

Oral Health-Related Quality of Life of Patients With Oral Lichen Planus, Oral Leukoplakia, or Oral Squamous Cell Carcinoma

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Purpose: To compare oral health-related quality of life (OHRQoL) of patients with oral lichen planus (OLP), oral leukoplakia (OL), or oral squamous cell carcinoma (OSCC).

Materials and Methods: Seventy-three patients with OLP, 44 with OL, and 37 with OSCC participated in this prospective study. The German version of the 14-item Oral Health Impact Profile (OHIP-G 14) was used to measure OHRQoL. Descriptive statistics and multivariate analysis of clinical forms, age, gender, alcohol consumption, and smoking habits were evaluated.

Results: No association to cumulative OHIP-14 score ($P = .086$) among the 3 groups was found. However, patients with OLP showed a higher “physical pain” score and a lower “social disability” score ($P = .026$) than patients with OSCC, followed by patients with OL. Women with OLP had a lower OHRQoL than men. After differentiation of clinical forms of OLP (symptomatic vs asymptomatic), an impact on these patients’ OHRQoL in the dimensions “physical pain” and “physical disability” was found.

Conclusion: Patients with OLP or OSCC and high OHIP-G 14 scores reported physical pain, which emphasizes the need for physical therapy. For improved OHRQoL, patients with symptomatic forms of OLP would gain more from a treatment compared with those with asymptomatic forms. In contrast, patients with asymptomatic OLP or OL and thus with a minimal impact on their OHRQoL might be at risk of delayed consultation, diagnosis, and treatment of their condition.

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Oral diseases, such as oral lichen planus (OLP), oral leukoplakia (OL), and oral squamous cell carcinoma (OSCC), are frequently seen in oral and maxillofacial surgical departments. In premalignant oral diseases, such as OL¹ and OLP,² malignant transformation into an OSCC can occur at a range of 1 to 18%.^{3,4} Monitoring such lesions by a specialist is strongly recommended to detect these carcinomas at an early stage.⁵ Frequently, the malignant potential of oral diseases is differentiated only through histologic evaluation and early detection of cancer remains the best way to ensure patient survival and quality of life.

The impact of OLP, OL or OSCC on oral health-related quality of life (OHRQoL) seems to be variable. Therefore, consultation of physicians can be delayed.⁶ For patients with OLP, high levels of stress, anxiety, and depression have been reported.⁷ Chaudhary⁷ described these psychological factors as the cause for the occurrence of OLP. Therefore, the clinical management of OLP characteristics poses considerable difficulties to the oral physician and the dermatologist. Different clinical classifications are used to characterize OLP. The most common classification was developed by Andreasen⁸ in 1968. Although OLP is often asymptomatic, it

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can cause symptoms ranging from burning sensations to severe pain, which interfere with speaking, eating, and swallowing.⁹ OHRQoL seems to play an important role in patients with OLP in relation to the chronic character, different clinical forms, psychological influences, and difficulties in treating the disease.^{10,11}

OL as a premalignant lesion has an important differential diagnosis from OLP and is often difficult to distinguish from OLP. OHRQoL of patients with OL has been evaluated in 2 articles.^{12,13} The main focus was mostly on the profiling of early OSCC. After treatment of OSCC, these patients have an impairment in OHRQoL,^{14,15} depending on tumor classification and therapy. To measure OHRQoL of patients with OSCC, scales of the European Organization for Research and Treatment of Cancer (EORTC) scales are often used. The EORTC QLQ-C-30 questionnaire was developed to assess the quality of life of patients with cancer supplemented by disease-specific modules for those with head and neck cancer (EORTC H&N-35).¹⁶⁻¹⁸ The impact of OSCC on patients' OHRQoL at the time of diagnosis and before treatment of OSCC, has been mentioned only in a small number of articles.¹⁹

The Oral Health Impact Profile (OHIP) is a common questionnaire used for measuring OHRQoL and is often used to measure OHRQoL during diagnosis and therapy of oral diseases.

The aim of this study was to measure and compare the OHRQoL of patients with OLP, OL, and OSCC using the German version of the 14-item OHIP (OHIP-G 14) and to determine whether the different clinical forms of OLP, OL, or OSCC and patients' gender, age, alcohol usage, and smoking behavior would have an influence on OHRQoL before therapy. The description of OHRQoL of these patients highlights the need for the improvement of the treatment depending on the influence of these diseases and their specific OHRQoL profile.

Materials and Methods

One hundred fifty-four patients participated in this prospective study. All patients presented sequentially in 2010 as new patients in the Department of Oral Surgery of the University Medical Center in Mainz, Germany. The inclusion criterion was a clinical diagnosis of OLP, OL, or OSCC. Patients who had been examined previously or underwent therapy for the oral lesions were excluded. The study protocol was approved by the local ethics committee. After a detailed explanation of the purpose of this project, informed verbal and written consent was obtained from each patient. Then, participants were asked to complete the OHIP-G 14, which was used to evaluate their OHRQoL. Three patients with clinical signs of OLP, 1 patient with OL, and 2 patients with OSCC refused to participate in the study. Reasons for refusal were a limit of time for 2 patients with OLP, a language barrier for 1 patient with OLP and 1 patient with OL, and multiple morbidities in 2 patients with OSCC.

The OHIP-14 (short form), developed by Slade²⁰ and translated into German by John et al,²¹ was used to determine the degree of impact of the different oral diseases on 7 dimensions (2 items per dimension; Table 1). The questions can be answered using a Likert scale (never = 0; barely = 1; sometimes = 2; often = 3; really often = 4). An analysis can be made of the total score or the score for each subscale. The maximum score for the complete OHIP-14 is 56, and in each dimension the maximum score is 8. The OHIP-G 14, as a standardized characterization of the subjective OHRQoL, was used as a snap-reading method to describe the oral pain and psychosocial effects on OHRQoL. The OHIP refers to the past month and it was chosen because of its common usage. It also proved to be useful in evaluating normal population data.

Table 1. COMPARISON OF PATIENTS WITH OLP, OL, AND OSCC IN SEVEN DIMENSIONS AND TOTAL OHIP-G 14 SCORE

OHIP-14 Dimensions*	P Value†	OLP (n = 73)	OL (n = 44)	OSCC (n = 37)
Functional limitation	.762	0.73 ± 1.5/1.3	0.66 ± 1.3/1.2	0.81 ± 1.5/1.6
Physical pain	.009	3.12 ± 2.8/5.6	1.73 ± 2.3/3.1	2.27 ± 1.9/4.6
Psychological discomfort	.933	2.01 ± 2.5/3.6	1.91 ± 2.6/3.4	1.81 ± 2.0/3.8
Physical disability	.116	1.15 ± 1.9/2.0	0.66 ± 1.8/1.2	0.78 ± 1.4/1.7
Psychological disability	.302	1.03 ± 1.7/1.8	0.82 ± 1.6/1.4	1.14 ± 1.6/2.3
Social disability	.026	0.68 ± 1.6/1.2	0.57 ± 1.2/1.0	1.11 ± 1.5/2.1
Handicap	.324	0.70 ± 1.4/1.3	0.61 ± 1.4/1.0	0.84 ± 1.3/1.4
OHIP-14 (all items)	.086	9.42 ± 11.4/16.8	6.95 ± 10.2/12.4	8.81 ± 8.6/19.1

Note: Values are presented as mean ± standard deviation/percentage.

Abbreviations: OHIP-G 14, German version of 14-item Oral Health Impact Profile; OLP, oral lichen planus; OL, oral leukoplakia; OSCC, oral squamous cell carcinoma.

* Total score: maximum, 56; each of the 7 dimensions comprising 2 questions: maximum, 8.

† One-way analysis of variance was used to compare groups.

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