Case Study 1: Case in Point

From the course entitled *Empowering Physicians, Nurses and Other Non-Dental Healthcare Providers in the Prevention and Early Detection of Oral and Oropharyngeal Cancer,* of the *Oral-Systemic Health for Non-Dental Healthcare Providers* curriculum.

This case study demonstrates a lost opportunity to identify a suspicious oral lesion and, subsequently, make a timely diagnosis and initiate treatment of oral cancer. This oversight is the result of a primary care provider (PCP) underestimating the malignant potential of a lesion of the tongue, which often occurs with younger patients. Unfortunately, cases like this are common.

Day 1: A 35-year-old female presented to her PCP, complaining of a tender area on the lateral border of her tongue. The patient was a non-smoker and drank alcohol occasionally. She had good oral care. The patient reported that she had had a sore throat prior to her tongue symptoms. On examination, a 1-cm area with both a red and white component was observed. The PCP placed the patient on an antibiotic for 10 days. (*Figure 1* shows an example of a typical clinical manifestation of an initial lesion of squamous cell carcinoma of the tongue.)

Day 30: The patient returned 29 days later and reported that the antibiotic had initially worked but that the soreness had returned. Because of the recent antibiotic use, the PCP thought this represented oral candidiasis, and prescribed a two-week course of Nystatin (Mycostatin®).

Day 45: Fifteen days later, the patient called the PCP's office and reported that her symptoms had not improved. At this point, the physician prescribed two more weeks of Nystatin and asked the patient to return in two weeks for follow-up.

Day 60: The PCP re-examined the patient's tongue and found an ulcer, along with patches of red and white. The patient complained of increased pain and worried that she might be biting her tongue. The PCP referred the patient to her dentist. (*Figure 2* shows an example of a typical clinical manifestation of an intermediate lesion of squamous cell carcinoma of the tongue.)

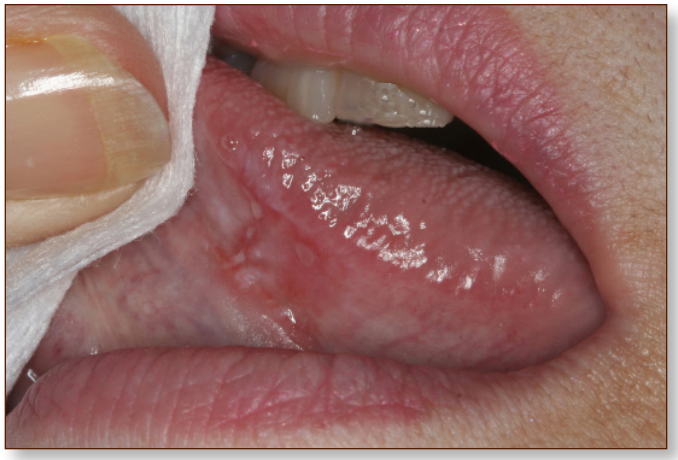

Figure 1. Initial squamous cell carcinoma. A typical clinical manifestation of an initial lesion of squamous cell carcinoma of the tongue. Photo source: Susan Müller. Used with permission.

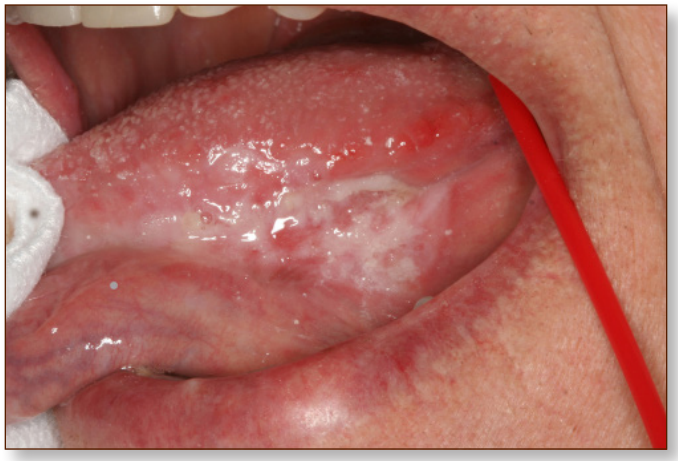

Figure 2. Intermediate squamous cell carcinoma. A typical clinical manifestation of an intermediate lesion of squamous cell carcinoma of the tongue. Photo source: Susan Müller. Used with permission.

Day 70: When the patient's dentist evaluated the lesion, he noted a 1.5-cm ulcerated area with both a red and white component. On palpation, the area was firm. The dentist suggested smoothing the adjacent teeth in case this was causing the ulceration. The dentist also suggested that the patient change toothpaste and discontinue chewing cinnamon gum.

Day 84: After a two-week vacation, the patient returned to her dentist and reported that her symptoms had become progressively worse. The pain kept her up at night and she felt her tongue was swollen. The dentist noted that the area had grown larger, now measuring more than 2 cm with a 1-cm ulcer centrally located. The dentist referred the patient for a biopsy. (*Figure 3* shows an example of a typical clinical manifestation of an advanced lesion of the tongue.)

Day 90: Approximately three months after the initial visit to her PCP, the patient had a biopsy, which confirmed squamous cell carcinoma. The biopsy and diagnosis were long overdue, demonstrating that even young, non-smoking patients can get oral cancer. The lesion was initially a stage T1, which could have required surgery alone. However, by this time, the lesion was a stage T2 tumour, which required a lymph node neck dissection and radiation. Consequently, this young patient's five-year survival rate decreased.

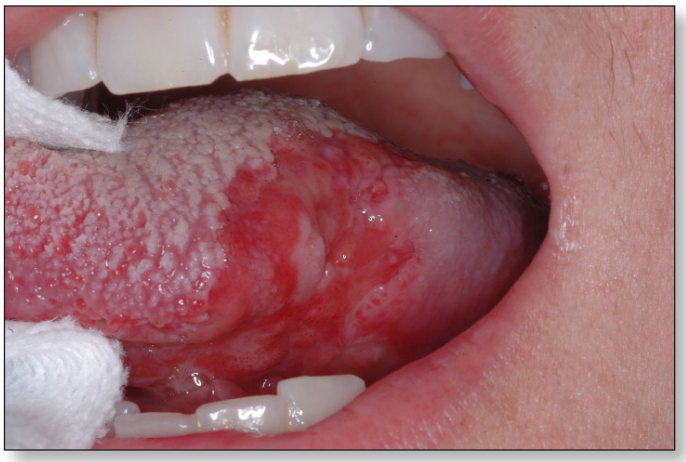

Figure 3. Advanced squamous cell carcinoma. A typical clinical manifestation of an advanced lesion of squamous cell carcinoma of the tongue. Photo source: Susan Müller. Used with permission.