COMMENT

Letters to the editor

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Oral cancer

Early/delayed diagnosis

Sir, during the last 75 years different definitions and criteria for diagnostic delay have been used when studying early/delayed oral cancer diagnosis, unveiling a remarkable lack of methodological and terminological consistence.[1]

The Aarhus guidelines,[2] issued to overcome these limitations, have proposed standardised time-intervals within a conceptual framework and the abandonment of the term 'diagnostic delay'. The mileposts in this model define the patient interval (first symptom to first presentation to a healthcare professional [HCP]), the primary care interval (first presentation to HCP to first referral to secondary care level), the diagnostic interval (first presentation to diagnosis), and the pretreatment interval (from diagnosis to the start of treatment). This approach gives consistent definitions and a methodological guide for improving the design of studies on this topic,[3] which in turn has permitted the demonstration of an association between longer time intervals to diagnosis and treatment of symptomatic oral cancers with poorer outcomes.

In this context, the role of the HCP (GDPs) is particularly relevant to achieve shorter patient and primary care intervals. Bearing in mind the existent 'alarming lack of public awareness', particularly in vulnerable subpopulations, strategies for increasing public awareness of this neoplasms should be prioritised, focusing on its most frequent signs and symptoms – persistent lump or swelling, and white or red patch – especially on those with a higher predictive positive value, such as a non-healing ulceration. Patients should avoid reinterpreting these symptoms as minor oral conditions.

GDPs should undertake specific continuous professional development programmes, as lack of knowledge at the primary care level has been shown to contribute to delay in referral and treatment. Moreover, and despite the lack of evidence for interventions to reduce the primary care delay in cancer referral, the NICE guidelines have proved useful for reducing the diagnostic interval in cancer, particularly in head and neck carcinomas.

In any case, GDPs should consider that the use of inadequate terminology for describing the period since the onset of signs/symptoms to the definitive diagnosis of oral cancer, like 'early/late', 'prompt/delayed', 'prompt/non-prompt', 'timely/untimely' may have negative connotations,[2] apart from being imprecise. Contrarily, the use of more descriptive terms [eg: short(er)/long(er)] to describe the different time intervals may help to improve terminological consistence in this field[2] and to ease scientific communication.

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1. Lyratzopoulos G. Markers and measures of timeliness of cancer diagnosis after symptom onset: a conceptual framework and its implications. *Cancer Epidemiol* 2014; **38:** 211–213.
2. Weller D, Vedsted P, Rubin G *et al.* The Aarhus statement: improving design and reporting of studies on early cancer diagnosis. *Br J Cancer* 2012; **106:** 1262–1267.
3. Varela-Centelles P, López-Cedrún J L, Fernández-San-román J *et al.* Key points and time intervals for early diagnosis in symptomatic oral cancer: a systematic review. *Int J Oral Maxillofac Surg* 2017; **46:** 1–10.

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Dental practice

Loyal and caring staff

Sir, I applaud P. Williams' longevity[1] as I have only achieved 36 years at Cotteswold House Dental Care. I do however have a nurse who will on 4 July celebrate 40 years at the practice and a receptionist who has 38 years of service.

While running and owning a successful caring business is to be applauded, I am so proud that my staff are the most loyal and caring imaginable. To work for one business, dental or other, for 40 years is, I imagine, extremely rare and Dawn Smith will get the big celebration she deserves.

S. Waters, Gloucester

1. Williams P. Dental practice: Longevity record? *Br Dent J* 2017; **222:** 323.

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OMFS

Dental fitness prior to cardiac surgery

Sir, I work in the oral and maxillofacial surgery unit of a district general hospital. In the past years we have seen an increasing number of patients due to undergo planned cardiac surgery referred to us by their general dental practitioners (GDPs) for removal of any poor prognosis teeth. Dental fitness is essential to reduce the risks associated with cardiac surgery and prevent post-operative infections related to dental causes.[1]

It has recently come to my attention that a number of these patients have brought with them a form requesting the oral surgeons to sign it. This form is a declaration of dental fitness and is issued by their cardiac surgeons. It has been highlighted that it needs to be signed prior to proceeding with their cardiac surgery. It is concerning that a couple of patients reported that they have not been given a date for the operation until this form is returned signed.

In this day and age most patients aim to retain their natural dentition for as long as possible. Our department as well as most oral and maxillofacial surgery departments non-affiliated with a dental hospital offer secondary surgical services but they are unable to provide routine dentistry. Upon completion of their oral surgery treatment, it is likely that further dental issues need to be addressed, including periodontal treatment, restorations and oral hygiene improvement. It is imperative that