Oral cancer: We can do better – now

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Ben Atkins writes in response to the recent *BDJ In Practice* cover feature on the impending crisis facing oral cancer

Given my proximity to the Mouth Cancer Action Month campaign, November's feature on the crisis facing the profession relating to oral cancer was intriguing.[1] The article – and those questioned within it – painted a dire picture of the current, immediate and worrying state of affairs regarding oral cancer and the issues building up.

From a dentist's perspective we have been struggling for years at equitability in the health arena, often an afterthought when funding is concerned. Over the years of practice ownership the only way of dealing with the situation of funding – or lack of – was to play by the rules and look for opportunities.

With that experience in mind, that's why I struggled so much with the article. If we do nothing with things will be dire – of course they will. Yet I see very little point in constantly pleading the case for more money when this year of all years the well is drier than it has ever been and is likely to be for some time to come. The slow progress made with the DDRB will be halted, so we can't expect to spend our way out of the waiting lists those questioned in the article refer to.

If we assume no extra funding will come into dentistry, how do we use current guidelines to make sure we do not miss any patients? After talking to friends and colleagues in the max fax world, they are – at the moment – not receiving the referrals they did pre-COVID-19. According to the figures obtained by the Oral Health Foundation, there's a 60% reduction on average. That should alarm us all.

Knowing your patients means you know where to look

It's about now my general rule of thumb becomes applicable; 80% of the decay I see

and treat is in 20% of the patients I see. So where is the oral cancer? Realistically it is in the same place as all the rest of the disease – in your high-risk patients with a history of tobacco use and higher than usual alcohol consumption. The question is how do we find and deal with these first?

You might be thinking 'why should I bother planning when there is so much uncertainty', and you might be right, but does doing nothing work? I suppose my answer to this is that it is the right way to do things. My job as a practice owner was to protect my business and make sure the practice was doing as much as it could to mitigate future risk. I may not have practised dentistry through a pandemic, but the fundamentals remain the same. In the long term it will allow you to increase access to new patients, and, for me, new patients have always been the largest source of oral cancer referrals and diagnoses in my 20 years. If we follow all the signs coming out from the DoH, capitation will become a driving force within NHS dentistry, so how do we increase our list sizes without breaking our practices? And, while you may think I'm barmy for discussing contract reform right now, that's the difference between those who will come out of the pandemic in a position to tackle the backlog of patients who have not been seen.

My suggestion is to start off by controlling your own patient base. If I look at my prototype practice information, of my patient list we had 18% high-risk 'red patients'. These are the patients who need six-month examinations – the rest had between 12 and 24 month recalls. Obviously not all of these had increased oral cancer risk, but they would statistically be within this group.

There is a lot to be said about performing an audit of your patient base and develop a greater understanding of the prototype (NICE) recall setting policy. My suggestion would be to maybe audit a day or two pre-COVID-19 and re-do the patient recalls (for yourself) to give you an idea of those patients who may need to come back in six months, 12 months or 24 months.

If I were a cynical dentist, and many including myself would say I am, I would want to become an expert on the prototype recall setting procedure before I started doing any work to change all the practice recalls. How manageable is it going to be to get everyone through the door when some sort of normality is returned? I know some may fear the threat of litigation, but I don't think this is the answer. And unfortunately, neither is a magical money tree the answer.

To plan or not to plan

This matters. When I tell people that we as a profession are not following NICE guidelines relating to recall periods, let's be generous and say there's a mixed reaction. Is it easier to just follow what the computer says and recall the patient in six months' time, or is it easier to see their mouth and decide for yourself?

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According to the Vital Signs NHS Report, in 2016, on average 55% of people attend the dentist every 3-9 months.[2] Four years ago we went through an adjustment within my business to align my UDA practices with the prototype practice. We pushed all our recalls to 12 months with an option to pull the high-risk patients back earlier if necessary (this was still not following the NICE guidelines fully, but it was a start).

After reviewing our patient base, we reduced our number attending the UDA practices in that 3-9 month window to 30% (on average). It wasn't the 20% figure the prototype practice was achieving, but it was a massive leap taken by the associates.

So what do you do with that free time not seeing existing patients during a stressful few months when we still had our UDAs to hit? We could see new patients and associates could expand their private portfolios. And what did we see in those new patients? Oral cancer.

I really feel that by prioritising your high needs patients now you will simultaneously be doing the right thing and catching any cancer patients early, hitting the 20% UDA figure on the correct patients, reducing the likelihood of managing a massive backlog and taking back control.

If you had started this process in March this year, you would have a quiet window now and until March next year. My teams really bought into this, and it enabled them to grow both in their NHS value and their private figures. It is hard and takes some plotting, but it is possible.

If we don't do something, there is no doubt we will miss cancerous lesions. My worry of having that 'if only you had come in earlier, we could have addressed your lesion at an earlier stage' conversation is very real. Those conversations are unpleasant, and only time will tell how many of them will take place as a result of the pandemic. We all experience patients with cancer within our practising life – I think three to five is the average number. Every time I have come across a patient who is about to start a traumatic journey, I ask myself: have I dealt with everything correctly? In the current environment and COVID-19, it is an easy thing to blame. However, like me when trying to do *anything* at the moment, that reason is wearing thin and will have very little reassurance to a patient.

I really worry about the hard to reach groups falling through the cracks. This is why the article frustrated me. It is possible. Yes, things are tough, but we cannot rest on our laurels and wait for things to drop in our lap. There are parallels with waiting for a vaccination; in the interim we have to help ourselves. We are an amazing profession and need to assess what we can do within our own remit. We have dealt with the challenging period of full lockdown, and we can make such a difference to our patients.

References

1. Westgarth D. Oral cancer: A ticking time bomb? *BDJ In Pract* 2020; **33**: 12-16.
2. NHS Business Authority. Vital Signs: The Dentistry Report. Available online at: https://www.nhsbsa.nhs.uk/dental-data/vital-signs (Accessed November 2020).

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