Summary of: A national survey of oral and maxillofacial surgeons' attitudes towards the treatment and dental rehabilitation of oral cancer patients

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FULL PAPER DETAILS

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Aims To investigate the attitudes of maxillofacial surgeons in the treatment and dental rehabilitation of oral cancer patients in the UK. **Material and methods** The survey was conducted by postal questionnaires with 17 close-ended questions. A total of 229 questionnaires were sent to members of the British Association of Oral and Maxillofacial Surgeons over a one week period. A follow-up was sent if a reply was not received within 12 weeks. These results were compared to a similar study that was carried out approximately 15 years ago. **Results** The response rate was 65.5% (150/229). Overall 62% of respondents (92/150) carried out maxillary resections, which represents a decline of 23% on the previous study. There has been an increase in surgeons reconstructing the maxillary defect from 38% in the 1995 study to 91% in the present study. Ninety-eight percent of respondents had their patients seen in a multidisciplinary team (MDT) clinic, but in only 30% of the cases was a restorative dentist present on these clinics. There has been an improvement in the accessibility of a restorative dentist for this patient cohort, from 65% to 90%. The use of implants for dental rehabilitation post-cancer surgery has increased from 43% to 93%. **Conclusion** This study highlights the changes in the dental and oral rehabilitation of patients undergoing resective surgery for oral cancer and especially those undergoing a maxillectomy procedure. It illustrates the increased use of implants for post-surgery rehabilitation and shows the different trends in which these implants are placed. An important aspect of this study is the input of the dental team. Current national guidelines state that a consultant restorative dentist needs to be a member of the MDT; this survey shows that this was the case in only 30% of responses.

EDITOR'S SUMMARY

This paper provides a very appropriate follow-up to our coverage in the previous issue on Mouth Cancer Awareness Month, by researching the dental rehabilitation of oral cancer sufferers.

Providing a comparison with a similar questionnaire in 1995, this survey has disclosed some interesting changes not only in after care but also in trends in the performance of the surgery itself. The move towards greater multidisciplinary team management of such patients makes complete sense and is itself a natural development of the logic of bringing together specialists in various fields to collaborate in the patient's best interests. As many of us know from experience in all walks of life, the assembly of teams is not always straightforward but the need to co-ordinate the many aspects of care post-operatively is crucial to successful management.

While the specialty of restorative dentistry is not so new, it is a relatively recent 'new kid on the block' and it may be that the lack of such expertise in 30% of the clinics is a reflection of this. However, with these findings now published there is even less reason why those responsible for organising care to this group of patients should overlook restorative dentists in the future; serving only to further emphasise the need to follow the national guidelines already in force. This is especially important given the increase in the use of implants in post-surgery rehabilitation and the valuable part they play in adding to the flexibility of treatment options and indeed the quality of function and life for the recipients.

While noting the changes in surgical approach over the 15 year period and the move towards more complex microvascular free-flaps for reconstruction in maxillectomy patients, it is interesting that no consensus has yet emerged on the 'ideal' technique. In the same way that the overall method of care has developed, so too, with time, will the evidence on technique. The authors call for similar attention to be paid to the use of hyperbaric oxygen and the need for further research to validate its inclusion.

The full paper can be accessed from the *BDJ* website (www.bdj.co.uk), under 'Research' in the table of contents for Volume 207 issue 11.

Stephen Hancocks,
Editor in Chief

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IN BRIEF

- There has been an increase in the number of oral and maxillofacial surgeons using implants for rehabilitation.
- There has been an increase in the number microvascular tissue grafts used to reconstruct maxillectomy defects over the last 15 years.
- The involvement of a consultant in restorative dentistry in the multidisciplinary cancer team is still limited at 30%.

RESEARCH

COMMENT

Patients diagnosed with oral cancer are at the beginning of a journey which requires care and support through treatment to rehabilitation and beyond. The success of this journey relies heavily on the composition and indeed the co-ordination of the multidisciplinary team (MDT) involved. Current guidance[1,2] details the members of the MDT.

This postal survey provides pooled responses from 150 oral and maxillofacial surgeons (OMFS) working in the UK. In summary, information on i) the annual frequency and mode of surgical intervention carried out for patients requiring a maxillectomy procedure, ii) the presence of, and members of the MDT, and iii) the rehabilitative treatment phase, was obtained. The change in management of these cases, which may possibly be in response to published guidance, is illustrated by reflecting on a similar survey carried out 15 years previously.[3]

The results reflect a shift towards a smaller proportion of OMFS carrying out maxillectomies and this smaller group carrying out a greater volume compared to that reported previously.[3] This sub-speciality specialisation should optimise the success of these demanding procedures. This is a positive response to concerns made previously.[1] There is a trend towards reconstructing the surgical defect using microvascular flaps, however the authors highlight the need for evidence of the 'best' surgical management of these patients.

Almost all respondents were working within a MDT, but despite published guidelines,[1] the consultant restorative dentist (RD) was included in only 30% of the MDTs. Almost 10% had no access to a RD.

The survey suggests that there has been a noticeable increase in the use of osseointegrated implants for rehabilitation. This further highlights the need for consultant RD membership of the MDT to contribute to the planning, sometimes placement and certainly restoration of the intraoral implant/s.

This article provides encouraging information that suggests that there has been a change in the management of patients diagnosed with oral cancer undergoing maxillectomy in line with national guidelines.[1,2] However, if the published guidance[1,2] is to be implemented fully (to ultimately improve the outcomes in head and neck cancer) then a consultant RD must be included in the membership of all these MDTs. This would clearly have resource implications for the NHS.

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AUTHOR QUESTIONS AND ANSWERS

1. Why did you undertake this research?

New technologies and national clinical guidelines have changed the ways in which oral cancer patients are treated and dentally rehabilitated. We wanted to assess the effects of these changes since a previous survey was conducted approximately 15 years ago.

2. What would you like to do next in this area to follow on from this work?

We are planning to survey consultants in restorative dentistry on their experiences and challenges in treating this emotive group to provide a 360 degree view of how to improve patient care. In particular we would like to investigate the workload, time constraints and resources that consultants in restorative dentistry face in dealing with newly diagnosed patients with oral cancer and their long term treatment. We would also like to survey their use of implants in dental rehabilitation but also newer technologies such as computer aided design of restorations. We hope that these surveys will raise awareness for this patient cohort both on a local and national level.