



Early diagnosis: A great marketing tool

For more on this topic, go to www.dentaleconomics.com and search using the following key words: *cancer, early diagnosis, adjunctive screening technologies, oral cancer, biopsy, dysplasias.*

“JUST THE FACTS, MA'AM ...”

- According to the CDC, 12% of all dysplasias will become cancer within five years.
- Delays in diagnosis or referral for biopsy by as little as three months have enabled malpractice victories.
- Diagnosis of a tissue lesion can only be made by surgical biopsy.
- Early detection saves lives.

Adjunctive screening technologies have made it possible to identify early tissue lesions that may become malignant. In fact, our focus in dentistry should be to look for and identify suspicious lesions well before they become cancer. Instead of assuming that the statistics say that we'll never see a case of oral cancer in our general practices, we should be assuming that we do see many potentially premalignant lesions and accept the fact that we need to do more to identify them.

Although brush sampling techniques may be helpful in identifying normal and abnormal tissues, and can be a valuable tool for helping a patient decide whether or not to allow a surgical biopsy, the only currently accepted diagnosis of a tissue lesion comes from a surgical biopsy. Any dentist who can perform a routine dental extraction can, and should, be comfortable performing a simple surgical biopsy anterior to the vibrating line and the pterygomandibular raphe. Since early diagnosis and appropriate treatment save lives, and because delays in biopsy by more than three months have been reported to be a major cause of malpractice lawsuits, general dentists should consider performing simple biopsies themselves.

Some surgical specialists may have been warned by their malpractice carriers against performing biopsies that have been referred by general dentists using adjunctive screening technologies if they do not accept the validity of these technologies. This is an interesting paradigm because if the standard of care in a community for a given procedure is determined by the specialists in that field within the community, what if the general dentist is more capable by virtue of training or equipment of performing a duty in a given field than the specialist in that same field? Ethical considerations in these situations cannot be overlooked. Would it not stand to reason that the clinician most capable of identifying and visualizing a lesion should be the one to perform the biopsy?

However, many general dentists are uncomfortable performing surgical biopsies. In this situation, it becomes imperative that appropriate referrals for biopsies are made, based on a standardized protocol. Good photographic and descriptive documentation is a must for clear communication of the lesion in question so that there are fewer misunderstandings. Alignment of philosophies about how to identify and manage suspicious lesions should be done between the general dentist and specialist well before the first referral is made. Sometimes, brush tissue sampling results can be helpful to the specialist in deciding whether or not to biopsy a lesion, so utilization of these technologies should also be discussed prior to the first referral.

Adding soft-tissue biopsies and adjunctive screening technologies to the procedure mix in a general practice can also be profitable, both in terms of new-patient referrals and additional revenue. Based on various fee analyses, fees for simple biopsies may approximate those of surgical extractions. The power of trust should not be underestimated for practice growth. In my personal experience, patients have been very appreciative of my willingness to perform biopsies rather than having to send them to another practice, although I always offer referral. There are only two results that can come from a general dentist performing a biopsy of an early suspicious lesion: a negative report gives the patient peace of mind and assurance that the dentist has acted in a timely and concerned manner; a positive result permits a sound and definite positive referral to a trusted specialist without wasting valuable time. One might argue that seeding of a lesion is a risk with a surgical biopsy, and that would be a valid argument. However, it has been my experience that most surgeons would likely perform an incisional biopsy for definitive diagnosis prior to an extensive excision anyway.

Lowering the incidence of oral cancer requires dentists to work outside of their comfort zones. We must be willing to look beyond what we think we know because we really don't know what we don't know. The best way for practice growth is word-of-mouth internal marketing. In my own practice, I know that last year I identified 10 dysplasias using a standardized oral cancer screening protocol that I had missed with visual inspection alone. What better way is there to build a practice than to save a life? **DE**

References

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