

Before You Re-Decorate.....

Philip Lewis recommends not overlooking the basics

Before you re-decorate it's a good idea to check that the house isn't on fire. You know what? The same logic applies when providing aesthetic services because the most beautiful dentistry in the world isn't worth anything at all if our patient doesn't survive to enjoy it!

Like everyone else I love marveling at the outstanding creations from our most talented clinicians. I really enjoy learning

new techniques and making the most of what art and science has to offer. This is right and proper. We owe it to our patients to produce work of the finest quality which not only looks beautiful but is long-lasting and as minimally invasive as we can make it. We want our patients to leave at least as healthy as they were when they arrived!

That's the crux of it, really. We're first and foremost health care professionals and our primary duty is to protect our patients' well-being.

By now I guess you can see where this is going. We spend hours gathering data, taking photos, digitally assessing and treatment planning to structure courses of treatment which may take many months to complete. During that time chances are we'll be concentrating on the tasks in hand. We possibly won't carry out another routine examination until the treatment course is over, or if we're seeing the patient on referral will assume their regular dentist will be taking care of this.

Don't rely on it!

A two minute examination for early signs of mouth cancer can literally make the difference between life and death.

How often? As often as possible! Something that takes so little time can easily be included in review and treatment appointments. Adjusting an orthodontic appliance? Working on second stage implant therapy? Reviewing hygiene before moving ahead with preps? There are endless opportunities to provide this highly important service.

Who needs regular exams? Everyone over the age of 16. Mouth cancer is no longer the disease of old colonels and while fine cigars and single malts may still have something to do with the risks of developing the disease, sadly, we're seeing many more cases among women and the young as well as among people who don't fall into the traditional high risk groups of tobacco users and spirit drinkers. We know other things are involved: social deprivation, age, gender, infection with some strains of the human papilloma virus for example but unfortunately we don't know what we don't know. There are probably other unrecognized risk factors-the bottom line is that the incidence of mouth cancer has increased by about 50% in the last 10 years. That's why everyone (including ourselves) need regular checks.



The incidence of mouth cancer has increased 50% in the last 10 years

So how do we carry out an examination. It's divided into 2 parts. The first part begins as the patient enters the room. We look for obvious asymmetry, listen to their voice; is it hoarse or unusual (if so, for how long?), are there any unusual blemishes of the skin that we should look at or question the patient about more closely?

We carry on by examining the head and neck for lumps. We need to access the tissues right down to the clavicles. It's essential we've told the patient in advance that this is planned or they may be suspicious of the procedure.

We stand directly in front and then behind the patient. Observing from a different angle may help to avoid missing swellings. We ask the patient to move the head from side to side. This stretches the skin over the deeper tissues making subcutaneous enlargements more obvious.

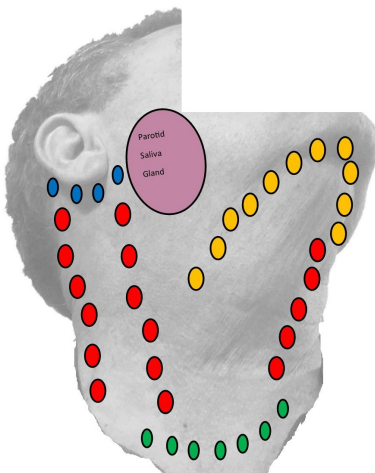
Fingers are walked over the tissues with gentle but firm pressure to identify enlarged lymph nodes. Lymph nodes are part of the immune system. They often enlarge when an individual is fighting an infection and are then readily palpable. Infections can either originate from the organs that they drain or primarily within the lymph node itself, referred to as lymphadenitis.



Skin lesions: 'Has it changed recently or got bigger? Does it itch or bleed?' The patient is a great source of information.

Position of the main groups of lymph nodes

- On either side of the major muscle that turns the head
- Under the jaw and chin
- In the hollow above the collar bones
- In front and behind the ear



Position of nodes

Lymph nodes enlarged because of infection tend to be:

- Soft, tender and warm. The inflammation may spread to the overlying skin, causing it to appear reddened. The nodes return to normal when the infection is over.

Malignancies can also involve the lymph nodes, either primarily for example in the case of lymphoma or as a site of metastasis. In either case, these nodes are generally:

- Firm, non-tender, matted (i.e. stuck to each other), fixed (i.e. not freely mobile but rather stuck down to underlying tissue) and increase in size over time.

The major lymph node groups are located along the anterior and posterior aspects of the sternocleidomastoid muscle and the underside of the jaw. If the nodes are quite big, they may be visible bulging under the skin, particularly if the enlargement is asymmetric.

Examine both sides of the head simultaneously, walking the fingers down the area in question while applying steady, gentle pressure.

The posterior cervical chains extend in a line posterior to the SCMs but in front of the trapezius, from the level of the mastoid bone to the clavicle. Further nodes will be found in front of the muscle.

Additional lymph node chains include:

Tonsillar: Located just below the angle of the mandible.

Sub-Mandibular: Along the underside of the jaw on either side.

Pre-auricular and post-auricular lymph nodes.

Sub-Mental: Just below the chin. Drainage: The teeth and intra-oral cavity.

Supra-clavicular: In the hollow above the clavicle, just lateral to where it joins the sternum.

It is also important to recall that swellings of the salivary glands can be an early indication of tumours, thus it is essential that the examination includes these structures.

Carefully record any unusual findings in the patient records.

The second part of the examination looks at the intra-oral tissues. We need to assess the lips, labial mucosa and sulcus, commissures, buccal mucosa and sulcus, gingiva and alveolar ridge, tongue, floor of the mouth and hard and soft palate.



The tongue is a high-risk area. Any unexplained lesions should be carefully investigated

During the intra-oral examination mirrors, spatulas or even fingers may be used to hold away tissues. It is essential the areas covered by these retractors are also examined as the examination moves on.

With the patient's tongue at rest, and mouth partially open, inspect the dorsum of the tongue for any swelling, ulceration, coating, or variation in size, colour, or texture.

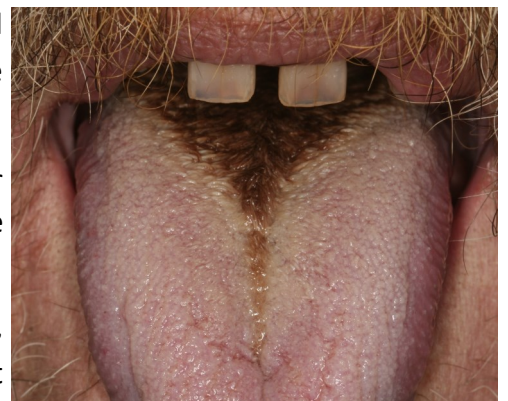
The patient should then protrude the tongue. The examiner should note any abnormality of tongue mobility or position. With the aid of mouth mirrors, inspect the right and left lateral margins of the tongue.

Grasping the tip of the tongue with a piece of gauze will assist full protrusion. Palpate the tongue to detect growths. Then examine the ventral surface.

With the tongue still elevated, inspect the floor of the mouth for changes in colour, texture, swellings, or other surface abnormalities.

With the mouth wide open and the patient's head tilted back, gently depress the base of the tongue with a mouth mirror. First inspect the hard and then the soft palate.

Examine all soft palate and oropharyngeal tissues.



A number of harmless conditions can also affect the appearance of the tongue, including black, hairy tongue shown here

Bimanually palpate the floor of the mouth for any abnormalities. Use one hand to support the floor of the mouth while examining with the fingers of the other hand. All mucosal or facial tissues that seem to be abnormal should be palpated.

It is important to emphasise the careful examination of the posterior floor of the mouth by placing a mirror on the lateral aspects of the posterior, non-protruded tongue to allow demonstration of this site.

Any unusual findings from the examination should be recorded in the patient's records. As well as a written description recording the shape, texture, colour and position of lesions. Identifying these on a mouth map is useful. Equally useful is a clinical photograph of the lesion. All these methods of recording enable clinicians to reliably track the progress of lesions.

Arrange to review or refer as appropriate.

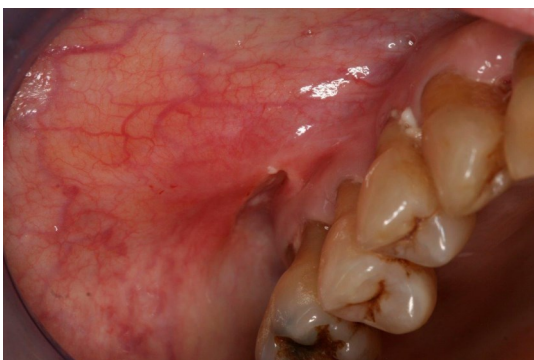
So what are we looking for? Well basically anything we find unusual. Of course there are many innocent things that make the appearance of the inside of the mouth unusual. Trauma, for example; however traumatic injuries will usually heal quickly and if we suspect that's what we're looking at we can review after a couple of weeks to make sure the problem has resolved.

What we're specifically looking for are:

- Red or white patches of no obvious cause
- Unexplained lumps
- Ulcers that don't heal in a maximum of 3 weeks
- Changes in texture or sensation
- Bleeding from the mouth or throat in the apparent absence of gum disease
- Teeth that loosen in the apparent absence of gum disease
- Hoarseness of the voice
- Reports of a feeling of something 'stuck' in the throat



People injure themselves in all sorts of ways. This traumatic ulcer was caused by the lower full denture driving into the gum during a fall and healed in about 3 days



All ulcers should heal in a maximum of 3 weeks



Red, white and mixed red and white patches should be investigated

If anything we find in our examination leads us to believe we may have discovered early mouth cancer THE PATIENT MUST BE REFERRED IMMEDIATELY FOR A SPECIALIST ASSESSMENT. Rapid referral pathways exist in all health areas. Find out how to access yours.

Patients should be encouraged to examine themselves regularly at home. Details of how to do this can be found on the Mouth Cancer Foundation website: www.mouthcancerfoundation.com 'Bite Back at Mouth Cancer'.

A full early detection examination including palpation takes less than 2 minutes.

Factoring that into our routine workflow could save a life and leave us free to continue carrying out the high quality aesthetic treatments our patients deserve.

Beautiful!



Leaflets on self-examination are available free of charge from the Mouth Cancer Foundation

Philip Lewis runs a private dental practice on the Isle of Wight

He has been involved in education about the early detection of mouth cancer for many years and helps design educational material for a number of groups.

Philip currently serves as President of the Mouth Cancer Foundation; a national charity aimed at supporting mouth cancer sufferers and survivors along with their families and friends, raising awareness of the disease among professionals and the public and providing information and resources for all.