

THE ROLE OF THE DENTAL HYGIENIST IN THE DETECTION OF ORAL CANCER

STEPHANIE BOSSENBERGER-JAMES, RDH, MS

Historically, the focus of the dental hygienists' practice has been on the treatment of oral diseases through the processes of routine treatment visits at the dental office. This role has evolved from the primary task of the dental hygienist who only cleans teeth in the private dental office to the disease prevention and health promotion professional specializing in oral health care. As oral health care changes from the repair of teeth to the prevention of oral diseases, it is widely recognized that health of the mouth is vital to overall health and well-being.

A national oral health and disease prevention initiative *Healthy People 2010* serves to integrate local, state and national agencies, organizations, governments and communities to strive to improve the oral health of all Americans. The overarching goal is to prevent disease, control disease that cannot be prevented and improve access to dental care and all related health care services. Having the scientific knowledge and clinical skills as well as education and experience in public health and health education coupled with a social sciences background, the dental hygienist is an ideal professional to work within this initiative.

What education does a dental hygienist have?

The registered dental hygienist has completed a program of study that meets the specific standards of the American Dental Association (ADA) Commission on Dental and Allied Dental Accreditation. Not all dental hygiene programs award the same degree, but the minimum

standards of education must be met for the program to be accredited. This graduate must successfully pass the Dental Hygiene National Board Examination (written test) and a state or regional board examination that evaluates the practical application of the dental hygienists' skills. After successful graduation, written and practical examinations and completion of jurisprudence examination (laws regulating the practice of dentistry and dental hygiene in a specific state), the dental hygienist is eligible to apply for a license to practice dental hygiene.

The majority of dental hygiene programs are three-year programs culminating in the degree of Associate of Science in Dental Hygiene that is awarded through a college or university. The course work in the first year of the dental hygiene program parallels that of a nursing program's initial curriculum. In depth courses in anatomy, physiology, chemistry and physics are prerequisites to the specialty courses in dental hygiene. The next two years of the program include courses in dental science, head and neck anatomy, oral pathology, dental medicine and periodontology. These courses provide a foundation of knowledge for the clinical practice of dental hygiene. The program also provides for two years of clinical practice in a college or university based clinic with patients under the direct supervision of dental hygiene faculty. In this practice, clinical skills such as intra oral and extra oral examination techniques, radiographic techniques, preventive services (scaling/cleaning teeth, applying fluorides or sealants to teeth) are practiced. But most importantly, a dental hygienist is a health educator and must communicate effectively with patients. The dental hygienists' education has the breadth and depth necessary for their evolving position within the arena of health care providers. It is the responsibility of the dental hygienist to be thorough in all aspects of dental hygiene practice, continue to grow in his/her knowledge and competence and to be up to date in technological advances.

What should you expect from your dental hygienist?

Oral health and its relationship to systemic health has been at the forefront of current research. Dental hygienists have knowledge that systemic disease has potential for oral manifestations and these manifestations may not be apparent to the patient. Patients should fully disclose their health status, but most importantly, those who are under the care of a physician for any disease or condition such as diabetes, heart disease, blood disorders, a recent surgery or taking any prescription medication. A thorough health history review is an important tool that is used to determine if any modifications in dental hygiene treatment should take place or that a referral to another health care provider for any reason should take place.

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COMING IN SUMMER 2004
Speech and Swallowing Function After
Treatment for Cancer of the Larynx
Jan S. Lewin, PhD.

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A comprehensive extra oral and intra oral examination should follow the health history review as the next procedure in a complete dental hygiene appointment. In the April 2002 issue of *News From SPOHNC*, the “Basic Head and Neck Self-Examination” was presented. This self-exam follows the overall pattern of a professional examination, however, coupled with the knowledge and experience of a dental hygienist, it can be even more effective.

What is an extra oral examination?

The extra oral tissues or structures include the head, neck, face and jaw. The lymph nodes that follow the length of the neck are exceptionally important as they provide information about infections or abnormalities in the lymph system. The examination begins with a visual inspection. The hygienist should “look” at the anatomy of the head and neck including the skin, evaluating the structures for abnormalities. Balance of movement of the eyes, jaw (temporomandibular joint), tongue and neck are also evaluated. The hygienist is looking for areas that do not “match” the other side of the face or abnormalities on the surface of the skin that appear inconsistent with adjacent areas. Next, the hygienist will “feel”, or palpate the structures of the head and neck. This is done by pressing on the skin and making small circular motions evaluating the surface tissues and then, the tissues that are slightly deeper. Again, through touch, extra oral anatomy is assessed for consistency.

The dental hygienist may also detect lesions on the skin that appear rough, scaly or raised that may require the attention of a physician. Whereas a patient may consider a “sun spot” or freckle as nothing, an observant dental hygienist will bring such lesions to the attention of the dentist who will refer the patient for follow-up care with his/her physician.

Literature suggests that the extra oral examination is frequently not offered to patients in the dental setting. A recent study investigated the patient’s perceptions regarding the extra oral examination performed during a dental hygiene appointment. It was explained to the patient that this examination was being performed in order to make their general dental examination more complete. The study results reported a positive response to the exam by the participants. Further, many of the participants responded that they had not had this service in the past and that they would like to have it performed in the future. The increasing recognition of the importance of the extra oral examination as a screening method potentially affords the patient more assurance that they are being provided with complete and comprehensive care.

What is an intra oral examination?

The intra oral examination is a more frequent, routine procedure that may go unnoticed by the patient because the dental hygienist or dentist may not be narrating or explaining the procedure while providing that service for the patient. The intra oral examination includes all the structures or tissues that are within the mouth, including the inner lining of the lips and cheeks, the throat, tongue, floor and the roof of the mouth. This portion of the examination begins with a

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visual inspection. Each area is inspected visually for abnormal appearance or asymmetry (one side of the structure being different from the other side). Next, every structure is evaluated by "feel". With the use of digital palpation, each area of the oral cavity is felt with the use of one finger, or bi-digitally (two fingers). These methods are used to evaluate the size, firmness and mobility of any lumps or bumps or tissue abnormalities in the mouth.

Dental hygienists are educated to identify abnormalities that may appear in the oral cavity as well as in the head and neck area. Very subtle changes in the oral tissues or structures of the head and neck need to be detected early to assure the best possible outcomes. Any changes from normal are called to the attention of the dentist who will ultimately decide if the changes require further attention of another health care professional.

What services should the patient anticipate at a dental appointment?

As a consumer of dental health care, the dental patient should expect:

- **A thorough and complete examination** of the head and neck and all extra oral and intra oral structures.

- **Open and complete communication** surrounding their treatment and examination. The patient should feel that their questions are acknowledged, answered fully and appropriately. Dental hygienists and dentists have the task to convey important information in ways that avoid professional jargon.

- The patient should be **fully informed of the findings** of the intra oral and extra oral examination.

- The patient should expect to be treated **without discrimination, with confidentiality** and in a respectful manner.

Dental hygienists have the responsibility to educate patients about high-quality oral health care. If a patient's oral health care needs are beyond the ability or scope of practice of the dental hygienist, the attending dentist will be consulted.

Technological advances have provided tools for early detection and initial biopsy techniques. One tool that is gaining popularity is the brush-biopsy technique. When a

suspicious lesion is detected, the surface of the lesion is lightly brushed to gather cells for evaluation. It is possible that a biopsy of surface cells can be taken immediately to ascertain the necessity for further investigation. Suspicious "areas" that were judged to be insignificant can be judged with improved accuracy. Research in early detection has motivated a wide variety of advances and the future should be brighter as interdisciplinary teams of health care workers join together in an effort to provide early detection and optimum treatments.

Summary

Dental hygienists are knowledgeable health care providers who together with attending dentists may participate fully in the early detection of head, neck and oral cancer. If a complete and comprehensive extra oral and intra oral examination is not provided for you, ask for it! Every patient should experience an optimum standard of care. Many dental hygienists provide oral screenings in public health settings, residential nursing care facilities, and private dental offices and in other places where oral health screenings are offered.

Editor's Note: Stephanie Bossenberger-James, RDH, MS is a Professor and Department Chair of Dental Hygiene at Weber State University Ogden Utah. She currently teaches community dental health, dental hygiene research, and serves as a clinical dental hygiene faculty at the Department of Veterans' Affairs Medical Center Dental Clinic, Salt Lake City Utah, extended campus site.

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A TIME FOR SHARING

Since my first contact with SPOHNC more than a year ago, I have read many inspiring stories in this column. Those stories have inspired me to write this story which, thankfully, still has a few chapters to play out in the future.

Like the other stories I've read, mine has a few nasty twists and turns, including unbearable sorrow, unthinking and uncaring medical decisions, and, in the end triumph when triumph should not have been possible.

In July of 1991, our third daughter, Sarah Elizabeth, was born with a very severe heart defect. She endured three major thoracic surgeries in her first 3 years of life, but was a happy, loving, intelligent, healthy child the rest of the time.

My problems began late in 1993 with some difficulty swallowing, and slightly slurred speech. Beginning in early 1994, I saw a series of doctors in different disciplines while my symptoms worsened. All of these doctors, without exception, assumed, without the slightest hard evidence, that my problems were neuromuscular. The various diagnoses included Myasthenia Gravis, Bulbar Motor Neuron Disease, and finally ALS (Lou Gehrig's disease). Then, in October, a small lump appeared on the side of my neck. It was checked with Ultrasound, CT, and MRI and finally there was a probable diagnosis – CANCER! It was squamous cell carcinoma (SCC) of the right base of tongue (T₄N_{3b}). At the time, this was actually somewhat of a relief as I knew that cancer was not quite the death sentence it used to be and certainly not like ALS. I saw a local ENT doctor who confirmed, with a laryngoscopic examination and a few days later a biopsy, that it was indeed cancer.

I was referred to the Tumor Board at a prominent southeastern university hospital for evaluation. It was the feeling of the board that my tumor was so advanced that the local regional oncology center would not be able to provide adequate treatment. This may have been an erroneous recommendation, as you will see later.

For reasons I have never clearly understood, surgery was not considered appropriate as treatment. On October 31st I

began chemotherapy. Since I had been having difficulty eating and drinking for almost a year, the side-effects of chemotherapy were magnified and I became quite sick during the first round. I ate and drank virtually nothing, and when I arrived home at the end of that first round, I was very weak and dehydrated.

My wife Dianne, who is a Registered Nurse, dragged me, over my protests, to see my doctor. She felt, and the doctor agreed, that a "Peg" tube (A feeding tube placed directly into the stomach) would be an appropriate measure at this time. I was admitted to the hospital on a Friday (Nov. 11th, 1994) to have the Peg tube inserted the following Monday, November 14th.

On Sunday November 13th, 1994, little Sarah Elizabeth passed away suddenly and without warning. The staff neonatologist and one of the staff pediatricians did everything possible to revive her, but it was too late, despite their heroic efforts. Unfortunately Sarah was at an in-between age where Neonatology and Intensive Care Pediatrics do not meet. We were later able to consult with her cardiologist and determined that even her thoracic surgeon would not have been able to help. All of her earlier surgical repairs had failed at the same time.

I'm sure I need not explain how extraordinarily devastating Sarah's passing was. There were quite a few moments when I wondered why I should continue this horrid treatment after losing someone SO special. But, in the end, I realized that my wife and our older daughters needed my support and from that point forward it did not occur to me that I might lose MY girl.

We had lots of support from Dianne's family, some of whom drove non-stop from Northern Michigan to be here with us in Florida. To this day, I don't know why my family in California stayed somewhat aloof, sending flowers and cards, but no one came to be with us. After Sarah's funeral, my treatment continued, and, because of the "Peg" tube, I no longer suffered quite as much. The chemotherapy continued for another 10 weeks with 7 days on and 7 days off for a total of 6 rounds. I was later told that the chemotherapy had cleared up 95%

of the original tumor.

In February of 1995, I began 6 weeks of twice daily radiation treatments. These were performed 5 days a week (they let me have the weekends off!). Again, because of the "peg" tube, I pretty much slid right through the radiation therapy with a minimum of problems. This is NOT to say that there were no problems, but my nutritional state was so high that I was strong enough to fight them off. I actually gained 4 pounds during the 6 week therapy.

At the end of the radiation therapy, an MRI was taken and I was told that there was no evidence of residual disease. I was CURED, or so we all thought.

By mid 1996, I was strong enough to look for and find full-time work. Work and school were pretty good therapy for all of us, so life began to take on a semblance of normalcy. I worked through '96 and '97 until in late '97 small sores appeared in several places on the right side of my tongue. Since my teeth were getting pretty nasty due to radiation side-effects and poor dental care, I thought these were just "sores". How wrong I was!

I went back to the cancer center for a routine follow-up and the oncologist who had replaced the oncologist I had seen during my earlier treatment told us that the sores were NOT caused by my teeth and strongly suggested I see my ENT doctor here and have a biopsy done. Well, you might be able to guess that the news from the biopsy was bad. The cancer was back or recurred or something. It didn't really matter that much at the time.

Once again I was referred to the Tumor Board. This time, however, the Board's verdict was different. They said, and these may not be their EXACT words, but the spirit of what they said was: "Go home to your "regional" oncology center and obtain whatever palliative care you can for as long as you have." Regional was definitely lower case when these folks said it and palliative means "supportive" or stated in plain terms – make me comfortable until I die. Coming from a hospital with a national reputation and listed among the top hospitals in the country, this was a pretty devastating

statement. Fortunately, the Regional Oncology Center here in Daytona Beach did not view my care as "palliative".

The doctors and nurses at this center took an aggressive approach to planning my treatment and I was enrolled in a Clinical Trial which was comparing high dose "conventional" treatment against one of the newer chemo drugs. Additional radiation was out of the question as I had been given a lifetime's worth in 1995.

Because of the contribution made by my "peg" tube in 1994/95, we decided that it would be beneficial to have one this time also. This would prove to be both a good and problematic decision.

My first 2 rounds of chemo in this high dose regimen were very difficult. The effects it had on my body and my mind were pretty awful. Eventually, after the end of the second round, my white blood cell count dropped to near zero. White cells are the key to the immune system. I developed what is described as "overwhelming sepsis" which, in essence, means my entire body was invaded by a staph infection. I was VERY sick. I eventually spent a month on my back in the hospital and finally went home feeling very weak.

A couple of weeks later, despite misgivings on my part, my chemo continued at 80% of its original level. And, it was supplemented by daily injections of a medication which boosts the creation of white cells, thereby, hopefully, avoiding any further adventures into infections. The rest of my chemo was pretty uneventful and was completed in August of 1998.

Now, one assumption that is usually made in oncology circles is that most head and neck cancers cannot be "cured" by chemotherapy alone. Well, it's now March of 2004, more than 5 years since my chemo was completed. Everyone involved now says that I am CURED. No one really knows why, and no one is really pursuing an answer.

Despite other unrelated problems with my health, and the long term side effects of both radiation and chemotherapy, I'm still here, rebuilding my strength and trying to keep busy with home projects and, occasionally, writing things like this story.

Now I'm pursuing some answers to those long-term side effects and hoping to erase all of this stuff from my body. I don't

have much hope of 100% success, but I'm working on it anyway.

An interesting side-light to all of this is a contact I had with the doctor who spoke those terrible words in 1998. He called me a little over a year ago and told me he had just heard that I was still around. He sounded very surprised and I commented that I recognized that he hadn't expected me to be around because of what he had said after the Tumor Board in 1998. I later wrote him a long letter detailing what had happened in the intervening years and ending with a comment which I felt was a statement on the condition of medical care as it stands right now. It read:

"It would be advisable, in my view, to approach patients with a lot more compassion and with a much more positive attitude at the Tumor Conference. Even if the consensus of the Tumor Board is that there is nothing further to be done at that facility, sending someone home to die is making an assumption that may not be valid. Buoying up the patient's spirit should be of the utmost importance when dealing with anyone with a serious disease, even one of the more devastating forms of cancer. Although it would be wrong to try to produce false hopes, in this world there are no absolutes and there is always some degree of hope."

The point is that no matter how devastating the disease, no matter how bad the prognosis, there is always hope. Even though we lost our precious daughter, we had her for 3 years. A decade earlier, we might have only had her for a few days. She added uncountable treasure to our lives and not a day goes by in which Sarah does not have an impact on our lives. I believe that, somehow, she gave me the strength to fight, and here I am to tell about it.

I have left out some of the detail of the medical aspects of all of my care and most of the details of family involvement, not because they are unimportant, but because their inclusion would be distracting from what I'm trying to convey.

What the future holds remains to be seen and that will be dealt with as it comes to pass. **NO MATTER WHAT, NEVER GIVE UP HOPE!**

Steve Reed
Port Orange, FL

"Survivor to Survivor"

Four years ago, my throat was treated with radiation and chemotherapy for squamous cell carcinoma. I had the usual side effects of dry mouth, trismus, swallowing difficulties and loss of taste, except for sweet and salty.

I can cope with most of these side effects, but I have great difficulty dealing with a constant, very strong bitter, sour taste in my mouth both day and night. Sometimes it changes to a strong stinging sensation of my tongue for several hours. I have tried acupuncture and zinc tablets without success.

Has anyone experienced this condition and found relief? Your help will be greatly appreciated.

Richard

I first had surgery for carcinoma of the tongue in 1966 (at the age of 17), and I had additional surgeries (tongue + radical neck dissections) in 1967, 1980 and 1990, as well as chemo and radiation in 1990-1991. I've been cancer-free for 13 years now, but in the past year or so I've had problems with my tongue swelling and rubbing against my teeth at night, causing persistent irritation on one side of my tongue. It seems to get worse just before my menstrual period, and now that I'm perimenopausal, it seems to be becoming more of a problem. (I'm not sure that there's a link with my hormonal fluctuations, but there does seem to be a clear pattern.)

I've had two biopsies on the area, both negative. My doctor thought I was biting my tongue during the night and told me to get a bite splint. I never believed that was the problem, but I have been using the bite splint. It doesn't seem to help. My dentist had me try an oral rinse (GelClair) before resorting to the bite splint, but that didn't help, either. For several years, I have slept with my head elevated, which seemed to help until recently. Now nothing seems to prevent the swelling and irritation.

Thanks for any help you can provide.

Nancy

Please email your responses to Richard or Nancy at info@spohnc.org or call 1-800-377-0928.

Benefit Puts Fund-Raising Group on Road to Fight Cancer

By Kathleen L. Radcliff
Bexley News Reporter

It takes spunk to survive cancer and Nancy Leupold is proof of that. Ms. Leupold is a 14-year survivor of head and neck cancer and president and founder of Support for People with Oral and Head and Neck Cancer Inc., or SPOHNC.

"It's a rallying cry for dollars for research and awareness and it may take us a few years to get there but we are well on the way, and I ask that you stay with us for the rest of the journey," he said.

And Ms. Leupold helped facilitate that Journey April 2nd and shared some of her personal experiences in the process.

Ms. Leupold, a New York resident, was diagnosed with cancer in April of 1990.

"It was picked up on a routine trip to a new dentist, that became anything but routine," Ms. Leupold

"We sat together in a circle, sharing their feelings," Ms. Leupold said. "It was a delight to see complete strangers respond to one another.

"They would come with tears and leave with smiles. After that first meeting, I was floating," Ms. Leupold said.

SPOHNC is a national nonprofit organization dedicated to meeting the needs of oral and head and neck cancer patients, their families and friends.

As a patient advocate, Ms. Leupold said her mission is to raise public awareness of oral and head and neck cancer.

"The first thing someone should do when diagnosed is to get a second opinion and where they get that second opinion is very important", Ms. Leupold said. She said a large teaching hospital is an optimal place to go.

SPOHNC is located in Locust Valley, NY. For more information call 800-377-0928 or visit its web site at www.spohnc.org.

For more information about the Joan Bisesi Fund for head and neck Oncology Research, visit www.joansfund.org or contact the development office at the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute at 614-293-3744.



Eric Gnezda, Emcee, Dr. David Schuller, Nancy Leupold and Phil Bisesi, Chairman

She had the opportunity to meet many fellow survivors she has helped throughout the years when more than 300 supporters of the Joan Bisesi Fund for Head and Neck Oncology Research gathered for their spring fund-raiser April 2 at the Westin Great Southern Hotel (Columbus, Ohio).

Bexley resident John Bisesi lost her battle with head and neck cancer on Thanksgiving day, 2001, according to event emcee speaker and songwriter, Eric Gnezda,

She left behind her husband, Phil, her daughter Mira, now 21/2 years old, family and friends.

Mr. Bisesi was on hand at the fund-raiser. "My journey in fundraising began when Joan was sick," he said. "I called in every favor. I called everybody I knew and some people I don't know.

One goal for the Joan Bisesi Fund for Head and Neck Oncology Research is to raise the fund's first \$250,000 by the end of 2004, Mr. Bisesi said.

said. "I was one of the lucky ones, because I only needed surgery as treatment and did not need to undergo radiation therapy."

On September 10, 1991, SPOHNC had its first meeting, Ms. Leupold said.

"It was exciting, but I was a bit frightened by the experience, because I didn't know what I was getting into," Ms. Leupold said, "But I decided just being a survivor wasn't good enough."

Thinking the group gathered would be small, Ms. Leupold said, she welcomed nine head and neck cancer survivors who attended the first meeting of SPOHNC.



Dr. David Schuller (far left), Director, Arthur G. James Cancer Hospital with oral and head and neck cancer survivors

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- SPOHNC-BOCA RATON, FL
- SPOHNC-BOSTON, MA
- SPOHNC-BRIDGewater, NJ
- SPOHNC-CHARLOTTE, NC
- SPOHNC-COLUMBUS, OH
- SPOHNC-DALLAS, TX
- SPOHNC-DALLAS, TX
- SPOHNC-DALLAS, TX
- SPOHNC-DENVER, CO
- SPOHNC-DETROIT, MI-HFHS
- SPOHNC-FAIRFAX, VA, Heads Up!
- SPOHNC-HOUSTON/TOMBALL, TX (new)
- SPOHNC-LONG ISLAND, NY
- SPOHNC-LONG ISLAND, NY, EAST
- SPOHNC-LOS ANGELES, CA- UCLA
- SPOHNC-MANHATTAN, NY
- SPOHNC-MAYWOOD, IL
- SPOHNC-MIAM, FL
- SPOHNC-MIAM, FL, Mort Silverblatt Head and Neck
- SPOHNC-MORRISTOWN, NJ
- SPOHNC-NJ-PA
- SPOHNC-OMAHA, NE
- SPOHNC-ORANGE, CA-UCI
- SPOHNC-PALM BEACH/BOYNTON BEACH, FL (new)
- SPOHNC-PHOENIX, AZ (new)
- SPOHNC-PITTSBURGH, PA-UPMC
- SPOHNC-SAN DIEGO
- SPOHNC-SAN FRANCISCO-UCSF
- SPOHNC-TROY, MI (new)
- SPOHNC-TOMS RIVER, NJ
- SPOHNC-WASHINGTON, DC-LCC