



## CNA HealthPro

### Early Detection Key to Treating Oral Cancer

Nearly 29,000 Americans will be diagnosed with oral cancer in 2002 and approximately 7,400 will die from the disease, according to estimates from the American Cancer Society (ACS).

When detected early, oral cancer has a far better prognosis than most cancers. Unfortunately, many oral cancers are not diagnosed until they are relatively advanced. The current overall five-year survival rate for oral cancer stands at only 56 percent – lower than the 62 percent overall cancer survival rate, and sixth lowest among the 18 major cancer sites listed in the ACS's "Cancer Facts & Figures 2002."

Of all healthcare professionals, dentists are in the best position to detect oral cancer and help lower the death rate. Most oral cancers occur in easily examined or palpated sites, including the tongue, lip and floor of the mouth. The key to early detection is the routine oral cancer screening, especially for higher-risk patients – those who smoke, chew tobacco or drink excessive amounts of alcohol.

The American Dental Association (ADA) has recently undertaken a number of initiatives to reduce the toll of oral cancer, including a public awareness campaign featuring print ads and billboards. The ADA also included a 48-page special supplement titled "Combating Oral Cancer: The Dentist's Role in Preventing, Detecting a Deadly Disease" with the November 2001 *Journal of the American Dental Association* (JADA). The supplement provides dentists with a broad array of oral cancer facts, figures and recommendations.

Every dentist should be well informed about oral cancer diagnosis and prevention. The ADA supplement, along with other oral cancer resources, is available online at the ADA Web site.

#### Liability Risks

When dental liability claims arise that are associated with oral cancer, the primary allegation is *failure to diagnose* the lesion. Allegations also are based on a *failure to refer* to an oral pathologist, oral surgeon or ear, nose and throat (ENT) physician.

It is both appropriate and within professional standards of care for a dentist to refer a patient with a suspicious lesion for further evaluation and biopsy. However, every dentist is expected to be able to identify possible cancerous growths through their own clinical examination of a patient. Asserting ignorance in how to perform an excisional biopsy, for example, would not provide a strong defense against a failure to diagnose or failure to refer allegation.

Claims alleging a failure to diagnose an oral cancer lesion during a dental examination or treatment may result in substantial defense costs and monetary damages. The average indemnity payment (a payment made to a patient on behalf of an insured dentist) for oral cancer claims at CNA is among the highest of any type of dental malpractice claim, with payments and associated costs ranging as high as \$2 million for a single claim. However, the percentage of oral cancer claims resulting in an indemnity payment is no greater than for dental claims as a whole, approximately 25 percent.

## Examinations

A comprehensive oral cancer examination serves as the most effective mechanism for protecting your patients' health and reducing your exposure to failure to diagnose claims. Every dental examination, including recalls, should include the evaluation of tissues for signs of oral cancer.

Even when oral cancer screening is part of an examination, many patients remain unaware that it has been performed. A Centers for Disease Control study in the early 1990s reported that only 14.3 percent of Americans believed they had ever received an oral cancer screening. More recent statistics indicate that only 13 percent of Americans believed they had an oral cancer evaluation within the year. Clearly, dentists must do a better job of informing patients that they have performed an oral cancer examination, and of conveying the results.

Dentists should query patients about tobacco use and alcohol consumption – the two leading oral cancer risk factors – during the initial interview and evaluation. Patients who chew tobacco should be informed of its inherent risks, tantamount to smoking cigarettes for this form of cancer. Other risk factors include

- certain viruses (such as human papillomavirus)
- exposure to sunlight (lip cancer)
- a higher incidence in patients greater than 45 years of age
- a higher incidence in the African-American population
- a higher incidence in males

Take the time to educate your patients about the dangers of oral cancer as well as its risk factors. Once you have identified an individual as being at increased risk for oral cancer, you are professionally obligated to exercise due diligence in routinely examining for suspicious lesions.

The *JADA* special supplement includes clinical photographs that demonstrate specific examination techniques. (The photos are also available online at the ADA Web site at the URL previously listed.) The examination should include an extraoral evaluation as well as a thorough assessment of the

- lips
- labial, buccal and pharyngeal mucosa
- gingiva
- tongue (especially the lateral borders)
- floor of the mouth
- hard and soft palate

During your exam, look for changes in the tissue's texture or color, bleeding, ulcerations, masses, lesions, and any lymphadenopathy. Because many premalignant and malignant lesions appear either relatively normal or resemble a benign lesion, they are often difficult to identify by visual inspection.

Keep in mind that the most common sites for oral cancer are the tongue, lips, and floor of the mouth. Pay particular attention to detail when examining these structures. Some dentists never examine the patient's tongue in an extended position after the initial appointment and examination. This omission limits the practitioner's ability to find suspicious lesions and take appropriate action.

## Evaluation and Diagnosis

Be sure to further evaluate any findings of abnormal or suspicious tissue. If you do not feel comfortable performing further evaluative tests or biopsies yourself, *promptly* refer the patient to an oral and maxillofacial pathologist, oral and maxillofacial surgeon, or ENT physician.

Practitioners who adopt a “wait and see” approach to suspicious areas should engage in a timely re-evaluation. Delays in diagnosis and/or treatment allow the tumor to enlarge or further invade tissues, increasing the extent of the patient’s injury – and the dentist’s potential legal risk.

In addition to visual inspection, other screening techniques exist that are generally easy to use. You can evaluate surface changes such as leukoplakia by examining the area with a chemoluminescent light stick or by staining the area with toluidine blue. Areas that elicit a positive response to either method should be evaluated on a cellular level.

A definitive diagnosis of oral cancer is made from a cytologic evaluation of the tissue sample. Tissue samples can be obtained via such methods as a scalpel biopsy, punch biopsy, brush biopsy or needle aspiration biopsy. The brush biopsy is a technique that most general dentists can easily learn and employ in their practices, even if other biopsy needs are referred to specialists.

## Documentation

Proper documentation of oral cancer diagnosis and treatment begins with the examination. Most commercially available examination forms have a section for documenting the condition of the lips, cheeks, tongue, floor of the mouth, hard palate, gingiva, etc.

Many dentists choose to leave these areas blank unless an area of pathology is specifically noted. The risk in adopting this approach lies in the vulnerability of the dentist to allegations by the plaintiff or plaintiff’s attorney – as we have seen in numerous oral cancer cases – that the area on the form was left blank because the anatomical structures were never examined.

While the dentist certainly may testify as to his or her routine documentation protocol, it would be more advantageous if a mark or notation appeared in the chart to affirmatively designate that the structure in question had been examined and was normal in appearance.

Dentists have used a variety of designations, such as +, ✓, OK and the abbreviation WNL (“within normal limits”) to convey this message. Whatever notation you choose, use it consistently on your exam forms to show that you have performed the exam.

It is also advisable to include a notation in the body of the progress note indicating that you have performed an oral cancer examination, as well as your findings. For most patients, this can be as simple as “Oral CA screening neg.” You should also record any education and counseling of patients who are at higher risk for oral cancer, such as tobacco users.

Whenever an abnormality is present, document your disclosure of this fact to the patient, as well as any pertinent aspects of your discussion. Also, thoroughly describe any recommendations for further evaluation or treatment, such as staining, biopsy or referral. Follow the description with a notation indicating the patient’s decision.

Early detection of oral cancer saves lives. Therefore, it is every dentist’s professional responsibility to perform and document a thorough examination of his or her patients for cancerous and precancerous lesions during each new and recall exam visit. By carefully screening patients, referring when appropriate, and communicating and consistently documenting their procedures, dentists can simultaneously protect their patients and reduce their own level of liability exposure.

Additional information is available from the following sources:

- National Cancer Institute: [www.nci.nih.gov](http://www.nci.nih.gov)
- American Cancer Society: [www.cancer.org](http://www.cancer.org)
- American Dental Association: [www.ada.org](http://www.ada.org)
- JADA Special Supplement November 2001: "Combating Oral Cancer: The Dentist's Role in Preventing, Detecting a Deadly Disease"

*This publication is for educational purposes only. It is not legal or dental advice. CNA makes no representations as to its correctness or completeness and accepts no liability for any injury or damage that may arise from its use. Specific legal or dental questions should be referred to a competent attorney or dental professional. This material may address and discuss matters for which your policy does not provide coverage, and the material does not create or imply the existence of coverage. Please consult your insurance policy for the specific terms and conditions of coverage.*

*CNA policies are underwritten by the property/casualty companies of CNA, Chicago, IL. CNA is a registered service mark of CNA Financial Corporation. ©2005 Continental Casualty Company. All rights reserved.*