“The patient should be told the truth”

An interview with Prof. Stephen Porter, UK

Prof. Stephen Porter: It is not uncommon for individuals not to be aware that cancer can arise in the mouth. Indeed, there are studies indicating that even patients without cancer who attend clinics that specialise in mouth cancer are unaware of the possibility. This trend regarding a lack of awareness occurs across the globe, although it varies between countries.

With celebrities like actor Michael Douglas struggling publicly with throat and mouth cancer, is it not about the condition nowadays?

Lawson John Diamond wrote a series of articles detailing the progress of his disease and its treatment that informed many of the impact this disease can have on an individual and his or her family.

Unfortunately, the Michael Douglas situation has perhaps confused the exact role of the human papillomavirus (HPV) in mouth cancer. Certainly, it can cause mouth cancer and it can be acquired through orogenital contact, but there is no evidence that such contact will lessen any subsequent risk of contracting mouth cancer.

Oral cancer figures are rising worldwide. What are the reasons for this, and does it fulfil the criteria for an epidemic, as it has been called in some media reports?

The exact risk that it carries is unclear but it has been suggested that the risk of HPV-related mouth and/or throat cancer climbs when someone has had more than nine different sexual partners.

What other factors besides smoking, drinking and HPV are currently being investigated, and what is their malignant potential?

People chew betel nut preparations (e.g. paan masal and gutka) in parts of India, Pakistan, Bangladesh and surrounding areas. These cause initial fibrosis of the oral tissue, termed “submucous fibrosis”, which carries a high risk of causing oral cancer of possible 30 per cent. Submucous fibrosis can arise even in young individuals and is irreversible, and thus patients are likely to have a lifelong risk of mouth cancer, even if they stop the causative habit. The nightmare scenario is that when examining a patient with submucous fibrosis the mouth opening can be so small that a clinician may be unable to see the cancer.

Mouth cancer can also arise in patients who have rare genetic disorders, such as Fanconi anaemia and dyskeratosis congenita, but the most common oral disorder that is considered to be potentially malignant is oral lichen planus. This is a chronic immune disorder, or indeed sexually transmitted infection, but a new phenomenon, but it has become much more common in the last 30 years. So, what is new is probably that oncogenic types of HPV are just more common in the sexually active population than in the past.

Isolated white or red patches on the oral mucosa (sometimes termed “leukoplakia” and “erythroplakia”) have malignant potential as well, but these are actually un-
common, particularly the latter, compared with oral lichen planus.

1. Besides new treatment concepts, prevention remains the most effective strategy against oral cancer. Why do so many dentists still appear to overlook obvious signs of the disease, and do current screening procedures have shortcomings?

The great majority of patients ultimately found to have mouth cancer will have been referred to a specialist service because a dentist or other dental professional will have noticed something abnormal. He or she might not have known what it was, but they did the correct thing by referring the patient to a specialist.

Screening for possible mouth cancer is straightforward. It is just a matter of examining the neck and mouth carefully. However, sometimes dentists do not know what to look for, as they have probably never seen more than one type of oral cancer in their professional lives.

Similarly, mouth cancer is more likely in socio-economically deprived groups than the wealthy. Socially disadvantaged people have a tendency not to attend health care providers, including dentists, on a regular basis nor to take up possible screening opportunities for common diseases and therefore have a variable awareness and practice of disease prevention strategies, whether concerning oral health or general health.

Clearly, the best option for screening would be opportunistic screening, where health care staff examine patients in risk groups for a particular disease, but this requires people to want to attend a clinic and to appreciate the possible benefits of such attendance for their health and well-being.

Is there any evidence that regular screenings could help prevent oral cancer?

There is no evidence that a particular frequency of dental examination will lessen the risk of mouth cancer. However, the more regularly a person is examined, the greater the chance that emerging malignant or potentially malignant disease will be detected and that any lesion present will be small.

However, overzealous review is likely to be wasteful and thus all patients should be advised that if they become aware of a change in their gingivae or oral mucosa that persists for more than three weeks and has no obvious local cause, or example a sharp tooth or filling, they should seek advice from their dentist.

In its 2008 policy statement, the FDI stresses the important role of dental professionals in the detection of oral cancer and patient education. To what extent are dental professionals fulfilling this role?

The majority of patients ultimately found to have oral cancer will have been identified by a dentist or other dental professional; thus, dental professionals are fulfilling this role to a great extent. However, dental professionals should also be able to provide advice about oral cancer prevention, for example tobacco and alcohol cessation, and information on where additional advice can be obtained, for example tobacco cessation services.

The current rule of thumb is that the more people smoke and the longer that habit the greater the risk of mouth cancer. The same applies to alcohol. There are some nuances as regards the type of tobacco or alcohol that may affect risk but these are really not of notable concern when communicating a disease prevention message. Of significance is that the risk of cancer developing if someone smokes and drinks is much higher than if someone smokes or drinks (i.e. there is a synergistic rather than additive effect).

Of course, many dentists will indicate that they have no experience of having seen oral cancer or having managed any patient who has previously had such disease. However, there are some simple rules. If a lesion is solitary, has been present for more than three weeks and has no local cause, the patient should be referred. Any lesion that strikes a dental professional as odd and/or destructive warrants referral.

Dentists should always keep an accurate and contemporaneous record of what is observed during clinical examination and be familiar with the contact details of local oral cancer specialists (typically oral and maxillofacial surgery or oral medicine).

Finally, the patient should be told the truth, i.e. that the dental professional has concerns that a lesion is possibly malignant or pre-malignant, and is thus referring the patient for further investigation.

Thank you very much for the interview.
Minimum intervention in dentistry

By Prof. Prathip Phanthumvanit, Thailand

The concept of minimum intervention in dentistry (MID) ranges from early diagnosis of oral disease to appropriate intervention, which includes prevention, control and treatment for the purpose of conserving natural tooth and periodontal structure. A number of MID measures have recently become available, including the very early detection of dental caries using QLF (Quantitative Light-induced Fluorescence) in order to detect mineral loss in enamel, as well as follow-up strategies, such as remineralisation and the use of sealant. Moreover, the visual FDI Caries Matrix, in terms of non-cavitated and cavitated lesions in enamel and dentine, has been proposed as a caries index for timely prevention and treatment. This early detection and diagnosis of dental caries will lead to proper prevention and control of caries before the development of a cavity, which can then only be treated.

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For caries restoration, partial caries removal during cavity preparation has been suggested, which, according to research, appears to reduce the incidence of iatrogenic pulp exposure and therefore the risk of pain and infection. Simplified and modified atraumatic restorative treatment, a further development of atraumatic restorative treatment (one of the original MID methods of restoration) and a preventive method of restoration for primary teeth that entails partial caries removal and filling with encapsulated self-curing glass ionomer cement, has been proposed. This concept makes preventive restoration in preschool children, even by trained dental auxiliaries, possible. Moreover, effective use of self-care fluoride toothpaste during toothbrushing has been suggested for every age group, especially the correct minimal amount of toothpaste used in children to prevent both caries and fluorosis.

There are several interesting MID measures in terms of periodontal disease, such as non-surgical or minimally invasive surgery in periodontal therapy, and single flap or flapless implant surgery. The single-flap approach is a minimally invasive surgical procedure for the reconstruction of intraosseous periodontal defects with early wound healing and highly predictable complete flap closure. The effectiveness of the buccal single-flap approach for surgical debridement of deep intraosseous defects has been shown to be comparable to the double-flap approach in terms of clinical attachment level gain, probing pocket depth reduction and minimal gingival recession, six months post-surgery. Another minimally invasive surgery method is flapless implant surgery conducted with help of the tissue punch technique and having to raise a mucoperiosteal flap. Reports show that this reduced operational time, accelerated post-surgical healing and even increased patient comfort in some cases.

MID can be applied in many areas of clinical dentistry. Importantly, it should be part of a science- and evidence-based practice that is able to provide dental services that are accessible to, acceptable to and affordable for an increasing number of people.

Prof. Prathip Phanthumvanit is currently Vice-Chairman of the Public Health Committee of the FDI World Dental Federation. Today, he will be presenting a paper titled “Minimum intervention dentistry” during one of the early morning sessions as part of the 2013 FDI AWC scientific programme.