Help fight these Cinderella cancers

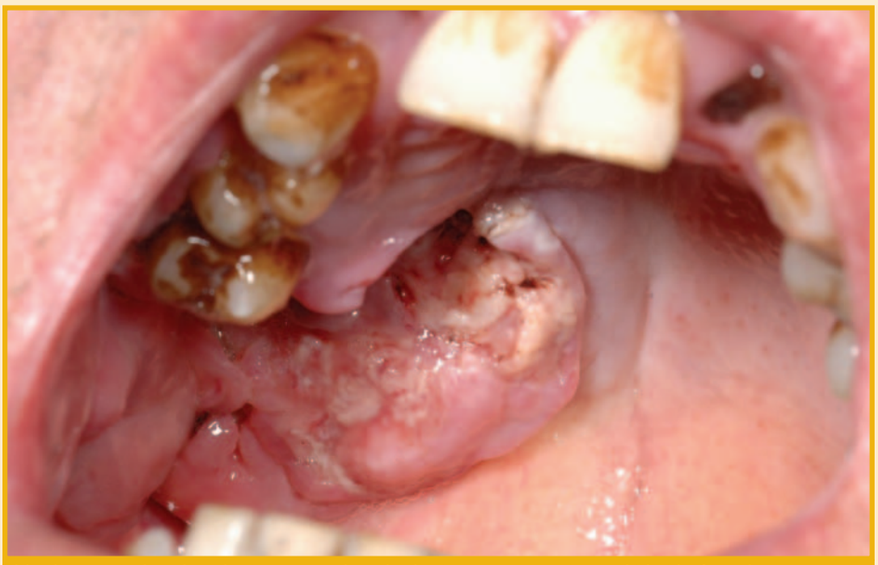
To preview Mouth Cancer Awareness Week, Vinod Joshi describes what dentists can do to help beat this disease

Head and neck cancer describes a variety of neoplasms in the head and neck, from the mouth, throat/upper gullet (pharynx), salivary glands and voice box (larynx). The definition excludes tumours of the brain and related tissues.

Over 7500 new cases were diagnosed in the UK in 2003. While the *NHS Cancer Plan* has brought about significant improvements in outcomes for the "big four cancers", there has been little improvement in the mortality rates of head and neck cancers. Head and neck cancers caused just over 2700 deaths in 2005. Overall survival rates have risen only slightly over the past 20 years and the mortality rates for men in their 30s, 40s and 50s have seen a small, but steady, increase.

In general, prognosis worsens with increasing inaccessibility of the tumour. The proportion of deaths per number of cases is still markedly higher than breast cancer, cervical cancer or skin melanoma. This is largely because of late diagnosis.

Why is the early detection rate so low?



Mouth cancer in the palate: dentists are urged to take the time to screen patients at high risk of mouth cancer

Dentists have lead role

As dental health professionals, we are best placed to be the leading advocates in increasing public awareness of these cancers (**below**). When screening our patients for cancers in the mouth, we should also be looking for other head and neck cancers. We should be involved in efforts to increase awareness of these cancers among patients to promote early detection and be warning them to avoid the common risk factors of tobacco use and alcohol abuse that most of these cancers share. The middle aged who smoke and drink are at a higher risk of mucosal cancers of the oral cavity, oropharynx or laryngopharyngeal region. Asians should be warned of the dangers of paan and gutka chewing.

Better screening needed

One answer to the low early detection rates may be poor screening. A recent study of primary care general medical practitioners (GPs) found that many GPs believed that routine head and neck screening should fall on dentists' shoulders.

Implementing opportunistic screening in a primary care setting, with education on risk factors, could increase early discovery of lesions and have a positive impact on morbidity and mortality. Identifiable co-existing risk factors like smoking and alcohol consumption in patients with a lesion should heighten suspicion, but it is important to remember that 25% of mouth cancer patients have no known risk factor. Aside from the risk factors of smoking and chewing tobacco, cancer in the mouth occurs more often among people who chew areca nuts in betel quids, such as paan, supari and gutka. This is a common cultural practice among the immigrant population in the UK who come from Pakistan, Bangladesh, India and other countries in that region.

Dentists and doctors who take advantage of routine check ups to screen their high-risk patients for mouth cancers may be the most cost-effective guard against the disease in the UK. Models suggest screening people aged 40 to 70 may be more cost effective than screening older patients. So, take the time to educate and screen your high-risk patients.

Suspect to detect

A high index of suspicion is a prerequisite for early diagnosis and referral of patients with oral cancer. The oral mucosa tends to heal itself in two weeks, so any changes to a patient's mouth that last three weeks or more should be checked. Extra-oral and perioral

Commonest cancer sites

Around 40% of mouth cancers are diagnosed in the mouth cavity

Around 30% of mouth cancers are diagnosed in the larynx

Around 20% of mouth cancers are diagnosed in the tongue

Around 15% of mouth cancers are diagnosed in the oropharynx (11.5%), nasopharynx (3.4%) and piriform sinus together

Around 5% of mouth cancers are diagnosed in the lip – least frequent type

What to look for

Sore or ulcer in the mouth that does not heal within three weeks

Lump or overgrowth of tissue anywhere in the mouth

White or red patch on the gums, tongue, or lining of the mouth

Difficulty in swallowing

Difficulty in chewing or moving the jaw or tongue

Numbness of the tongue or other area of the mouth

Feeling that something is caught in the throat

Chronic sore throat or hoarseness that persists more than six weeks, particularly in smokers over 50 years old and heavy drinkers

Swelling of the jaw that causes dentures to fit poorly or become uncomfortable

Neck swelling present for more than three weeks

Unexplained tooth mobility persisting for more than three weeks

Unilateral nasal mass/ulceration/ obstruction, particularly associated with purulent or bloody discharge

tissues should be examined first, followed by the intra-oral tissue. Malignant lesions, usually discrete entities in the high-risk areas of the mouth, are not associated with a specific aetiology and persist despite removal of local factors. Patients with urgent referral symptoms should be referred to a specialist immediately.

Major on the mouth

The most common areas for cancer in the mouth to develop are on the tongue and the floor of the mouth. People who use chewing tobacco are likely to have them develop in the sulcus between the lip or cheek and teeth in the lower jaw. Cancers of the hard palate are uncommon, though not unknown. The bases of the tongue at the back of the mouth and on the pillars of the tonsils are other sites where it is commonly found.

The earliest and most consistent clinical presentation of squamous carcinoma is the persistent red (erythroplakia) or mixed red and white (erytholeukoplakia) lesion. This is an innocuous appearing lesion, which is inflammatory, atrophic and shows mucosal alteration, with or without a keratinised component. Purely white (leukoplakia) lesions that can't be rubbed off and arise without apparent cause are considered to be pre-malignant, but the rate of change to malignancy in the Western World is comparatively slow with only 0.1 to 6% eventually becoming malignant. Only 6% of early invasive carcinomas or carcinoma *in situ* have been shown to be purely white lesions.

Unfortunately, the typical presentation of oral cancer as an ulcer with a raised rolled edge, which feels firm on palpation, is often a late sign of oral cancer. In some cases the lesion may be raised *without* ulceration and there may be erythroplakia or leukoplakia associated with the lesion. In some cases of tongue cancer, the ulceration may be posterior, and difficult to observe, or absent. It is good practice to palpate the tongue – a mass or thickening may confirm the need for urgent referral. So, any lesion, whether it looks benign or malignant, should be palpated.

Don't ignore the neck

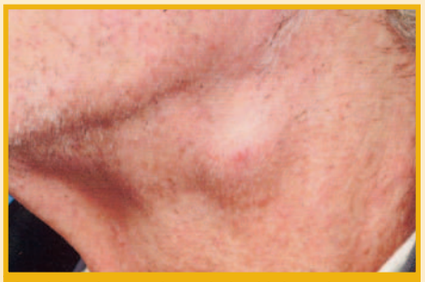
Clinical evaluation of adults with a lump in the lateral neck is aimed at excluding cancer. It is important that the possiblity of a diagnosis of cancer is not overlooked. Always ask for a history of any previously treated cancer of the skin, lip, oral cavity or other mucosal sites as there is a higher incidence of second primary tumours in those who use tobacco and/or use alcohol. Associated symptoms such as ear pain (referred from the posterior oropharynx), voice change, dysphagia or weight loss should be sought. In adults, a lump in the neck should always be promptly referred to the patient's doctor for investigation: a safe rule is that any adult with a lump in the lateral neck has cancer until it is proved otherwise (referral guidelines for suspected cancer **http://www.nice.org.uk/pdf/cg027niceguideline.pdf**).

Awareness resources

The Mouth Cancer Foundation (**www.mouthcancerfoundation.org**) provides mouth cancer awareness materials and organises mouth cancer awareness events. Leaflets and posters on lowering the risk of mouth cancers are available free to dentists, and can be used as discussion tools during consultations or displayed in the waiting room.

The Second Mouth Cancer Awareness Walk (**www.mouthcancerwalk.org**) is on Sunday 14 October 2007 in Hyde Park, London. This year, in addition to the Mouth Cancer Walk, the Mouth Cancer Foundation is organising a new event to raise awareness of this Cinderella disease: the Mouth Cancer Voice Awards (MCVA) in London. These are designed to increase awareness of mouth cancers among university students.

The MCVA will be looking for the newest, most talented, brightest young stars for a talent show of university students that aims to raise their awareness of the risk factors (smoking, drinking and HPV) as well as the symptoms of mouth cancer by making them appreciate their voice, which can be lost through mouth cancer. University students from across the country will be invited to perform a short demo for one of four categories and upload their demo to the Mouth Cancer Voice Awards 2007 Website (**www.mouthcancervoice.org**). These demos will be turned into video clips that will be voted for, by the general public. Voting will close at midnight on Wednesday 14 November 2007. Three acts in each category will be short listed to attend the grand final at the Vanburgh Theatre, Royal Academy of Dramatic Art (RADA) where they will perform live on Sunday 18 November 2007 before a panel of judges and be in with the chance of winning the prize of a lifetime.



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Mouth Cancer Awareness Week 2007

This year's Mouth Cancer Awareness Week campaign runs from 11 to 17 November 2007. This annual campaign is co-ordinated by the British Dental Health Foundation and more details about how to get involved will be published in next month's issue of **bda**news. Further information can be seen at **www.mouthcancerawarenessweek.org.uk**

Mouth Cancer Awareness Week is co-ordinated by the British Dental Health Foundation (BDHF) and supported by the Mouth Cancer Foundation and a wide range of leading national health organisations. These include Cancer Research UK, Denplan, Action on Smoking and Health (ASH), British Dental Association, British Association of Head and Neck Oncologists (BAHNO), British Association of Oral and Maxillofacial Surgeons (BAOMS), the health departments of the four UK countries, GKT, Pharmacy Health Link, QUIT and Scope.

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