The Royal Marsden GP Education Series

The Royal Marsden

Oral cancer and Primary Care

18th October 2016

Dr Richard Roope
RCGP and Cancer Research UK Cancer Clinical Champion
Senior Clinical Advisor Cancer Research UK
Oral cancer and Primary Care

- Training
- Incidence
- Prevention
- Oral Cancer recognition tool kit
- Referral Guidelines – NICE Guidance
- Case Study
Where is oral cancer in medical training?
Where is oral cancer in medical training?

Prior to qualifying as a Doctor, how much teaching or training did you have on oral cancer?
Prior to qualifying as a Doctor, how much teaching or training did you have on oral cancer?

A. None  
B. Up to 1 day  
C. Up to 1 week  
D. Up to 1 month  
E. More than 1 month

36%  
41%  
12%  
6%  
5%
Where is oral cancer in medical training?

Since qualifying as a GP, how much teaching or training have you had on oral cancer prior to today?
Since qualifying as a GP, how much teaching or training have you had on oral cancer prior to today?

A. None
B. Up to 1 hour
C. Up to 1 day
D. Up to 1 week
E. More than 1 week

Diagram:
- None: 29%
- Up to 1 hour: 25%
- Up to 1 day: 29%
- Up to 1 week: 10%
- More than 1 week: 8%
Where is oral cancer?
How often is there likely to be a case of oral cancer in a practice of 10,000 patients?

A. 4 cases per year
B. 2 case per year
C. 1 case per year
D. 1 case every 2 years
E. 1 case every 4 years
Where is oral cancer?

How often is there likely to be a case of oral cancer in a practice of 10,000 patients?

1. 4 cases per year
2. 2 case per year
3. **1 case per year**
4. 1 case every 2 years
5. 1 case every 4 years
Where is oral cancer?

Which is the rank order for increase of incidence cancer sites 2002-4 to 2011-13?

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<th>3</th>
<th>4</th>
<th>5</th>
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Which is the rank order for increase of incidence cancer sites 2002-4 to 2011-13?

1. Oral, liver, melanoma, stomach, bladder
2. Melanoma, oral, bladder, liver, stomach
3. Liver, melanoma, oral, bladder, stomach
4. Melanoma, liver, stomach, oral, bladder
5. Oral, bladder, liver, melanoma, stomach
Where is oral cancer?

Which is the rank order for increase of incidence cancer sites 2002-4 to 2011-13?

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cancer Site 1</th>
<th>Increase</th>
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<tbody>
<tr>
<td>1</td>
<td>Oral</td>
<td>52.1%</td>
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<tr>
<td>2</td>
<td>Melanoma</td>
<td>47.2%</td>
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<tr>
<td>3</td>
<td>Oral</td>
<td>37.1%</td>
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<td>4</td>
<td>Bladder</td>
<td>-12.6%</td>
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<td>5</td>
<td>Stomach</td>
<td>-28.3%</td>
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Where is oral cancer?

% change 2002-4 to 2011-3

- Malignant Melanoma
- Oral
- Kidney
- Uterus
- Non-Hodgkin Lymphoma
- Myeloma
- Pancreas
- CNS
- Mesothelioma
- Breast
- Prostate
- Bowel
- Leukaemia
- Cervix
- Lung
- Oesophagus
- Ovary
- Bladder
- Stomach
Where is oral cancer?

% change 2002-4 to 2011-3
Where is oral cancer?

![Graph showing the rate of oral cancer incidence over time for males, females, and all persons.](http://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/oral-cancer/incidence#heading-Two)
Oral Cancer

MOUTH CANCER RATES ON THE RISE

INCIDENCE RATES OF MOUTH CANCER
PER 100,000 POPULATION, UK

**MEN**

- 2004: 12.5
- 2006: 15.0
- 2008: 16.5
- 2010: 17.7
- 2012: 18.2

**WOMEN**

- 2004: 6.0
- 2006: 6.5
- 2008: 7.0
- 2010: 7.9
- 2012: 8.5

**INCREASE OVER THE LAST 10 YEARS**

- **MEN**: 32%
- **WOMEN**: 33%

**10TH MOST COMMON CANCER**

**15TH MOST COMMON CANCER**

Source: cruk.org/cancer
Where is oral cancer?

Oral Cancer 5 year moving average annual change

Where is oral cancer?
Where is oral cancer?

- **Gum**: 4% (2), 8% (2)
- **Palate**: 6% (2), 9% (2)
- **Tonsil**: 20% (1), 14% (1)
- **Floor of mouth (Under the tongue)**: 8% (1), 8% (1)
- **Base of tongue**: 13% (1), 7% (1)
- **Lip**: 5% (1), 5% (1)
- **Other and unspecified parts of tongue**: 18% (1), 25% (1)
- **Oropharynx**: 6% (1), 4% (1)
- **Hypopharynx**: 4% (1), 3% (1)
- **Piriform sinus**: 6% (1), 3% (1)
- **Other, unspecified parts of mouth and ill-defined lip, cavity and pharynx**: 12% (1), 16% (1)
Where is oral cancer?

MOUTH CANCERS AND THE AVERAGE NUMBER OF CASES PER YEAR  
UK, 2010-2012

- Lips: 370
- Gums: 370
- Palate: 470
- Back of the throat (Oropharynx): 330
- Tonsils: 1,240
- Other (includes unspecified and ill defined): 890
- Other throat (Piriform sinus and hypopharynx): 580
- Under tongue (Floor of mouth): 520
- Tongue: 2,140

Source: Cancer Research Science blog
Accessed February 2016
Where is oral cancer?
Oral Cancer
Oral Cancer

- 7591 new cases per year (21 per day) in 2013
- 2119 deaths per year (6 per day) in 2012
EDUCATION AND PREVENTION ARE KEY

RISK FACTORS FOR ORAL CANCER:
• Dependent on many factors, including age, genetics and exposure to risk factors, which can vary by the site of oral cancer
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RISK FACTORS FOR ORAL CANCER:
• Dependent on many factors, including age, genetics and exposure to risk factors, which can vary by the site of oral cancer

Up to 91% of oral cancers are linked to preventable lifestyle factors

EDUCATION AND PREVENTION ARE KEY

Option 1
1. Cigarette smoking
2. Pipe smoking
3. Alcohol 1.5u/day
4. Caffeinated coffee
5. Exercise

Option 2
1. Pipe smoking
2. Cigarette smoking
3. Alcohol 1.5u/day
4. Exercise
5. Caffeinated coffee

Option 3
1. Cigarette smoking
2. Pipe smoking
3. Alcohol 1.5u/day
4. Exercise
5. Caffeinated coffee

Option 4
1. Pipe smoking
2. Alcohol 1.5u/day
3. Cigarette smoking
4. Exercise
5. Caffeinated coffee

Which ranking is correct in listing the factor increasing risk of oral cancer the most to the factor protecting against oral the most?

VOTE NOW...
Which ranking is correct in listing the factor increasing risk of oral cancer the most to the factor protecting against oral the most?

A. Cigarette smoking, pipe smoking, 1.5 u alcohol/day, caffeinated coffee, exercise
B. Pipe smoking, cigarette smoking, alcohol, exercise, coffee
C. Cigarette, pipe smoking, coffee, exercise, alcohol
D. Pipe, alcohol, cigarette smoking, exercise, coffee
EDUCATION AND PREVENTION ARE KEY

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<td>4. Exercise: -35%</td>
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Pipe smoking: +300%
Cigarette smoking: +200%
Alcohol 1.5u/day: +35%
Exercise: -35%
Caffeinated coffee: -39%
EDUCATION AND PREVENTION ARE KEY

Change in risk of oral cancer

- pipe smoking: 300%
- cigar smoking: 250%
- cigarette smoking: 200%
- EtOH 6u/day: 150%
- FH oral cancer: 100%
- EtOH 1.5u/day: 50%
- Vit C supplements: -50%
- high vegetable: -50%
- exercise: -50%
- high folate: -50%
- Ca++ supplements: -50%
- caffeinated coffee: -50%
- high fruit: -50%

Oral Cancer – Prevention?

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Oral Cancer Recognition Toolkit
Oral Cancer Recognition Toolkit

Improve your knowledge of the prevention and detection of oral cancer, including what to look out for and when and how to respond. This toolkit covers oral and oropharyngeal cancers including lip cancer.

Referral decision guide
This practical tool illustrates the red flags which should prompt referral to secondary care via a suspected cancer pathway.

› View referral decision guide

Test your knowledge
Boost your knowledge of oral cancer and appropriate referral pathways with this eCME quiz.

› Take the eCME quiz

Lesion recognition resource
Browse images and descriptions of different types of lesion.

› View resource

VIDEO: Oral, head and neck examination
Watch a 3 minute video demonstrating how to perform an examination.

› View oral cancer risk factors

http://www.doctors.net.uk/eClient/CRUK/oral_cancer_toolkit_2015/
AIMS of the Toolkit

• Overall aim of the project is to improve patient outcomes for oral cancer
• To create practical online training tool with ongoing support
• To apply learnings from the successful skin cancer toolkit produced three years ago which delivered an average increase in knowledge of 11.41%

Dr Nigel Carter OBE, Chief Executive of the British Dental Health Foundation, stated that “Early diagnosis transforms our chances of beating the disease from 50% to 90% so it is crucial that we know what to look out for and that we do not hesitate in seeking advice from a health professional”
OBJECTIVES

PREVENTION

• To encourage GPs to disseminate prevention messaging to their patients
• To increase GPs’ knowledge around prevention and detection of oral cancer

DETECTION

• To increase GPs’ confidence to refer suspicious oral lesions as appropriate to secondary care
• To increase awareness among GPs of the two-week wait pathway and increase its use
• To encourage GPs to undertake oral screening when appropriate
DEVELOPMENT

EXPERT COLLABORATION IS KEY TO SUCCESS:

• Collaboration with an expert panel, the British Dental Association and British Society for Dental Hygiene and Therapy to shape the content of the toolkit to include:
  • Image library of normal, borderline and suspicious lesions
  • Examination guide relevant to GPs
  • National suspected cancer referral guidelines
  • 3 real life case studies
  • CPD RCGP accredited quiz
  • Risk factors

With special thanks to: Professor Richard Shaw, Professor Peter Brennan, Professor Saman Warnakulasuriya, Dr Afsana Safa, Mr Craig Wales, Professor Mark McGurk, Professor Crispian Scully, Dr Nigel Carter and Dr Caroline McCarthy
SIMPLIFYING THE PROCESS:

- During development the expert advisory group had concerns that the recommendations within NG12 may introduce an additional barrier and may delay diagnosis for patients that did receive a diagnosis of oral cancer.
- As such the panel agreed to simplify the NICE referral recommendations by suggesting that:
  - GPs should consider referring patients directly for further investigation if they have symptoms suggestive of oral cancer
ENGLAND, WALES, NORTHERN IRELAND: NICE RECOGNITION AND REFERRAL GUIDELINES

− Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for oral cancer in people with either:
  • unexplained ulceration in the oral cavity lasting for more than 3 weeks or
  • a persistent and unexplained lump in the neck

− Consider an urgent referral (for an appointment within 2 weeks) for assessment for possible oral cancer by a dentist in people who have either:
  • a lump on the lip or in the oral cavity or
  • a red or red and white patch in the oral cavity consistent with erythroplakia or erythroleukoplakia

− Consider a suspected cancer pathway referral by the dentist (for an appointment within 2 weeks) for oral cancer in people when assessed by a dentist as having either:
  • a lump on the lip or in the oral cavity consistent with oral cancer or
  • a red or red and white patch in the oral cavity consistent with erythroplakia or erythroleukoplakia

REFERRAL RECOMMENDATIONS
REFERRAL RECOMMENDATIONS

CANCER RESEARCH UK REFERRAL RECOMMENDATIONS:

• For the following conditions, GPs and dentists should consider referring patients to secondary care via a suspected cancer pathway:

  • unexplained ulceration in the oral cavity (lasting more than 3 weeks)
  • lump on the lip or in the oral cavity consistent with oral cancer
  • persistent and unexplained lump in the neck
  • red or red and white patch consistent with erythroplakia or erythroleukoplakia
REASONS FOR RECOMMENDATIONS

This Oral Cancer Recognition Toolkit deviates somewhat from advice given in the new NICE guidelines 2015, following an evidence review and advice to Cancer Research UK from clinical specialists.

The reasons for this deviation are as follows:

- Cross referral from GP to dentist introduces an additional step and potential delay into the diagnostic pathway for some patients.
- Many people (and potentially those more likely to develop mouth cancer due to behaviour/lifestyle factors) do not have a dentist, and dentists have no obligation to accept patients.
- For some patients attendance at a dentist is associated with financial outlay.
- The extra step may confuse/inhibit patients from attending further appointments.
- Referring a lump/ulcer/other lesion to a dentist rather than secondary care could compromise the outcome for the minority who have oral cancer, as it could introduce delay.
Examination of the Oral Cavity:

https://youtu.be/nM5J7yDfeAM
LESION RECOGNITION RESOURCE

3 MAIN SECTIONS:

– Images of confirmed oral cancer by different cancer site
– Images of suspicious lesions
– Images of potentially malignant lesions
– Also includes:
  • Images of other mucosal disorders and normal images of the mouth
ORAL CANCER: URGENT REFERRAL

THESE ARE JUST SOME OF THE IMAGES FROM THE ORAL CANCER RECOGNITION TOOLKIT:

Carcinoma of floor of the mouth (FOM)
A mixed red-white, irregular lesion with erosive features, on the floor of mouth. The lesion crosses the midline but is predominantly on the right side. This lesion is amenable to resection.

T1 squamous cell carcinoma (SCC) of anterior FOM
A small lesion whose appearance would not necessarily be obvious for SCC. The anterior floor of mouth is a high risk site for oral SCC, particularly in smokers and requires specific targeted examination to reveal lesions such as this. At this stage the lesion is highly curable with minor surgery and few functional effects.

T1 squamous cell carcinoma (SCC) of anterior FOM
A very small lesion whose appearance would not necessarily be obvious for SCC. The anterior floor of mouth is a high risk site for oral SCC, particularly in smokers and requires specific targeted examination to reveal lesions such as this. At this stage the lesion is highly curable with minor surgery and few functional effects.

T2 oral SCC of anterior FOM
This was a rapidly growing endophytic (growing in rather than out) ulcer in the floor of mouth, a typical site for oral SCC accounting for around 40% of all cases.
ORAL CANCER: URGENT REFERRAL

THESE ARE JUST SOME OF THE IMAGES FROM THE ORAL CANCER RECOGNITION TOOLKIT:

**Carcinoma of the right tongue**
Exophytic indurated squamous cell carcinoma (SCC) on the right ventral tongue. Seen here in a heavy smoker. On examination the tongue may be tethered and speech affected.

**Carcinoma of the tongue**
An obvious oral cancer: a large ulcerated mass on the left posterior dorsal tongue. The periphery of the lesion looks indurated and appears to be spreading across the tongue.

**Tongue melanoma**
Irregular pigmented area on right lateral tongue. This may mimic a benign vascular lesion. Finding out the duration and history here is crucial.

**T2 ventral tongue**
This small lump shows surface irregularity but not frank ulceration. Surrounding white patches (leukoplakia) suggest there was a preceding lesion for sometime that might have been missed.
ORAL CANCER: SUSPICIOUS URGENT REFERRAL

THESE ARE JUST SOME OF THE IMAGES FROM THE ORAL CANCER RECOGNITION TOOLKIT:

**Erythroleukoplakia**
Red plaques in the mouth are associated with early malignancy in around 50% so referral on the 2-week-cancer pathway is entirely justified.

**Erythroleukoplakia on the buccal mucosa**
Aggressive looking lesion affecting buccal mucosa commissure. A biopsy is required to exclude squamous cell carcinoma (SCC).

**Erythroleukoplakia on hard palate**
A mixed red-white lesion centrally on the hard palate. The lesion is reasonably small but given the non-homogenous appearance, excision would be considered.

**Erythroplakia**
Fulminant erythematous area left floor of mouth. Dysplasia requires exclusion.
POTENTIALLY MALIGNANT

THESE ARE JUST SOME OF THE IMAGES FROM THE ORAL CANCER RECOGNITION TOOLKIT:

**Leukoplakia**
Idiopathic white plaques are referred but not on the 2-week-cancer pathway. There is a risk of malignant transformation, but it is not always a high risk and may take years to progress. Specialist opinion and ongoing review is mandatory and a biopsy is required.

**Leukoplakia on gingiva**
Homogenous leukoplakia with a verrucous surface, on the upper right attached/unattached gingivae. This type of lesion is typically seen in patients with proliferative verrucous leukoplakia, which carries a high risk of malignant transformation.

**Leukoplakia on floor of mouth**
A large homogenous leukoplakia on the floor of mouth, bilaterally. This lesion carries a high risk for malignant transformation due to the site and size.

**Candidal leukoplakia**
Leukoplakiic patch on left buccal mucosa onto commissure. A biopsy is useful to exclude dysplasia but anti-fungals may be employed in addition.
CASE STUDIES
JIM’S STORY:

Jim, a 62-year-old lorry driver, presented to his GP after noticing an increasingly painful mass on his tongue. He had not been to a dentist in over 20 years and has poor dental health. He is a regular drinker, and although he has tried to give up, he still smokes over 20 cigarettes a day. These habits have been lifelong. He has chronic obstructive pulmonary disease and hypertension. Jim is divorced with grown up children who work abroad.

He presented to his GP with a 4-month history of pain, increasing difficulty in swallowing and halitosis. He had lost weight recently and has a fairly limited diet. The GP notices a worrying sloughy ulcer on the left side of the tongue, with rolled edges which showed obvious contact bleeding.

What did the GP do next?
JIM’S STORY:

The GP felt that the lesion was highly suspicious for oral squamous cell carcinoma (SCC) and arranged an urgent 2-week wait referral. He needed immediate nutritional support and pain management.

The important learning points are:

- Traditional risk factors for oral cavity SCC are **smoking and alcohol**.
- Late presentation is quite common with about **50% of lesions presenting with stage III/IV**, which has a relatively poor prognosis and severe functional impairment in survivors. Treatment is likely to entail major surgery, complex reconstruction and adjuvant radiotherapy or chemoradiotherapy.
- **Many patients with a high risk of oral cancer do not receive regular dental inspections**, but significant smoking/ alcohol habits make the need for dental care and oral examination more necessary.
- Patients whose tumours are **stage I/II may have excellent cure rates** with minor surgery and few functional sequelae, highlighting the need for early diagnosis and heightened awareness in GPs and dentists.
TOOLKIT FEEDBACK
TOOLKIT FEEDBACK

“Really helpful resource”
Dentist

“I liked the quiz, I found it a very useful refresher of my cancer knowledge, I read the case histories and will finesse my examination technique after having watched the video. A useful exercise for me, Thank you”
GP

“So pleased I found this toolkit, very well presented and given me confidence to further my oral exam skills”
GP

“Concise and easy to follow”
Dentist

“I found it a very useful refresher of my cancer knowledge, I read the case histories and will finesse my examination technique after having watched the video a useful exercise for me thankyou”
GP

“Good Pictures”
Dentist

“Excellent really quick and easy to go through and very informative”
GP

Royal College of General Practitioners
TOOLKIT Website:

https://www.youtube.com/watch?v=nM5J7yDfeAM
Oral cancer and Primary Care

- Training
- Incidence
- Prevention
- Oral Cancer recognition tool kit
- Referral Guidelines – NICE Guidance
- Case Study
Learning

A. Significance of Oral Cancer
B. Significance of prevention
C. Recognition toolkit
D. Examining the oral cavity
E. All the above
THANK YOU