AWARENESS OF ORAL CANCER AMONG HEALTH CARE PROFESSIONALS

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ABSTRACT:

Oral cancer or oral cavity cancer, a subtype of head and neck cancer, is any cancerous tissue growth located in the oral cavity. There are several types of oral cancers, some being squamous cell carcinomas, basal cell carcinomas, verrucous carcinomas, nasopharyngeal carcinomas, malignant melanoma, ameloblastoma, mucoepidermoid carcinoma, and so on; around 90% are squamous cell carcinomas, originating in the tissues that line the mouth and lips. Oral cancer is the eleventh most common cancer in the world with an estimated 267,000 cases and 128,000 deaths in around 2000, two-third of which occurs in developing countries. Delayed diagnosis or referral is the major trigger for death due to oral cancer. This paper concentrates on the causes for delayed diagnosis & guidelines for its prevention.

Keywords: Oral cancer awareness, General Dental Practitioners(GDP's), General Medical Practitioners(GMP's), Delayed diagnosis & referral

INTRODUCTION:

Oral cancer or oral cavity cancer, a subtype of head and neck cancer, is any cancerous tissue growth located in the oral cavity[1]. There are several types of oral cancers, some being squamous cell carcinomas, basal cell carcinomas, verrucous carcinomas, nasopharyngeal carcinomas, malignant melanoma, ameloblastoma, mucoepidermoid carcinoma, and so on; around 90% are squamous cell carcinomas, originating in the tissues that line the mouth and lips. Many other different types of carcinomas of oral cavity can finally become malignant and result in a squamous cell carcinoma.

Oral or mouth cancer most commonly involves the tongue. It may also occur on the floor of the mouth, cheek lining, gingiva(gums), lips, palate(roof of the mouth), maxilla or mandible[2].

Current Global & Indian Scenario of Oral Cancer

The International Agency for Research on Cancer(IARC) has released a latest data on Cancer in December 2013, which figured the global cancer burden estimates to be 14.1 million new cases(with the 2008 estimates being 12.7 million new cases), 8.2 million cancer deaths, & 5-year prevalence of 32.6 million cancers in individuals above the age of 15years. In the Indian scene, 1.1

million new cancer cases were estimated, indicating India as a single country contributing to 7.8% of the global cancer burden; contributing to 8.33% of global cancer deaths; & the five year prevalence was 1.8 million individuals with cancer corresponding to 5.52% of global prevalence[3].

Oral cancer is the eleventh most common cancer in the world with an estimated 267,000 cases and 128,000 deaths in around 2000, two-third of which occurs in developing countries. The Indian subcontinent accounts for one-third of the world burden[4]. In South Asia, oral cancers account for about up to 40% of all cancers. In India, the incidence of oral cancer is about 3-7 times more common as compared to resource rich countries. India tops in the prevalence of oral cancer in the world and remains the commonest cancer amongst the male population. Oral cancer is the third most common cancer in India after cervical and breast cancer amongst women. The increased prevalence of the oral cancer in the Indian subcontinent seems to be due to the high exposure to sunlight due to farming, smoking and other smokeless tobacco habits, alcohol, spicy food, and neglect of overall oral health. The highest age-adjusted incidence for oral cancer is highest in India, i.e. 15.7 per100,000 and lowest in Japan which is 0.2 per 100,000 and the difference is predominantly due to use of tobacco between the two nations. In the West, the cancer of tongue and floor of mouth is common whereas in Indian subcontinent the cancers of gingival and buccal mucosa are common due to placement of tobacco quid in the oral cavity. This cancer of gingivobuccal complex is termed as Indian oral cancer(Oral Cancer Prevention and Research Foundation, India). Human Papilloma Virus(HPV) especially types 16 and 18 are known risk factors and independent causative factor for oral cancer[5].

Concept of Delayed Diagnosis

The National Patient Safety Agency has developed a working definition of the concept of delayed diagnosis which states that delayed diagnosis in cancer is when someone who has cancer

a. is not investigated or referred for investigation;

b. having been investigated, is not diagnosed at the time of the investigation;

c. is diagnosed incorrectly;

d. where a positive test result or diagnosis is not communicated effectively to a clinician with the ability to act on the information;

e. or where a positive test result or diagnosis is not acted upon and treatment commenced as appropriate[6].

Types of Delays

Delays in diagnosis of oral cancer could be due to:

i.   Patient delay is generally defined as the time from the patient's first awareness of a

symptom to seeking their first consultation with a healthcare professional[7,8].

ii. Professional delay is defined either as the time from the first consultation with a healthcare professional to the first consultation with a treating specialist,[8,9] or to the definitive diagnosis being made,[7,10,11] or to the patient being admitted for definitive treatment[12].

How to Prevent Delayed Diagnosis?

The most important prognostic factor in oral cancer is the stage of the tumour at the time of diagnosis[13]. This forms a strong argument for reducing any delays in diagnosis so that cancer treatment can be initiated at as early a stage as possible. However, the proliferative activity of the cancer must also be considered as an important confounding factor, as aggressive tumours with a poor prognosis will not usually be associated with diagnostic delay, whereas tumours with low proliferative activity may have a good prognosis despite a long diagnostic delay[14].

But, in patients with potentially malignant disorders, equal or even more attention should be given as their lesion might get transferred into oral cancer in future, irrespective of time. So, these patients should be screened properly & necessary screening, investigations & treatment should be done.

Stategies of a Professional

Ideally, if the practitioner suspects cancer, he/she should arrange for a specialist appointment by phone, before the patient goes home orelse tell the patient that he/she will contact the specialist as quickly as possible afterwards and call back immediately. The practitioner will also need to write to the consultant about what are the oral findings. The practitioner should follow the NICE guidelines for urgent referrals. A referral letter should be addressed to a named consultant or specialist and give:

i. patient personal details (age, sex, personal details, occupation)

ii. relevant medical history details (or a copy of the medical history record)

iii. relevant lifestyle factors

iv. brief details of counselling provided and perceived level of patient understanding of the situation

v. detailed dental history (attendance patterns,oral hygiene and periodontal condition)

vi. details of the suspect area/lesion (colour,texture, size, position, mobility)

vii. whether any regional nodes are palpable

viii. copy of completed mouth map[15]

ix. copy of previous mouth map if lesion has been under review

x. intra-oral photographs of visible lesion or stained area (if available)

xi. if applicable, mention results from chairside tests

xii. thanks for agreeing to see the patient and a request for an opinion and test results

It is necessary that the doctor should give the letter to the patient to take, rather than post it orelse should telephone or fax the consultant. Most will then fast track the patient to an earlier consultation. If you mark the letter "urgent" and say "malignancy suspected", the patient should be seen within two weeks of referral.

NICE(National Institute for Clinical Excellence) Guidelines For Urgent Referrals[16]

The NICE guidelines for suspected cancer recommend urgent referral for patients meeting the following criteria:

i. red or red and white patches of the oral mucosa which persist for more than three weeks at any particular site

ii. ulceration of oral mucosa or oropharynx that persists for more than three weeks

iii. oral swellings that persist for more than three weeks

iv. unexplained tooth mobility not associated with periodontal disease persistent, particularly unilateral, discomfort in the throat for more than four weeks

v. pain on swallowing persisting for three weeks, which does not resolve with antibiotics

vi. dysphagia that persists for more than three weeks

vii. hoarseness that persists for more than three weeks

viii. stridor (requires same day referral)

ix. unresolved head or neck mass that persists for more than three weeks

x. unilateral serosanguineous nasal discharge that persists for more than three weeks, particularly with associated symptoms

xi. facial palsy, weakness or severe facial pain or numbness

xii. orbital masses

xiii. ear pain without evidence of local ear abnormalities

Dentists should note that patients are likely to report to a dental practice with the symptoms at the top of the list (first four symptoms). The remaining symptoms may be more often dealt by general practitioners by referral to ENT colleagues. White plaques or patches without any associated redness are not listed as a criterion for suspecting malignancy and should be in the category of prompt referral.

CONCLUSION:

Awareness of oral cancer is the first measure that should be undertaken. Secondly, stoppage of habits which are nothing but factors triggering oral cancer development. Thirdly, knowledge of oral cancer & its precedents by the GDPs & GMPs.

In summary, many of these problems could be reduced by training as part of CPD for all members of the dental & medical team.

The development and use of an oral cancer checklist as an accessible diagnostic primary care tool is something that could also improve outcomes for patients[17]. The NICE guidelines should be followed so that GDPs & GMP's can be confident of an appropriate referral. Patients who are under risk should be given more attention & their treatment should be planned accordingly.

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