COMMENT

Letters to the editor

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OMFS

Can you over-consent?

Sir, as healthcare professionals, we understand the importance of transparent communication of risks when obtaining valid consent. We carried out an audit across a network of Oral & Maxillofacial Surgery (OMFS) departments across four hospitals, collecting data from 200 consent forms for removal of wisdom teeth. We found that 96% of the consent forms specifically for mandibular third molar (M3M) extractions had included altered or loss of sensation to lower lip, chin, teeth. However, none of the consent forms audited mentioned the small risk of mandible fracture.

The patient's age and gender, excessive clinician force and level of M3M impaction can all increase the risk of mandibular fracture. According to the Royal College of Surgeons (RCS), the risk of mandible fracture during M3M extraction is only one in 22,000. Despite the low risk, they advise that patients with 'inadequate bone' around the M3M must be informed of their increased risk in mandible fracture.[1]

Our audit raised an interesting debate amongst the consultants in our network. Can you 'over-consent the patient'? One could argue the risk of mandible fracture is so low during M3M removal, that to consent a patient for this risk may unnecessarily deter them from having the procedure. However, after the landmark 2015 Montgomery case, patients have the right to be made aware of any material risks to them, no matter what their clinician deems as important or not.[2] The OMFS consultants could not reach a consensus on whether the risk of mandibular fracture during M3M removal should be included on wisdom teeth extraction consent forms. The debate continues.

It is pertinent to remind readers to be up to date with the most recent M3M removal guidance to ensure consent forms are compliant with RCS guidelines and patients are informed of all relevant risks prior to undertaking treatment.

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Just say 'AAAHH'

Sir, I am writing with regards to my recent experience as a DCT1 in a district general OMFS department during a consultation with a patient. In this encounter, saying 'AAHHH' revealed a previously unseen sinister lesion of the right pharyngeal tonsil. Following biopsy, tonsillar squamous cell carcinoma (SCC) was diagnosed, measuring 3.0 x 2.5 cm. The lesion was unrelated to the initial reason for referral, with surprisingly few symptoms.

Many 'self-checklists' for oral cancer screening exist and I had completed these but saw nothing of concern. Since working in OMFS and shadowing colleagues, the importance of asking the patient to say 'AAAHH' has been reiterated, acting to depress the tongue and raise the soft palate. It also reminds the clinician to pay attention to the oropharynx as part of their habitual examination. In some patients, just sticking the tongue forward will give a good view of the oropharynx and tonsillar area. However, as an anaesthetic Mallampati score shows[1] (Fig. 1), this is not the case for everyone. Individual factors, along with lying in the supine position (often the case at the dentist), can make this area difficult to properly assess with protrusion of the tongue alone, possibly leading to lesions in the area being missed.

Tonsillar carcinoma is the most common site of SCC of the oropharynx and the incidence of oropharyngeal cancer is increasing, mainly due to the increased prevalence of human papillomavirus (HPV).[2] The simple practice of depressing the tongue with a dental mirror and having the patient loudly say 'AAAHH' allows a thorough examination of this area, revealing anatomy which may otherwise remain hidden.

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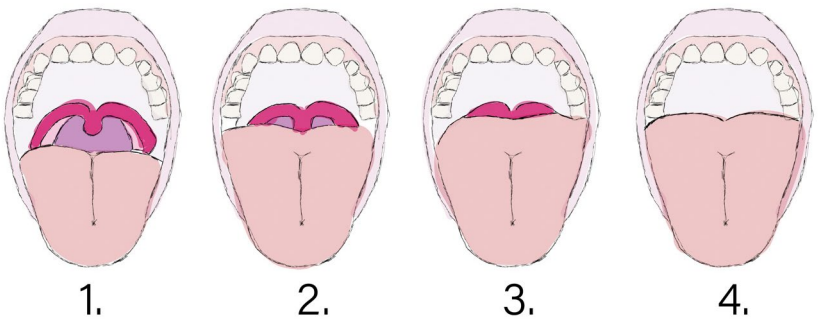

Fig. 1 Anaesthetic Mallampati score. Illustrating patient variation in visualising the soft palate and oropharynx with protrusion of the tongue.[1] Illustration by Joseph Ash