX patients³⁰. When fixed prostheses are indicated, it should be taking in consideration that the tooth substrate after the RTX become more fragile, reducing the predictability of this treatment¹⁰. Another alternative for oral rehabilitation is the use of dental implants supported prostheses without interfering with compromised mucous membranes and teeth^{30, 31}. The installation of implants prior to RTX is safer procedure with high success and survival levels³¹. The installation of implants after the RTX period present a slightly higher level of complication compared with the

implants installed in the general population³⁰. The innovations on macrostructure and microstructure implants surface, and on the implant installation techniques guided by surgery without flap opening, can make the rehabilitation of post-radiotherapy patients increasingly safer and more predictable, but this clinical procedures still requires further investigations.

Discussion

The treatment of head and neck cancer is an extremely challenging condition for maintain the patient's quality of life. The patients tend to resist to the highly aggressive treatments such as extensive surgery to remove the tumor, the RTX protocol, and in many situations to perform multiple tooth extractions prior to the RTX³. During and after the period of active treatment, therapeutic planning aiming proper oral rehabilitation is necessary in order to limit the acute and chronic damage caused by cancer treatment². It is important to recognize that the effects of RTX are cumulative, and the indication of the dental procedures must consider the limitations imposed by the alterations on the dental and bone caused by irradiation, avoiding as much as possible the occurrence of ORN.

To avoid this complication, has been suggested not performing dental extraction due the ORN¹⁷. Bone tissue intervention should ideally be performed before RTX³. This indication is based on the progressive process of connective tissue fibrosis that reduces the vascularization, cellularity and oxygenation of oral tissues, especially bone tissue, which can impair the repair processes^{5, 10, 11, 26}. The bone tissue has the slower regenerative potential than soft tissues^{2, 5, 12, 26}. During the healing phase, especially the post-extraction alveolar repair occurred by second intention, makes this tissue more susceptible to contamination and subsequent development of necrotic lesions, which are difficult to treat².

There is an important relationship between the occurrence of cancer in the head and neck region and poor periodontal conditions, since the risk factors are shared^{25, 27}. It is expected that patients indicated for RTX treatment may have more severe and active periodontal disease than the general population²⁷. Periodontal treatment after RTX should be performed as quickly and less aggressively as possible, avoiding surgical procedures to access root surfaces^{6, 27}. Supportive periodontal therapy should be performed at least every 3 months to prevent disease progression that the risk of tooth loss⁴. It is recommended that teeth with a

questionable periodontal prognosis should be removed at least 14 days prior to initiation of RTX²⁶.

If the treatment plan and preventive procedures before RTX are indicated for the teeth maintenance. Special attention is essential due the changes in the protein portion on the dentin, enamel and at the cementoenamel junction substrate. Associated with the salivary flow reduction the developing radiation carious lesions is increased^{13, 20}. The adhesive systems efficiency is reduced in forming proper hybrid layer to dentin substrate and the different restorative materials¹⁰. Thus, restorative materials that allow the continuous release the fluoride, such as conventional or resin modified glass ionomer cements should be chosen, reducing the recurrent carious lesions, and the dependence on the bonding interface promoted by adhesive systems¹⁰. More extensive carious lesions with pulp involvement may indicate endodontic therapy, that will further weaken the tooth structure affected by RTX³².

The dosage used and the time elapsed of the RTX should be taken in consideration during the planning of the rehabilitation of the edentulous areas²⁶. It has been described that muco-supported prostheses must be well adapted to avoid trauma to the mucosa, as this tissue is also fragile and can more easily lose its integrity and expose the adjacent bone tissue²⁹. The denture-supported dentures planning must consider the quality of the remaining abutment teeth, avoiding involving teeth with large restorations with endodontic treatment as abutments^{9, 19}. Teeth with a history of periodontal disease are more susceptible to disease progression after RTX and should also be avoided as support for prostheses⁴.

The security of the implant placement in patients after the RTX are inconclusive. It has been described that the rehabilitation with dental implants has been indicated as a good alternative to rehabilitate patients after RTX and has shown relatively good levels of clinical survival³¹. It has been also showed that the bone tissue surgery may present higher risk factor for the ORN installation³¹. Indeed, the myriad of protocols of RTX impairs a properly documentation regarding the safety for implants placement in these patients¹⁷.

Technological advances may improve the outcomes of the oral treatment in the RTX patients. The advances in the mechanical of the restorative materials associated with adhesive procedures, and preventive protocols may improve the treatment complication related with the carious lesions^{9, 28}. The implants design and microstructure advantages, as well as the use of less traumatic surgeries may

enhance the oral rehabilitation predictability³³. In addition, the dental therapy may become more safety as much the RTX protocols become more focused on injuries³⁰. The dental treatment after RTX is possible to be performed, but they should be less invasive as possible.

In conclusion, the dental procedures before, during and after RTX should be performed, however they should be always less invasive as possible. However, the type complexity of the treatment is patient and moment dependent. A maintenance plan performed before, during and after RTX is strongly recommended to reduce the necessity for major and more invasive treatments after radiotherapy.

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