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A Short Note on the Quality of Life of Patients with Tongue Cancer

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Introduction

Speech- language pathology occurs in the presence of head and neck excrescences that affect the regions of the nose, lips, lingo, jaw, nib, hard and soft palate, naso pharynx, oropharynx, hypo pharynx, larynx, thyroid, salivary glands, and oral depression. Due to these excrescences' position, the proposed treatments of surgery, chemo radiotherapy, or combination, will affect in temporary or endless speech diseases. The oncological speech therapist is responsible for coordinating the comprehensive care with the multidisciplinary platoon, both in primary care(forestallment, creation, support, palliative care) and in technical care, following from the stage of opinion, ahead, during, and after clinical or surgical treatment The prevalence of oral depression cancer is high in Brazil, ranking fifth among the most common excrescences in men.1 Epidemiological studies conducted in several Brazilian metropolises indicate that the lingo is one of the main spots affected by these excrescences, with a 30 – 40 frequence, and is responsible for high morbidity and mortality rates.

The lingo is the promoter in the deglutition process. In the oral phase, it provides perception of the gelcap' volume, thickness, and flavor, situating it and serving as the main source of pressure for propelling it towards the pharynx and esophagus. The effectiveness of this phase is abecedarian for the posterior phases to do stoutly, and the integrity of complex neurophysiological control is necessary for its functionality [1]. Concern has been expressed in the literature about the description and evaluation of swallowing QOL in lingo cancer cases still, studies on speech remedy intervention in these cases are still uncommon, generally case studies or interventions performed by multidisciplinary brigades. Therefore, the present study aimed to corroborate the impact of speech remedy on swallowing QOL in lingo cancer cases after treatment[2]. In the first speech remedy session, the SG entered guidance on deglutition operation, including implements use, meter and posture while eating, and acclimations in the thickness, volume, and temperature of the food [3]. They were also tutored exercises and speech remedy ways to be repeated in five sets, three times a day. The ways were aimed at perfecting swallowing and were named in view of the actors 'post-surgical deconstruction, grounded on both clinical practice and the literature. Orofacial and laryngeal muscle stretching and mobility exercises, airway protection pushes and tactile/ thermal/ gustatory sensitive stimulation ways were used [4]. The guidelines and exercises were handed in writing to the actors at the first session, with posterior sessions conforming of review and reorientation According to tone- reported enhancement in dysphagia inflexibility andpost-intervention QOL scores, speech remedy had a positive impact on swallowing QOL cases who had been treated for lingo cancer. There was also a significant correlation between QOL enhancement, reduced dysphagia inflexibility and advanced FOIS scores, which led to more swallowing function[5]. still, in general, the speech therapist's performance, in utmost cases, is confined to the mending phase. There are veritably many cases when the speech therapist participates during thepre-treatment phase in a multidisciplinary platoon and in the remedial decision[6]. The most common is the performance after surgical treatment and or chemoradiotherapy. In surgical cases, speech remedy generally starts 15 days after surgery if there are no complications. This period varies according to each sanitarium and depends on the suggestion of the medical platoon[7]. When allowed to start conditioning, the speech therapist performs a clinical and necessary evaluation of all the remaining structures and functions. In the original phase of treatment, speech remedy's primary ideal in head and neck cancer is the recuperation of swallowing. Utmost of the time, the case witnessing surgery uses a feeding tube, gastrostomy or jejunostomy, to eat. When the case can swallow safely, without aspiration and with acceptable oral conveyance time, the indispensable feeding route can be removed [8]. During the training for the oral route's reintroduction, the speech therapist defines the most applicable thickness of the food and starts to perform sensitive stimulation, pushes to cover the airways and postures, strengthening exercises followed by the function[9]. A set of conduct to grease swallowing is indicated for each case. Speech remedy monitoring contributes to expand the communicative eventuality, esteeming the rehabilitative prospects and limits of the complaint[10]. Rehabilitation will seek to alleviate the anatomical changes detected in the case, leading to advanced quality of life and socialization. This monitoring will be short, medium, or long term, depending on the sequelae's inflexibility. still, the process doesn't always develop in this ideal way. In a retrospective descriptive study conducted in Olinda PE in 2016, with a quantitative approach, cancers of the lingo and oropharynx were the main primary excrescence spots set up among the subjects who failed. likewise, in this sample, only a many entered an suggestion for speech remedy during the complaint. still, the process doesn't always develop in this ideal way[11]. In a retrospective descriptive study conducted in Olinda PE in 2016, with a quantitative approach, cancers of the lingo and oropharynx were the main primary excrescence spots set up among the subjects who failed. likewise, in this sample, only a many entered an suggestion for speech remedy during the complaint[12]. Phononcology is busy dealing with conditions' consequences and, despite an little given subspecialty in the speech remedy field, relates specifically to a recuperation process among cancer cases with tremendous scientific exploration in the literature.

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