Oral Cavity and Oropharyngeal Cancer Early Detection, Diagnosis, and Staging

Detection and Diagnosis

Catching cancer early often allows for more treatment options. Some early cancers may have signs and symptoms that can be noticed, but that is not always the case.

- Can Oral Cavity and Oropharyngeal Cancers Be Found Early?
- Signs and Symptoms of Oral Cavity and Oropharyngeal Cancer
- How Are Oral Cavity and Oropharyngeal Cancers Diagnosed?

Stages and Outlook (Prognosis)

After a cancer diagnosis, staging provides important information about the extent of cancer in the body and anticipated response to treatment.

- How Are Oral Cavity and Oropharyngeal Cancers Staged?
- Survival Rates for Oral Cavity and Oropharyngeal Cancer by Stage

Questions to Ask Your Cancer Care Team

Here are some questions you can ask your cancer care team to help you better understand your cancer diagnosis and treatment options.

- What Should You Ask Your Doctor About Oral Cavity and Oropharyngeal Cancers?

Can Oral Cavity and Oropharyngeal Cancers Be Found Early?
Many pre-cancers and cancers of the oral cavity and oropharynx can be found early, during routine screening exams by a dentist, doctor, dental hygienist, or by self-exam.

Some early cancers have symptoms that cause patients to seek medical or dental attention. (See How Are Oral Cavity and Oropharyngeal Cancers Diagnosed?) Unfortunately, some cancers may not cause symptoms until they’ve reached an advanced stage, or they may cause symptoms similar to those caused by a disease other than cancer, such as a toothache. Some dentists and doctors recommend that you look at your mouth in a mirror every month to check for any abnormal areas.

Regular dental checkups that include an exam of the entire mouth are important in finding oral and oropharyngeal cancers (and pre-cancers) early. The American Cancer Society also recommends that doctors examine the mouth and throat as part of a routine cancer-related checkup.

Along with a clinical exam of the mouth and throat, some dentists and doctors may use special dyes and/or lights to look for abnormal areas, especially if you are at higher risk for these cancers. If an abnormal area is spotted, some of these tests may also be used to help determine if they might be cancers (and therefore will need a biopsy) or to choose the best area to sample for a biopsy.

- One method uses a dye called toluidine blue. If the dye is spread over an abnormal area, it will stain blue.
- Another method uses laser light. When the light is reflected off abnormal tissue, it looks different from the light reflected off normal tissue.
- Another system uses a special light to view the area after the mouth has been rinsed with a solution of acetic acid (the acid in vinegar).
- If an abnormal area is found, sometimes it can be evaluated by exfoliative cytology. In this technique, the lesion is scraped with a stiff brush (brush biopsy), and the cells from the scraping can be looked at under the microscope.

References
See all references for Oral Cavity and Oropharyngeal Cancers

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Signs and Symptoms of Oral Cavity and Oropharyngeal Cancer

Possible signs and symptoms of these cancers can include:

- A sore in the mouth that does not heal (most common symptom)
- Pain in the mouth that doesn’t go away (also very common)
- A lump or thickening in the cheek
- A white or red patch on the gums, tongue, tonsil, or lining of the mouth
- A sore throat or a feeling that something is caught in the throat that doesn’t go away
- Trouble chewing or swallowing
- Trouble moving the jaw or tongue
- Numbness of the tongue or other area of the mouth
- Swelling of the jaw that causes dentures to fit poorly or become uncomfortable
- Loosening of the teeth or pain around the teeth or jaw
- Voice changes
- A lump or mass in the neck
- Weight loss
- Constant bad breath

Many of these signs and symptoms can also be caused by things other than cancer, or even by other cancers. Still, it is very important to see a doctor or dentist if any of these conditions lasts more than 2 weeks so that the cause can be found and treated, if needed.

- References
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Cancers Diagnosed?

A doctor or dentist may find some cancers or pre-cancers of the mouth and throat during an exam, but many of these cancers are found because of signs or symptoms a person is having. The patient should see a doctor who will examine him or her. Then, if cancer is suspected, tests will be needed.

Exams by a doctor

Medical history and physical exam

As a first step, your doctor will probably ask you questions about symptoms, possible risk factors, and any other medical conditions you may have.

Your doctor will examine you to look for possible signs of an oral or oropharyngeal cancer (or pre-cancer). These could be bumps or other abnormal areas on your head, face or neck, or problems with the nerves of the face and mouth. The doctor will look at the entire inside of your mouth, and might feel around in it with a gloved finger. He or she may also use other tests to look for abnormal areas in the mouth or throat, or to get a better sense of what an abnormal area might be. Some of these tests are described in the section Can Oral Cavity and Oropharyngeal Cancers Be Found Early?

If there is a reason to think you might have cancer, your doctor will refer you to a doctor who specializes in these cancers, such as an oral and maxillofacial surgeon or a head and neck surgeon (also known as an ear, nose, and throat [ENT] doctor or an otolaryngologist). This specialist will probably do other exams and tests.

Complete head and neck exam

The specialist will pay special attention to the head and neck area, being sure to look and feel for any abnormal areas. This exam will include the lymph nodes of the neck, which will be felt carefully for any signs of cancer.

Because the oropharynx is deep inside the neck and some parts are not easily seen, the doctor may use mirrors or special fiber-optic scopes to examine these areas while you are in the doctor’s office.

Indirect pharyngoscopy and laryngoscopy: For this exam, the doctor uses small mirrors placed at the back of your mouth to look at the throat, base of the tongue, and
part of the larynx (voice box).

**Direct (flexible) pharyngoscopy and laryngoscopy:** For this exam, the doctor inserts a flexible fiber-optic scope (called an *endoscope*) through the mouth or nose to look at some areas that can’t easily be seen with mirrors, such as the region behind the nose (nasopharynx) and the larynx, or to see certain areas clearer.

Both types of exams can be done in the doctor’s office. For either type of exam, the doctor may spray the back of your throat with numbing medicine first to help make the exam easier.

**Panendoscopy**

During a panendoscopy, the doctor uses different types of endoscopes passed down the mouth or nose to perform laryngoscopy, esophagoscopy, and (at times) bronchoscopy. This lets the doctor thoroughly examine the oral cavity, oropharynx, larynx (voice box), esophagus (tube leading to the stomach), and the trachea (windpipe) and bronchi (breathing passageways in the lungs).

This exam is usually done in an operating room while you are under general anesthesia (asleep). The doctor uses a laryngoscope to look for tumors in the throat and larynx. Other parts of the mouth, nose, and throat are examined as well. If a tumor is found that is large or seems likely to spread, the doctor may also need to use an esophagoscope to look into the esophagus or a bronchoscope to look into the trachea and bronchi.

Your doctor will look at these areas through the scopes to find any tumors, see how large they are, and see how far they may have spread to surrounding areas. A small piece of tissue from any tumors or other abnormal areas may be removed (biopsied) to be looked at under a microscope to see if they contain cancer. Biopsies can be done with special instruments operated through the scopes.

**Biopsy**

In a biopsy, the doctor removes a sample of tissue to be looked at under a microscope. The actual diagnosis of oral and oropharyngeal cancers can only be made by a biopsy. A sample of tissue or cells is always needed to confirm that cancer is really present before treatment is started. Several types of biopsies may be used, depending on each case.

**Exfoliative cytology**
In this technique, the doctor scrapes a suspicious area and smears the collected tissue onto a glass slide. The sample is then stained with a dye so the cells can be seen under the microscope. If any of the cells look abnormal, the area can then be biopsied.

The advantage of this technique is that it is easy, and even only slightly abnormal-looking areas can be examined. This can make for an earlier diagnosis and a greater chance of cure if there is cancer. But this method does not detect all cancers. Sometimes it’s not possible to tell the difference between cancerous cells and abnormal but non-cancerous cells (dysplasia) with this approach, so a biopsy would still be needed.

**Incisional biopsy**

For this type of biopsy, the doctor cuts a small piece of tissue from an area that looks abnormal. This is the most common type of biopsy to sample areas in the mouth or throat.

The biopsy can be done either in the doctor’s office or in the operating room, depending on where the tumor is and how easy it is to get a good tissue sample. If it can be done in the doctor’s office, the area around the tumor will be numbed before the biopsy is taken. If the tumor is deep inside the mouth or throat, the biopsy might be done in the operating room with the patient under general anesthesia (in a deep sleep). The surgeon uses special instruments through an endoscope to remove small tissue samples.

**Fine needle aspiration (FNA) biopsy**

For this test, the doctor uses a very thin, hollow needle attached to a syringe to draw (aspirate) some cells from a tumor or lump. These cells are then looked at under a microscope to see if cancer is present.

FNA biopsy is not used to sample abnormal areas in the mouth or throat, but is sometimes used when a patient has a neck mass that can be felt or seen on a CT scan. FNA can be helpful in several different situations, such as:

**Finding the cause of a new neck mass:** An FNA biopsy is sometimes used as the first test for someone with a newly found neck lump.

The FNA may show that the neck mass is a benign (non-cancerous) lymph node that has grown in reaction to a nearby infection, such as a sinus or tooth infection. In this case, treatment of the infection is all that is needed. Or the FNA may find a benign,
fluid-filled cyst that can be cured by surgery. But even when the FNA results are benign, if the patient has symptoms suggesting cancer, more tests (such as pharyngoscopy and panendoscopy) are needed.

If the FNA finds cancer, the doctor looking at the sample can usually tell what type of cancer it is. If the cells look like a squamous cell cancer, more exams will be done to search for the source of the cancer in the mouth and throat. If the FNA shows a different type of cancer, such as lymphoma or a cancer that has spread to a lymph node in the neck from another organ (like the thyroid, stomach, or lungs) more tests will be done to find it, and specific treatment for that type of cancer will be given.

**Learning the extent of a known cancer:** FNA is often done in patients who are known to have oral or oropharyngeal cancer to find out if the cancer has spread to lymph nodes in the neck. This information will help the doctor decide the best treatment for the cancer.

**Seeing if cancer has come back after treatment:** FNA may be used in patients whose cancer has been treated by surgery and/or radiation therapy, to find out if a new neck mass in the treated area is scar tissue or a cancer that has come back.

**Lab tests of biopsy samples**

All biopsy samples are sent to a lab to be viewed under a microscope by a pathologist, a doctor who is specially trained to diagnose cancer with lab tests. The doctor can usually tell cancer cells from normal cells, as well as what type of cancer it is, by the way the cells look. In some cases, the doctor may need to coat the cells with special stains to help tell what type of cancer it is.

**HPV testing:** For cancers of the throat, doctors often have the biopsy samples tested to see if HPV infection is present. This information can help the doctor predict the probable course of the cancer, as people whose cancers are linked to HPV tend to do better than those whose cancers are not.

This testing is not routinely used to guide treatment at this time, but in the future it might help doctors decide which patients might be able to get less aggressive treatment.

See [Testing Biopsy and Cytology Specimens for Cancer](#) to learn more about different types of biopsies, how the tissue is used in the lab for disease diagnosis, and what the results will tell you.

**Imaging tests**
Imaging tests use x-rays, magnetic fields, or radioactive substances to create pictures of the inside of your body. Imaging tests are not used to diagnose oral cavity or oropharyngeal cancers, but they may be done for a number of reasons both before and after a cancer diagnosis, including:

- To help look for a tumor if one is suspected
- To learn how far cancer may have spread
- To help determine if treatment has been effective
- To look for possible signs of cancer recurrence after treatment

**Chest x-ray**

An x-ray of your chest may be done to see if the cancer has spread to your lungs. Unless your cancer is far advanced, it is not likely that it will have spread. This x-ray is most often done in an outpatient setting. If the results are not normal, your doctor may order a computed tomography (CT) scan or other test to look at your lungs in more detail.

**Computed tomography (CT)**

The computed tomography (CT) scan uses x-rays to produce detailed, cross-sectional images of your body. Instead of taking one picture, like a standard x-ray, a CT scanner takes many pictures as it rotates around you. A computer then combines these pictures into an image of a slice of your body. Unlike a regular x-ray, a CT scan creates detailed images of the soft tissues and organs in the body.

This test can help your doctor determine the size and location of a tumor, if it is growing into nearby tissues, and if it has spread to lymph nodes in the neck. The test also may be done to look for spread of cancer to the lungs.

A CT scanner has been described as a large donut, with a narrow table that slides in and out of the middle opening. You will need to lie still on the table while the scan is being done. CT scans take longer than regular x-rays, and you might feel a bit confined by the ring while the pictures are being taken.

For some scans, you might be asked to drink a contrast solution. This helps better outline the digestive tract so that tumors can be seen more clearly and certain areas are not mistaken for tumors. After the first set of pictures is taken you might also receive an intravenous (IV) injection of a contrast dye. This can also help tumors be seen more clearly. A second set of pictures is then taken.
The injection may cause some flushing (a feeling of warmth, especially in the face). Some people are allergic and get hives, or rarely, have more serious reactions like trouble breathing or low blood pressure. Be sure to tell the doctor if you have any allergies or have ever had a reaction to any contrast material used for x-rays.

**Magnetic resonance imaging (MRI)**

MRI scans use radio waves and strong magnets instead of x-rays. The energy from the radio waves is absorbed by the body and then released in a specific pattern formed by the type of body tissue and by certain diseases. A computer translates the pattern into detailed images of parts of the body. As with a CT scan, a contrast material might be injected, but this is a different substance than what is used for CT (so being allergic to one, doesn’t mean you are allergic to the other.

Because it provides a very detailed picture, an MRI scan may be done to look for spread of the cancer in the neck. These scans can also be very useful in looking at other areas of the body as well, especially the brain and spinal cord.

MRI scans are a little more uncomfortable than CT scans. First, they take longer — often up to an hour. During the scan, you need to lie still inside a narrow tube, which is confining and can upset people who have claustrophobia (fear of enclosed spaces). Special, more open MRI machines can sometimes help with this if needed, although the images may not be as sharp in some cases. The machine also makes clicking and buzzing noises that disturb some people. Some places provide earplugs to block this noise out.

**Positron emission tomography (PET)**

For a PET scan, a form of radioactive sugar (fluorodeoxyglucose or FDG) is injected into the blood. The amount of radioactivity used is very low and it will pass out of the body over the next day or so. Because cancer cells use glucose at a higher rate than normal cells, they will absorb more of the radioactive sugar, and the radioactivity will to concentrate in the cancer. After about an hour, you will be moved onto a table in the PET scanner. You lie on the table for about 30 minutes while a special camera creates a picture of areas of radioactivity in the body. The picture is not finely detailed like a CT or MRI scan, but it provides helpful information about your whole body.

A PET scan may be used to look for possible areas of cancer spread, especially if there is a good chance that the cancer is more advanced. This test also can be used to help tell if a suspicious area seen on another imaging test is cancer or not.
A PET scan is often combined with a CT scan using a machine that can perform both scans at the same time (PET/CT scan). This lets the doctor compare areas of higher radioactivity on the PET with the more detailed appearance of that area on the CT.

**Barium swallow**

A barium swallow can be used to examine the lining of the upper part of the digestive system, especially the esophagus (the tube connecting the throat to the stomach). In this test, you drink a chalky liquid called barium to coat the walls of your throat and esophagus. A series of x-rays of the throat and esophagus is taken as you swallow, which the barium outlines clearly.

Because patients with oral and oropharyngeal cancers are at risk for cancer of the esophagus, your doctor may order this test to check for this cancer. It is also useful to see if the cancer is causing problems with normal swallowing.

For more information on imaging tests, see our document Imaging (Radiology) Tests.

**Other tests**

Other tests may be done as part of a workup if a patient has been diagnosed with oral cavity or oropharyngeal cancer. These tests are not used to diagnose the cancer, but they may be done for other reasons, such as to see if a person is healthy enough for treatments such as surgery, radiation therapy, or chemotherapy.

**Blood tests**

No blood tests can diagnose cancer in the oral cavity or oropharynx. However, your doctor may order routine blood tests to help determine your overall health, especially before treatment such as surgery. Such tests can help diagnose malnutrition, low red blood cell counts (anemia), liver disease, and kidney disease. Blood tests may also suggest the cancer has spread to the liver or bone. When this occurs, more testing is needed.

**Other tests before surgery**

If surgery is planned, you might also have an electrocardiogram (EKG) to make sure your heart is functioning well. Some people having surgery also may need tests of their lung function. These are known as pulmonary function tests (PFTs).
Dental exam

When radiation therapy will be used as part of the treatment, it is likely you will be asked to see a dentist, who will help with preventive dental care and may remove teeth, if necessary, before radiation treatment is started.

If the cancer is located in your jaw or the roof of your mouth, a dentist with special training (a prosthodontist) may be asked to evaluate you. This dentist can make replacements for missing teeth or other structures of the oral cavity to help restore your appearance, comfort, and ability to chew, swallow, and speak after treatment. If part of the jaw or roof of the mouth (palate) will be removed with the tumor, the prosthodontist will work to ensure that the replacement artificial teeth and the remaining natural teeth fit together correctly. This can be done with dentures, other types of prostheses, or dental implants.

- References

See all references for Oral Cavity and Oropharyngeal Cancers

How Are Oral Cavity and Oropharyngeal Cancers Staged?

Staging is the process of finding out how far a cancer has spread. The outlook (prognosis) for people with cancer depends, to a large extent, on the cancer’s stage. The stage of oral cavity and oropharyngeal cancers is one of the most important factors in choosing treatment.

Cancers are staged based on the results of physical and endoscopy exams, biopsies, and imaging tests (CT scan, MRI, chest x-ray, and/or PET scans), which are described in the section How Are Oral Cavity and Oropharyngeal Cancers Diagnosed?

The TNM staging system
A staging system is a standard way for doctors to describe and summarize how far a patient’s cancer has spread. The most common system used to describe the extent of oral cavity and oropharyngeal cancers is the TNM system of the American Joint Committee on Cancer (AJCC). The TNM system for staging describes 3 key pieces of information:

- **T** indicates the size of the main (primary) tumor and which, if any, tissues of the oral cavity or oropharynx it has spread to.
- **N** describes the extent of spread to nearby (regional) lymph nodes. Lymph nodes are small bean-shaped collections of immune system cells to which cancers often spread first.
- **M** indicates whether the cancer has spread (metastasized) to other organs of the body. (The most common site of spread is to the lungs. The next most common sites are the liver and bones.)

Numbers or letters appear after T, N, and M to provide details about each of these factors:

- The numbers 0 through 4 indicate increasing severity.
- The letter X means “cannot be assessed” because the information is not available.

**T categories for cancers of the lip, oral cavity, and oropharynx**

**TX:** Primary tumor cannot be assessed; information not known

**T0:** No evidence of primary tumor

**Tis:** Carcinoma in situ. This means the cancer is still within the epithelium (the top layer of cells lining the oral cavity and oropharynx) and has not yet grown into deeper layers.

**T1:** Tumor is 2 cm (about ¾ inch) across or smaller

**T2:** Tumor is larger than 2 cm across, but smaller than 4 cm (about 1 ½ inch)

**T3:** Tumor is larger than 4 cm across. For cancers of the oropharynx, T3 also includes tumors that are growing into the epiglottis.

**T4a:** Tumor is growing into nearby structures. This is known as moderately advanced local disease.

- For oral cavity cancers: the tumor is growing into nearby structures, such as the
bones of the jaw or face, deep muscle of the tongue, skin of the face, or the maxillary sinus.

- For lip cancers: the tumor is growing into nearby bone, the inferior alveolar nerve (the nerve to the jawbone), the floor of the mouth, or the skin of the chin or nose.
- For oropharyngeal cancers: the tumor is growing into the larynx (voice box), the tongue muscle, or bones such as the medial pterygoid, the hard palate, or the jaw.

**T4b:** The tumor has grown through nearby structures and into deeper areas or tissues. This is known as *very advanced local disease.* Any of the following may be true:

- The tumor is growing into other bones, such as the pterygoid plates and/or the skull base (for any oral cavity or oropharyngeal cancer).
- The tumor surrounds the internal carotid artery (for any oral cavity or oropharyngeal cancer).
- For lip and oral cavity cancers: the tumor is growing into an area called the masticator space.
- For oropharyngeal cancers: the tumor is growing into a muscle called the lateral pterygoid muscle.
- For oropharyngeal cancers: the tumor is growing into the nasopharynx (the area of the throat that is behind the nose).

**N categories**

**NX:** Nearby lymph nodes cannot be assessed; information not known

**N0:** The cancer has not spread to nearby lymph nodes

**N1:** The cancer has spread to one lymph node on the same side of the head or neck as the primary tumor; this lymph node is no more than 3 cm (about 1¼ inch) across

**N2** includes 3 subgroups:

- **N2a:** The cancer has spread to one lymph node on the same side as the primary tumor; the lymph node is larger than 3 cm across but no larger than 6 cm (about 2 ½ inches)
- **N2b:** The cancer has spread to 2 or more lymph nodes on the same side as the primary tumor, but none are larger than 6 cm across
- **N2c:** The cancer has spread to one or more lymph nodes on both sides of the neck or on the side opposite the primary tumor, but none are larger than 6 cm across

**N3:** The cancer has spread to a lymph node that is larger than 6 cm across
M categories

M0: No distant spread

M1: The cancer has spread to distant sites outside the head and neck region (for example, the lungs)

Stage grouping

Once the T, N, and M categories have been assigned, this information is combined by a process called stage grouping to assign an overall stage of 0, I, II, III, or IV. Stage IV is further divided into A, B, and C.

Stage 0

Tis, N0, M0: Carcinoma in situ. The cancer is only growing in the epithelium, the outer layer of oral or oropharyngeal tissue (Tis). It has not yet grown into a deeper layer or spread to nearby structures, lymph nodes (N0), or distant sites (M0).

Stage I

T1, N0, M0: The tumor is 2 cm (about ¾ inch) across or smaller (T1) and has not spread to nearby structures, lymph nodes (N0), or distant sites (M0).

Stage II

T2, N0, M0: The tumor is larger than 2 cm across but smaller than 4 cm (T2) and has not spread to nearby structures, lymph nodes (N0), or distant sites (M0).

Stage III

One of the following applies:

- T3, N0, M0: The tumor is larger than 4 cm across (T3), but it hasn’t grown into nearby structures or spread to the lymph nodes (N0) or distant sites (M0).

OR

- T1 to T3, N1, M0: The tumor is any size and hasn’t grown into nearby structures (T1 to T3). It has spread to one lymph node on the same side of the head or neck, which is no larger than 3 cm across (N1). The cancer hasn’t spread to distant sites
Stage IVA

One of the following applies:

- **T4a, N0 or N1, M0:** The tumor is growing into nearby structures (T4a). It can be any size. It has either not spread to the lymph nodes (N0) or has spread to one lymph node on the same side of the head or neck, which is no larger than 3 cm across (N1). The cancer hasn’t spread to distant sites (M0).

  **OR**

- **T1 to T4a, N2, M0:** The tumor is any size and may or may not grow into nearby structures (T1 to T4a). It has not spread to distant sites (M0). It has spread to one of the following:

  1. One lymph node on the same side of the head and neck that is between 3 and 6 cm across (N2a), or 2. One lymph node on the opposite side of the head and neck that is no more than 6 cm across (N2b), or 3. Two or more lymph nodes, all of which are no more than 6 cm across. The lymph nodes can be on any side of the neck (N2c)

Stage IVB

One of the following applies:

- **T4b, any N, M0:** The tumor is growing into deeper areas and/or tissues (very advanced local disease - T4b). It may (or may not) have spread to lymph nodes (any N). It has not spread to distant sites (M0).

  **OR**

- **Any T, N3, M0:** The tumor is any size and it may or may not have grown into other structures (any T). It has spread to one or more lymph nodes larger than 6 cm across (N3), but it hasn’t spread to distant sites (M0).

Stage IVC

**Any T, Any N, M1:** The tumor is any size (any T), and it may or may not have spread to lymph nodes (any N). It has spread to distant sites (M1), most commonly the lungs.

**Recurrent (relapsed) cancer**
This is not an actual stage in the TNM system. Recurrent (relapsed) disease means that the cancer has come back (recurred) after treatment. Recurrent oral cavity or oropharyngeal cancer may return in the mouth or throat (local recurrence), in nearby lymph nodes (regional recurrence) or in another part of the body, such as the lungs (distant recurrence).

Talk with your doctor if you have any questions about the stage of your cancer or how it affects your treatment.

- References

See all references for Oral Cavity and Oropharyngeal Cancers

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Survival Rates for Oral Cavity and Oropharyngeal Cancer by Stage

Survival rates are often used by doctors as a standard way of discussing a person’s prognosis (outlook). Some patients with cancer may want to know the survival statistics for people in similar situations, while others may not find the numbers helpful, or may even not want to know them. If you don’t want to read about the survival statistics below for oral cavity and oropharyngeal cancer, stop reading here and skip to the next section.

The 5-year survival rate refers to the percentage of patients who live at least 5 years after their cancer is diagnosed. Of course, many of these people live much longer than 5 years.

Five-year relative survival rates, such as the numbers below, assume that some people will die of other causes and compares the observed survival of people with cancer with that expected for people without cancer. This is a more accurate way to describe the impact that a particular type and stage of cancer may have on survival.

To get 5-year survival rates, doctors have to look at people who were treated at least 5 years ago. Improvements in treatment since then may result in a more favorable outlook.
for people now being diagnosed with these cancers.

Survival rates are often based on previous outcomes of large numbers of people who had the disease, but they cannot predict what will happen in any individual's case. Many other factors may affect a person’s outlook, such as the patient’s age and health, the treatment received, and how well the cancer responds to treatment. Your doctor can tell you how the numbers below may apply to you, because they are familiar with the aspects of your particular situation.

The following survival statistics come from the National Cancer Institute’s SEER program. They are based on large numbers of patients diagnosed between 2000 and 2014. SEER doesn’t provide recent statistics by AJCC stage. Instead, cancers are divided into the summary stages:

- Local: the cancer is only in the area where it started. This includes stages I and II, as well as some stage III cancers that haven’t spread to any lymph nodes.
- Regional: the cancer has spread to nearby tissues and/or lymph nodes. This includes some stage III cancers, as well as stage IV cancers that haven’t spread to distant sites
- Distant: the cancer has spread to distant sites

Also, these statistics are based on the stage of the cancer when it was first diagnosed. They do not apply to cancers that have come back or spread, for example.

### Lip

<table>
<thead>
<tr>
<th>Stage</th>
<th>5-Year Relative Survival Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local</td>
<td>93%</td>
</tr>
<tr>
<td>Regional</td>
<td>48%</td>
</tr>
<tr>
<td>Distant</td>
<td>52%</td>
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</tbody>
</table>

### Tongue

<table>
<thead>
<tr>
<th>Stage</th>
<th>5-Year Relative Survival Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local</td>
<td></td>
</tr>
<tr>
<td>Regional</td>
<td></td>
</tr>
<tr>
<td>Distant</td>
<td></td>
</tr>
</tbody>
</table>
• Local 78%
• Regional 63%
• Distant 36%

Floor of the mouth

• Stage
  • Local 75%
  • Regional 38%
  • Distant 20%

For cancers of the oropharynx and tonsil, the relative 5-year survival rate was 66%, but survival by stage is not available.

For cancers of the gums and other parts of the mouth, the relative survival was 60%, but survival by stage is not available.

• References
  See all references for Oral Cavity and Oropharyngeal Cancers

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What Should You Ask Your Doctor About Oral Cavity and Oropharyngeal Cancers?

As you cope with cancer and cancer treatment, we encourage you to have honest, open discussions with your doctor. Ask any question, no matter how small it might seem.
Nurses, social workers, and other members of the treatment team may also be able to answer many of your questions. Here are some questions to start.

- What kind of oral cavity or oropharyngeal cancer do I have?
- Where is my cancer located?
- Has my cancer spread beyond the main (primary) site?
- What is the stage of my cancer? What does the stage mean?
- Will I need other tests before we can decide on treatment?
- Are there other doctors I need to see?
- How much experience do you have treating this type of cancer?
- What are my treatment choices? Which do you recommend? Why?
- What is the goal of the treatment?
- What are the chances my cancer be cured with treatment?
- How quickly do we need to decide on treatment?
- What should I do to be ready for treatment?
- How long will treatment last? What will it be like? Where will it be done?
- How would treatment affect my daily activities?
- What risks and side effects can I expect? How long are they likely to last?
- Will this treatment affect the way I look? If so, what are my options for reconstruction?
- What are our options if the treatment doesn’t work or if the cancer recurs?
- What type of follow-up will I need after treatment?
- Where can I find more information and support?

In addition to these sample questions, be sure to write down some of your own. For instance, you might want more information about recovery times so you can plan your work or activity schedule. Or you may want to ask about second opinions or about clinical trials for which you may qualify. You can find more information about communicating with your health care team in our document The Doctor-Patient Relationship.

- References

See all references for Oral Cavity and Oropharyngeal Cancers

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For additional assistance please contact your American Cancer Society
1-800-227-2345 or www.cancer.org