The National Society of Dental Practitioners and the Dentist's Advantage Insurance Program for Dentists

RISK MANAGEMENT ARTICLE

The Significance of Claims Involving Oral Cancer

The statistics regarding oral cancer in America may be surprising to many. Approximately 42,000 Americans are diagnosed with oral or pharyngeal cancer each year. Of those, approximately 8,000 die each year and only 57% will live more than 5 years after the diagnosis. These numbers can be surprising to most general dentists as many will tell you he or she has never "found" oral cancer in practice. Unfortunately, the death rate associated with these types of cancers is particularly high due to routine late discovery.

The importance of thorough oral cancer screening on each and every patient cannot be stressed enough. The trends in the occurrence of oral cancer are changing over time, and it is no longer just the over 50 year old male heavy smokers that a dentist or hygienist should carefully screen. Currently, for every woman diagnosed with oral cancer there are 2 men diagnosed. That is a significant increase in the number of female oral cancer patients over the last 20 years. Also, African Americans are twice as likely to have oral cancer as Caucasians. Although lifestyle choice remains the biggest risk factor (smoking, alcohol, diet lacking fresh fruits and vegetables), viral sources, specifically the HPV16 virus, are currently becoming more and more common. Importantly, cancerous lesions in the anterior of the mouth, usually caused by tobacco and alcohol use, have declined; whereas lesions in the posterior of the oral cavity, associated with the HPV16 virus, are on the rise.

Although claims involving oral cancer are few and far between, the claims alleging a failure to diagnose or failure to timely refer for evaluation of a potentially cancerous lesion can be disastrous. As the claims administrator for the Dentist Advantage program, any time we receive a claim involving oral cancer, it is immediately flagged as a potentially catastrophic claim.

Case Study[1]

Doctor Sheridan is a general dentist in downtown Minneapolis. She has been practicing for about 8 years and recently opened her own practice. She employs two part time hygienists and runs a busy practice with three restorative operatories. Dr. Sheridan expects that her hygienists will perform routine oral cancer screenings on each patient at his or her routine recall appointments and ensures the findings of the screening is documented in the patient chart. However, she does not necessarily routinely perform screenings on patients who present for emergency or restorative treatment.

Ms. Wilson first presented to Dr. Sheridan's practice for an emergency exam complaining of a broken molar that was irritating the inside of her cheek. Dr. Sheridan did a limited exam and diagnosed a fractured buccal cusp on tooth #3 with some trauma to the adjacent buccal mucosa, apparently from repeated biting of the tissue. Dr. Sheridan prepped the tooth for a crown and seated the permanent crown about 10 days later. Approximately a week after the crown was seated Ms. Wilson returned to Dr. Sheridan's office complaining that she was still biting the inside of her cheek while eating and the area was quite sore.

Over the next six or seven months Ms. Wilson returned multiple times complaining that she was continuing to bite the inside of her cheek despite Dr. Sheridan's attempts to adjust the crown and adjacent teeth. During this time Ms. Wilson saw one of the hygienists who noted a hard callused area adjacent to tooth #3, which the patient attributed to chronic cheek biting.

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After approximately seven months of being unable to successfully make Ms. Wilson comfortable, Dr. Sheridan referred Ms. Wilson to an orthodontist to evaluate Ms. Wilson's occlusion. The orthodontist did an initial evaluation and due to his concern for the chronic lesion in the buccal mucosa, he immediately referred Ms. Wilson to an oral surgeon. The oral surgeon performed a biopsy of the lesion which came back positive for squamous cell carcinoma.

Ms. Wilson, a 36 year old professional mother of two, died within 2 years from complications from the metastasizing cancer.

Ms. Wilson's widower now brings a lawsuit against Dr. Sheridan for failing to either timely diagnose the cancer or timely refer to a specialist for evaluation of the lesion. Because Dr. Sheridan failed to properly refer Ms. Wilson to an appropriate specialist for evaluation in a timely manner, she faces a catastrophic lawsuit as well as the emotional burden of knowing Ms. Wilson may have survived had Dr. Sheridan timely referred Ms. Wilson to an oral surgeon.

Because Ms. Wilson first presented to Dr. Sheridan with what appeared to be a logical explanation for the lesion adjacent to the fractured molar, she failed to recognize the possibility of an alternative cause for the presence of the lesion, and why the lesion failed to heal. Making such an assumption was a vital error.

As a general dentist one of the tools for protecting yourself from disastrous claims such as this one is keeping in mind the above stated statistics and screening each and every patient for oral cancer. An accepted standard is if the lesion persists for more than a week or two following palliative treatment, the patient must have a biopsy or be referred for one. Although dentists may reasonably rely upon his or her hygienists to perform oral cancer screenings at recall appointments, it is important to keep in mind that many patients come to your practice with a problem that requires immediate attention before a preventative recall appointment routine is in place. It was this situation that allowed Ms. Wilson to "slip through the cracks." A screening should be performed routinely, even if the patient is not presenting for routine recall appointments.

As all dentists learned in dental school, any lesion that does not timely heal should be treated as potentially cancerous. The lesions can present as leukoplakia or erythroplakia, as well as lumps or thickening of the oral tissues, or soreness or lumps in the throat. Recall that the occurrence of cancers originating in the posterior of the oral cavity are on the rise, so take special care to check the tonsilar and pharyngeal areas in the oral cavity. Also take note of complaints of difficulty chewing or swallowing, ear pain, difficulty moving the jaw or tongue, numbness of the tongue or mouth, or swelling of the jaw. Be sure to perform both an intra oral and extra oral exam. Just as important, always thoroughly document that an oral cancer screening has been done, as well as any findings. Any findings should include a specific description of the location, size and characteristics of the lesion. Always ask the patient if they are aware of the lesion, and if so, how long it has been present. Note this is the chart. If the lesion has been present for more than 10 days, immediate refer to an oral surgeon. If the lesion has been present for less than 10 days, be sure to advise the patient he or she needs to return to your office for a follow up exam in one week to reevaluate the area. Also note this conversation in the chart. The key to complying with the standard of care is timely biopsy or referral. If the lesion has been present for more than a week or two, immediately refer to an oral surgeon. An oral cancer screening takes no more than a couple minutes and can significantly reduce your risk of facing a serious professional liability claim, and more importantly, may save someone's life.

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[1]The following represents an actual claim handled by our office. The names and some non-relevant facts have been changed for confidentiality.

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