

# Our role in early detection of Head and neck cancer

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Last November, I had the honour of attending the Swallows/Your Cancer Journey International Head and Neck Cancer Conference in Nottingham. The conference is organised by the founder and chairman of the Swallows Charity, Chris Curtis, a pharyngeal cancer survivor: he was diagnosed in 2011 with throat cancer, which had gone undetected by his dentist during regular routine dental checks.

I was there to carry out intra and extra oral screening and to raise awareness of the need for early detection. I was profoundly moved by the stories of the patients who were attending this conference and I feel compelled to shout out about the vital part we play in preventing and detecting head and neck, mouth and pharyngeal cancer.

I wonder just how many of you reading this have first-hand experience of a friend, colleague, loved one or patient who is living with the devastating after effects of a mouth, pharyngeal or head and neck cancer?

## The International Head and Neck Cancer Conference 2018

Chris, his wife Sharon, and a dedicated team at the Swallows Charity provide a crucial support system for people who have undergone and survived treatment for head and neck cancer. He is a world head and neck cancer ambassador and is passionate about raising awareness of some of the causative factors of head and neck cancers and the importance of early detection screening. He brings together an international group of professional and patient speakers who consist of leading doctors, oncologists, specialist nurses, researchers, radiologists, surgeons, dental practitioners, mouth, pharyngeal and head neck cancer survivors and their families. There is also an array of support professions whose work assists the medical teams and the patients through their journey. These professions consist of pharmaceutical companies who provide products to help manage the after effects of radiotherapy on the body, such as oral mucositis and extreme skin irritation; nutritional companies who create tasty and appetising pureed meals;

companies which manufacture percutaneous endoscopic gastroscopy support; companies who make inventive and creative radiotherapy thermoplastic guide masks; support for returning to work after cancer, and get-aways for when it all gets too much to cope with or to help with rehabilitation.

What struck me most was the realisation that we could be doing more to prevent these experiences from happening. The people I met have all suffered, not just the patients, but their families also. Their experiences are horrific and their faces literally bear the scars. They live with the psychosocial stigma of facial disfigurement, speech distortion, or sometimes no speech at all, and unbearable oral discomfort. Some are unable to eat or drink ever again therefore losing one of life's great pleasures. However, they are all triumphant survivors. They have lived to tell their tale and share their stories. But what about those whose diagnosis is made too late? The ones who didn't survive?

## Facts and figures

Head and neck cancers are differentiated in to sub groups depending on location: mouth cancers affect the lips, salivary glands, tongue, gums, palate and inside of the cheeks, while tumours at the root of the tongue, soft palate, tonsils and the upper part of the pharynx are defined as pharyngeal cancer. Cancers affecting the nasal cavity and paranasal air sinuses are also included in head and neck cancers.

The Mouth Cancer Foundation and Cancer Research UK statistics show that:

- In 2014 over 11,000 new cases were diagnosed and there were 2,386 deaths.
- Head and neck cancer diagnoses are increasing when other cancers are reducing in incidence.
- Head and neck cancers are up by 30% since 1990 and are projected to rise by a further 33% by 2035.
- For men under 50, the rate has jumped by 67% in the last 20 years going up from around 340 cases to around 640 cases each year.



- For men aged 50 and over, rates have increased by 59% climbing from around 2,100 cases to around 4,400 cases annually.
- In the UK 38,000 people are living with a diagnosis of head and neck cancer.
- Approximately 60,000 more people in the UK will be diagnosed in the next 10 years.
- Mouth and throat cancers grow and spread very quickly.
- One person dies from mouth cancer every 3 hours in the UK because of late detection.

We know that the increase in diagnoses is attributable in the large part to HPV transmission, more so now than alcohol and tobacco as causative factors but 25% of mouth cancers have no known causative factors. We also know that by the time a mouth cancer is visible or detectable to us it is already in its advanced stages. This makes it very difficult to treat and significantly lowers the five year survival statistics.

Of everyone that I screened or discussed routine head and neck cancer screening with at this conference, only one was aware that they had ever had an extra oral or intra oral examination performed by a dental professional. Almost none remembered having their lymph glands palpated. My patients over these two days were the researchers, the doctors, the carers, the survivors, the exhibitors and even the venue staff; people who are overall knowledgeable in the cancer world. Does this mean that it is not being done, or that the patient is not sufficiently informed that it is being done?

What I have come to realise in my ongoing work for early detection is that many dental professionals may not be aware of what 'doing their bit' entails. I also had the privilege recently to observe an oral medicine referral clinic run by Professor Mike Lewis at Cardiff University Dental Hospital. There were plenty of worrying cases presenting at this clinic and I learned that it is very important that we know what and when to refer.

### So what should we be doing?

We should be educating our patients, young and old, about the known social and sexual risk factors, particularly of the mouth and pharyngeal structures, and we should also be clearly informing them that they are being screened (subject to their consent). Traditional beliefs about high risk groups are now blurred, especially with increased HPV related pharyngeal cancers. We should be adhering to GDC guidelines concerning early detection by using every available resource we have. This includes keeping our knowledge current with vital CPD, by using thorough screening protocols at least once every year and using emerging technologies

to assist early detection.

The Mouth Cancer Foundation [[www.mouthcancerfoundation.org](http://www.mouthcancerfoundation.org)] has a detailed breakdown of a thorough intra and extra oral screening process.

Cancer Research UK [[www.cancerresearchuk.org](http://www.cancerresearchuk.org)] has developed an oral cancer toolkit to help spot abnormalities and know when to refer. This includes NICE referral guidelines, videos, recognising abnormality photos and quizzes:

[www.doctors.net.uk/eclientopen/cruk/oral\\_cancer\\_toolkit\\_2015\\_open/](http://www.doctors.net.uk/eclientopen/cruk/oral_cancer_toolkit_2015_open/)

### Early detection technology

For the past four years I have been using adjunctive tissue auto fluorescence technology to help show up potentially pathologically altered tissues. It's a device for our toolbox for early detection. Auto fluorescence first came into medicine in the 1920's for cervical cancer screening. The concept has good research to show that it can detect early, moderate and advanced dysplastic cells, carcinoma in situ and

squamous cell carcinomas. If a malignancy is clear to see, tissue auto fluorescence can help determine the borders for biopsy and excision procedures.



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