

Assessment of Oral Health Related Quality Of Life among Oral Cancer Patients- An Insight Review

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Abstract: Recent legislation aims to improve oral health by increasing access to care and focusing research attention on subjective patient evaluations related to OHRQoL (Oral Health Related Quality of Life). Oral health and quality of life are compromised in radiation and chemotherapy of the head and neck. Given our current economic and healthcare challenges and the resulting political debate around curtailing healthcare costs, access to care is a major policy issue. Using the association between oral health conditions and OHRQoL among oral cancer patients can be an effective mechanism to communicate with policymakers to reveal the importance of oral health and equal access to care. Assessment of OHRQoL may facilitate decision-making for oral cancer patients, healthcare providers, and policymakers.

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Despite recent advances in diagnosis and treatment, oral cancer remains associated with disfigurement and dysfunctions that affect essential domains of life. The importance of assessing the self-reported evaluation of functional status and well-being of patients with cancer has been well documented in the literature.

The adoption of a QOL assessment as a standard procedure in hospital settings can contribute to anticipate interventions aimed at reducing the impact of therapeutic applications and improve subsequent patient management. For patients with oral cancer, the self-oriented QOL evaluation is a useful adjunct to the more traditional measures assessing the effectiveness of therapies.^{1,2}

The term “quality of life” can be identified in Aristotle’s classical writings of 330 BC. In his Nichomachian ethics, he recognizes the multiple relationships between happiness, well-being, “eudemonia,” and quality of life. Historically, the concept of quality of life has undergone various interpretations involving personal experience, perceptions and beliefs, attitudes concerning philosophical, cultural, spiritual, psychological, political, and financial aspects of everyday living.

Quality of life is used to describe not only individuals’ general “well-being,” but of societies, as well; and it is quite different with the concept of standard of living, which is based primarily on income. Widely adopted indicators of the quality of life include wealth, employment, built environment, physical and mental health, education, recreation, and social belonging.

Quality of life has been extensively used both as an outcome and as an explanatory factor in relation to human health, in various clinical trials, epidemiologic studies, and health interview surveys. In particular, several randomized clinical trials have assessed the impact of the tested intervention on patients’ physical and mental health, while observational studies have assessed the role of quality of life on peoples’ health status and life expectancy.³ During the past years quality-of-life scales have become firmly established as a routine part of evaluating interventions and in planning health care, including oral health.⁴

The impact of oral diseases on the quality of life is very obvious. The psychological and social impact of such diseases on daily life is easily comprehensible which makes them of considerable importance. It is evident from the literature that the notion of OHRQoL appeared only in the early 1980s in contrast to the general HRQoL notion that started to emerge in the late 1960s. Several authors have explored the evolution of OHRQoL and documented the circumstances that have led to its prominence. Thus OHRQoL concept started to evolve as more evidence grew of the impact of oral disease on social roles.

A simple definition is the one provided by the United States Surgeon General’s report on oral health which defines OHRQoL as “a multidimensional construct that reflects (among other things) people’s comfort when eating, sleeping, and engaging in social interaction; their self-esteem; and their satisfaction with respect to their oral health”.

The concept of OHRQoL is significant to 3 areas of dental health in particular; these are the clinical practice of dentistry, dental education and dental research. OHRQoL has an obvious role in clinical dentistry which translates into the clinicians’ recognition that they do not treat teeth and gums, but human beings.

Also oral-related behaviour such as practising good oral hygiene, having regular check-ups, and spending more money on aesthetic dental care are motivated by OHRQoL concerns. Likewise, the same approach is more useful to educate individuals about their oral health. People are more likely to behave positively when they understand how oral diseases affect their general health and quality of life rather than simply the affect of such disease on their teeth or gums.

The notion of OHRQoL is tremendously important at all levels of dental research. Successful research, whether basic scientific research, clinical studies or community research, makes a contribution to patients' quality of life. At the community research level, the concept of OHRQoL is especially vital to promote oral health care and access to care.⁵

Researchers have developed quality of life instruments specific to oral health and the number continues to grow rapidly to comply with the demand of more specific measures. OHRQoL instruments vary widely in terms of the number of questions (items), and format of questions and responses. Multiple items questionnaires are the most widely used method to assess OHRQoL.

One of the most widely used indicators in different cultures and sociodemographic profile is the oral health impact profile (OHIP). The OHIP measures people's perception of the social impact of oral disorders on their well-being.

Developed by Slade and Spencer, the proposed questionnaire measures dysfunction, discomfort and disability attributed to oral condition. Originally composed of 49 items, the conceptual index involves seven dimensions: functional limitation (e.g., chewing difficulty), physical pain (e.g., toothache), psychological discomfort (e.g., self-confidence), physical disability (e.g., food restriction), psychological incapacity (e.g., affected concentration), social disability (e.g., is less lenient with others) and functional incapacity (e.g., become completely incapable functionally). The questionnaire is answered on a five-point Likert type, scale (never, rarely, sometimes, often and always).⁶

If a condition-specific OHRQoL measure is being developed, the condition and/or its symptoms must also be responsive to treatment. In short, the measure must have effective evaluative properties.⁷ Since OHRQoL is considered an important value to analyze the progression in oral cancer, multiple methods have been developed in order to gather the data. Diary and closed- and open-ended psychological interviews with a different structure have been used, which preceded regulated questionnaires with a precise number of graded questions.

From the time of the diagnosis, the quality of life for every cancer patient and survivor is affected in some way or the other. The American Cancer Society has identified four quality of life factors that affect cancer patients and their families. These factors are social, psychological, physical and spiritual. Aesthetics and functional sequelae which are caused by surgical incisions and cancer resections, which are often associated with pre or post operative radiotherapy, always modify the patient's self perception and their ability to interact with others in the daily social life. While the body scars and alterations are usually hidden during the social activities, and dramatic situations such as a permanent colostomy or a vascular shunt for dialysis can be easily managed in public, the head and neck cancer patients cannot hide the post treatment functional changes and they must therefore, deal with the subsequent negative impact on their self-esteem and confidence in all the realms.⁸

Oral cancer normally causes an important lack of quality of life (QL) in patients. After the diagnosis and treatment of a patient with oral cancer, the mostly values of the orofacial sphere affected are deglutition, mastication, salivation and speech skills. Patient's and family's social relationships can also be affected, prompting isolation and a loss of general cognitive, social, emotional or physical functions. This will determine a decrease in general QL assessment and specific items that measure oral cavity and facial esthetic functionality. Nowadays, patients with oral cancer are orientated towards a multidisciplinary approach establishing an integral treatment strategy. This strategy must fulfill the patient's needs and expectations from the first consultation until all complications derived from the disease and treatment have been solved.⁹

With increasing focus of health policy to address health promotion and disease prevention, HRQoL and OHRQoL have come to incorporate both positive and negative perceptions of oral health and health outcomes (Broder and Wilson-Genderson, 2007). Thus, assessments of oral health can reflect both negative impact and enhancement of self and well-being.⁷

Future lines of work should be aimed not only at the control of the oral cancer, but also to a function and esthetic improvement after treatment, turning to ultimate microsurgery reconstruction techniques and dental restoration with implants, as well as psychological support for the patient and family, all this targeted to achieve patients satisfaction, minimizing resources and alterations caused by iatrogenic interventions. Essential oral care before, during and after cancer treatment can prevent or ease the occurrence and severity of oral complications, improving patient survival and OHRQoL.

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