

Oral cancer screenings: Dental practice overview

Dentists are responsible for periodically, and thoroughly, examining their patients' faces, necks and oral cavities for the presence of lesions and diseases. While dentists need not possess extraordinary diagnostic abilities or knowledge, they are held to an "standard of care" in the eyes of the law, based on current, accepted treatment protocols. The definition of this standard of care varies. The ADA has a standard of care statement, as do various dental societies and associations. Rather than discuss the differences in each of these position statements, let us agree that dentists, like any other profession, are held to a standard, and failing to meet it, place themselves at risk of liability.

Dentists are taught in dental school, and throughout their careers in continuing education courses, how to examine the orofacial region and recognize the manifestations of the various diseases that affect it. Certainly oral cancer is covered in detail in both of these venues. In today's practice of dentistry, it is the accepted standard of care for the dental practitioner to not only be educated in the proper diagnosis of malignant lesions, but to engage in the routine examination of their patients for oral cancer. A patient may successfully sue for malpractice if a dentist does not satisfy the accepted standard of care. This includes the failure to use reasonable care or judgment in the management of a patient, directly resulting in harm to that patient. It is possible to argue that negligence could be proven if a dentist fails to incorporate an oral cancer screening as part of his examination protocol, or worse monitors, without intervention, a suspicious lesion which prevails for an extended period, without proper diagnosis or referral. A delay in diagnosis which compromises the patient's health, and which allows a localized, focal lesion to prosper into a later stage malignancy resulting in additional morbidity, or worse the death of the patient, certainly would bring severe legal consequence.

DIAGNOSTIC PROTOCOL

The protocol for diagnosing oral lesions, including oral cancer, is part of the overall process of taking a personal, medical, and habit history as well as performing a clinical oral examination for each patient.¹ Characteristics in the personal history, such as age, sex, ethnic background and occupation, are important considerations in assessing risk factors for oral cancer. For example, fair-skinned people who spend considerable time outdoors are at much higher risk of developing facial and labial cancer than are other patients. A history of habitual use of any form of tobacco, alcohol or both can be critical. The medical history should include questions about systemic diseases that may predispose a patient to develop oral cancer. A short list of diseases would include anemia, liver disease, human immunodeficiency virus positivity and previous malignancy. Dentists should note that periodic oral updates of all histories are also standard procedure.

The clinical oral examination is by far the dentist's most potent tool for discovering oral lesions. This procedure often takes only 30 to 120 seconds and should be performed at the initial visit and at each recall appointment. The dentist should begin by observing the face, head and neck, with particular emphasis placed on the vermilion of the lips. The systematic intraoral examination should include all mucous membrane and gingival surfaces, with emphasis placed on the lateral border of the tongue, floor of the mouth, and pharynx, which are prime sites for oral cancer. The dentist then should perform bimanual, digital palpation to determine if there are any abnormal enlargements of facial or cervical lymph nodes or of salivary glands.

FOLLOW-UP

If the dentist observes a suspicious area, he or she should document it thoroughly in the patient's dental record with regard to size, shape, consistency, color and duration. If possible, a photograph also should be taken to provide a baseline record of the lesion from which changes can be noted. The dentist must then decide who is best suited to diagnose and, if necessary, treat the observed lesion. It is important to keep in mind that any delay in the diagnosis and treatment of premalignant or frank malignant lesions could seriously compromise the patient's health; therefore, a timely and decisive response is important. Dentists should not think that referral of a patient for diagnosis implies incompetence. Rather, patients genuinely appreciate dentists' concern for their health.

If the examination reveals a malignant lesion, then—absent unusual circumstances—the patient should be so informed. Treatment, or referral for treatment, then follows. Premalignant lesions with low transformation potential (as documented by a biopsy) may be treated locally or observed for changes at appropriate intervals, usually no greater than six months. If the dentist opts to observe the patient, he or she should note any ominous clinical changes in the lesion and perform another biopsy. In addition, the patient should be apprised of, and agree to, the attendant risks of such treatment or observation.

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This article is informational only and does not constitute legal advice. Dentists must consult with their private attorneys for such advice.

1. Marder MZ. The standard of care for oral diagnosis as it relates to oral cancer. *Compendium* 1998;19(6):569-84.