Head and Neck Cancer Referral Advice for Primary Care

Head and neck cancers involve the oral cavity, pharynx, larynx, salivary glands, nasal cavity, sinuses and middle ear. Over 500 new cases are diagnosed in Ireland each year. Laryngeal and tongue cancers are the most common. The classical risk factors are: being male, increasing age, a history of smoking and heavy alcohol consumption. Oropharyngeal cancers are now being diagnosed in younger men and women. This group does not necessarily have all the classical risk factors and their illness may be associated with Human Papilloma Virus (HPV). Ireland's 5-year survival rate for head and neck cancer is just 48% as over two-thirds of patients are diagnosed with late stage disease (Stage III and IV). Excellent outcomes can be achieved for patients presenting with early stage disease. **(NCRI, 2014)**

This is a toolkit to assist Medical and Dental Practitioners and Pharmacists to recognise clinical features that are suspicious of mouth, head and neck cancer and require urgent referral for specialist investigation.

URGENT REFERRAL
a patient with ANY ONE of these clinical features for 3 weeks

UPPER AERO-DIGESTIVE TRACT / LARYNX:

- Hoarseness
- Unexplained persistent sore throat
- Unexplained ear pain
- Dysphagia (demands urgent endoscopy)

NERVE PALSY:

- Unexplained facial nerve palsy
- Hypoglossal nerve palsy (abnormal tongue movement)
- Ocular palsy – refer to ophthalmology

LUMP:

- Unexplained neck lump
- New facial / salivary gland / jaw lump
- Any unilateral swelling, especially if hard, firm or rubbery

ORAL CAVITY / LIP / OROPHARYNX

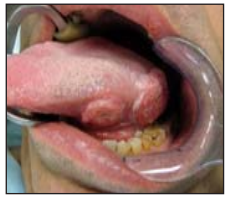
- Unexplained ulceration
- Unexplained red and white patches inside the mouth that are painful or swollen or bleeding
- Unexplained ear pain / unilateral neck or head pain – especially with limited mouth opening, but with normal otoscopy
- Irregular pigmented mucosal area (suggestive of melanoma)
- Tongue numbness or fixation

- **Tooth mobility of unknown cause***
- **Non-healing dental extraction site***

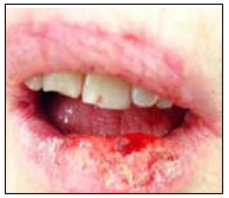
*(*If concerned refer **immediately** for initial dental examination and further specialist opinion as indicated).*

One for 3 weeks

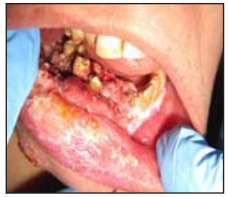
Clinical features suggestive of cancer



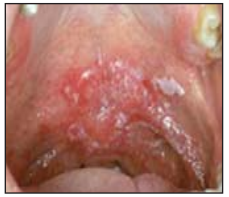
Tongue SCC: can present as a hard ulcer with rolled edges



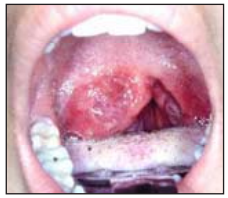
Lip SCC: can present as a crusted ulcer that does not heal



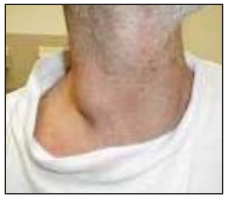
SCC Floor of mouth



SCC soft palate

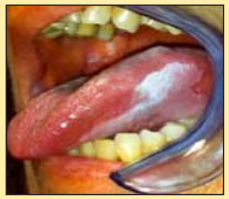


Tonsil cancer

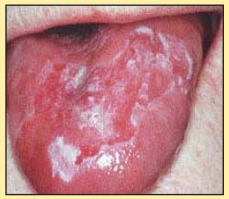


Neck lump: in an adult this is cancer until proven otherwise. Refer as URGENT

Both leukoplakia and erythroplakia have a risk of becoming malignant



Leukoplakia: a white lesion of the oral mucosa that cannot be scraped off. Refer as non-urgent



Erythroplakia / Erythroleukoplakia: are red or red and white patches of the oral mucosa

EARLY DETECTION AND REFERRAL SAVE LIVES

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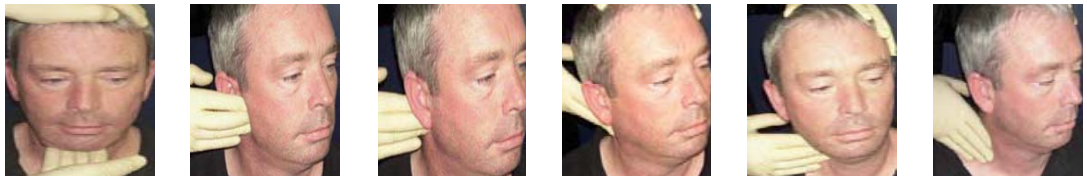
CLINICAL EXAMINATION

A clinical examination is one of the most effective ways of detecting oral disease early, including cancer.

Extra-oral clinical examination involves:

- Examination of the neck, salivary glands and facial bones
- Assessment of nerve function, especially in patients with facial pain

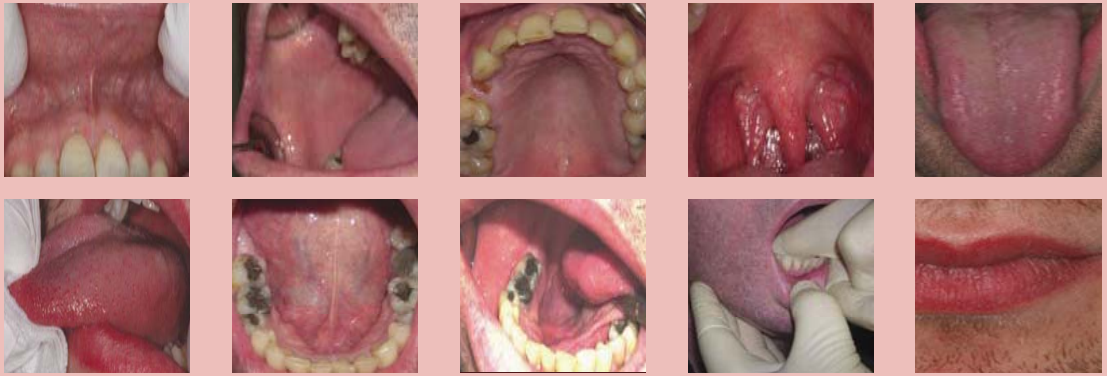


Facial weakness in the presence of a parotid mass suggests rapid growth and malignant change.

Oral examination always includes:

- Visual inspection of all parts of the mouth with a good light
- Retraction of the lips and tongue to properly view the oral cavity
- Palpation of the oral mucosa with a gloved hand to detect change

If an oral cavity lesion is thought to be due to dental trauma or irritation, identify and remove the source. Always review. If the lesion persists for more than 3 weeks afterwards, refer urgently.



Hard mucosal change or an ulcer with rolled edges is highly suggestive of cancer.

PREVENTION AND EARLY DETECTION

- Everyone should have an annual dental check-up, including edentulous patients
- A population based screening programme for oral head and neck cancer is not recommended, but opportunistic assessment is advocated as an integral part of routine medical and dental examinations
- Tobacco, alcohol and HPV are the main risk factors for head and neck cancer. Smokers should always be offered smoking cessation therapy i.e. a combination of counselling and pharmacotherapy
- HPV vaccination should be encouraged
- Skin cancer may be picked up as an incidental finding

REFERRAL ADVICE

- Many specialties are involved in the management of oral, head and neck cancers. These include ENT, oral-maxillofacial and oesophageal surgery and dental hospitals
- The priority is that a patient with unexplained and persistent clinical features is referred URGENTLY for specialist opnion
- Suspicious clinical features should be described and highlighted in your referral letter
- Suspicious pigmented lesions should be referred with lesion INTACT
- Dysphagia demands urgent endoscopy by ENT, gastroenterology or an oesophageal specialist. Consider ENT referral for endoscopy if you suspect a pharyngeal lesion

Reference:
MacCarthy D, Flint SR, Healy C, Stassen LFA Oral and Neck Examination for early detection of oral CANCER – a practical guid. Journal of the Irish dental Association 2011; 57(4) 195-199.

EARLY DETECTION AND REFERRAL SAVE LIVES