PEDIATRIC ORAL & MAXILLOFACIAL TUMOURS

LIBRARY DISSERTATION

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"In order to cure a disease you have to first understand its patterns". This applies to any disease occurring in patients in every age group but it becomes especially important when we deal with cancers in children. A child has more years of life to be lost or gained as a result of cancer than any adult with cancer; they have an entire lifetime at stake in comparison to adults. Hence it is important for the clinicians involved in the diagnosis & treatment of pediatric head & neck tumours to understand certain of the patterns that follow the development of these lesions, so that misdiagnosis & delays in treatment can be avoided.

Cancer ranks second only to trauma as a cause of childhood mortality. It represents the leading cause of death from disease in children 1-15years of age. The majority of childhood cancers are malignant solid tumours in children. An estimated 5-10% of primary malignant tumours in children originate in the head & neck area, & one in four malignant lesions have eventual manifestations in the head & neck region. **(Cunningham et al, 1996)[1]**

Oral tumours in children constitute approximately 3% of all tumour like growths in the oral cavity, jaws & salivary glands in all age groups. **(Bluestone et al, 1996)[2]**

The principal difference between cancers of children & adults is that the former include several embryonic tumours & the latter are most often epithelial tumours. The most obvious difference between these two kinds of tumours is that the precursor target cell is a generative stem cell in one (e.g. retinoblast, neuroblast, nephroblast) & a renewal stem cell in the other. 80% of observed adult cancer cases are induced; hence preventive