

Communication, Counseling and Compassionate Care: The least explored and challenging Palliative Care approaches among Primary Care Physicians - Clinical Case series of Oral Potentially malignant disorders in Tamil Nadu

Praveena Raman

Department of Oral Medicine and Radiology, Sathyabama Dental College and Hospital, Chennai, India

ABSTRACT

Background: Globally, the sixth most common malignancy is oral cancer, which is predominantly due to consumption of potent, proven carcinogens which includes smoking and smokeless form of tobacco and areca nut. Habits associated oral malignancies are mostly preceded by clinically asymptomatic oral lesions collectively referred under the umbrella term as oral potentially malignant disorders (OPMDs). There is a delayed presentation of oral pre cancer and oral cancer in India, as approximately 50% of patients are diagnosed at last stage since the asymptomatic pre cancer lesions are missed by oral physicians/dentists either due to lack of timely communication and habit counseling, lack of knowledge, or inappropriate attitude, putting all in a nut shell --- sheer lack of empathy and commitment towards patient care and society. Early diagnosis greatly increases patient's chances of survival. Patient awareness is much spoken in literature; however, the flip side of the coin lies within the attitude of the primary care physician. They play a pivotal role in effective communication and timely counseling of patients with OPMDs and should prevent malignant transformation to improve quality of life of patients. Poor compliance to attend for oral cancer screening links to the attitude and ignorance of the primary care physician. Palliative care concepts should be integrated to dentistry especially to oral medicine speciality. **Clinical Significance:** The author believes that the three most important, least explored and challenging palliative care approaches namely, "Communication," "Counseling," and "Compassionate care," should be effectively practiced by a primary care physician, to improve their level of commitment to society and attitude towards patient care which can help in early diagnosis of OPMDs and decreased incidence of oral cancer, thus improving quality of life of patients.

Keywords: Care, communication, compassionate, counseling, empathy, holistic care, oral cancer, oral pre cancer, palliative care, potentially malignant disorders

Address for correspondence: Dr. Praveena Raman,
Lemon Dental, #4/3, Krishna Street, Vivekananda Nagar,
Nesapakkam, Chennai-600 078.
E-mail: drpraveena7@gmail.com

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Introduction

90% of oral cancer constitutes oral squamous cell carcinoma (OSCC). In South Asian countries, consumption of tobacco in any form (smoking/smokeless) and areca nut products are the main causative factor for the initiation and progression

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of OSCC.^[1] Most cases of oral malignancies associated with smoking or smokeless tobacco/areca nut are clinically preceded by asymptomatic lesions collectively referred as oral potentially malignant disorders (OPMDs) where a significant proportion of OPMD transform to Malignancy.^[2-4] It is the duty of the primary care physician to get actively involved in the early detection and prevention of transformation of OPMDs to oral cancer.

According to the World Health Organization (WHO), palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment, and treatment of pain and other problems – physical, psychosocial, and spiritual. Palliative care services should be provided from the time of diagnosis of life-threatening illness and it should be integrated into the existing health system at all levels of care, especially community and home-based care and it should be strategically linked to cancer prevention, early detection, and treatment services.^[5]

There is a delayed presentation of oral pre cancer (OPMD) and oral cancer in India, as approximately 50% of patients are diagnosed at last stage since the asymptomatic precancer lesions are missed by the primary care physicians either due to lack of timely communication and habit counseling, lack of knowledge, or inappropriate attitude, putting all in a nut shell --- sheer lack of empathy and commitment towards patient care and society. Patient awareness is much spoken in literature; however, the flip side of the coin lies within the attitude of the primary care physicians. They play a pivotal role in effective communication and timely counseling of patients with OPMDs.

Physician is not a person who deals with malfunctioning organs, but someone who deals with a distressed fellow human being. According to Charaka, education should enable a physician to hold that light, which enters the patient consciousness and snap the snares of suffering. Poor compliance to attend for oral cancer screening links to the attitude, lack of knowledge, and ignorance of the primary care physician. The author believes palliative care concepts/principles should be implemented by a primary care physician to provide a holistic care to patients especially in OPMD cases.

Hence, this article discusses case series of OPMDs from the rural belt of Tamil Nadu, imparting the importance of the three least explored, most important and challenging palliative care approaches among oral physicians namely, “Communication,” “Counseling,” and “Compassionate care,” as all the presented cases were reported late to diagnose and all of them had multiple previous dental visits, and more over none of the patient was

informed that they have a potentially malignant lesion in their oral cavity and it could turn malignant.

Case Presentation

Informed consent was obtained from all the patients; however, only their intraoral presentations are used in this article as figures and none of the details revealing patient identity is used.

Case 1

Patient had a chief complaint of decay tooth. Intraoral examination revealed nonscrapable diffuse greyish white patch on the left buccal mucosa, extending anteriorly from mid buccal mucosa and posteriorly up-to retro molar region, surrounded by hyperpigmentation's.

Case 2

Patient had a chief complaint of deposits in his tooth. Intraoral examination revealed bilateral blanching of buccal mucosa with hypo and hyper pigmentations throughout the rigid and non-resilient mucosa with normal mouth opening.

Case 3

Patient had a chief complaint of dirt and stains in his tooth. Intraoral examination revealed non scrapable, grayish white patch at left buccal mucosa interspersed with hyperpigmentations.

Case 4

Patient had a chief complaint of decay tooth. Intraoral examination revealed nonscrapable, well-defined rhomboidal shape greyish white patch at left posterior buccal mucosa, few mm below upper buccal vestibule, appearing cracked mud.

Case 5

Patient had a chief complaint of missing tooth and the patient wanted a removable denture. Intraoral examination revealed non scrapable, diffuse grayish white patch on entire anterior 2/3rd of right half of tongue, appearing cracked mud.

Case 6

Patient had a chief complaint of pain in his tooth. Intraoral examination revealed diffuse pigmented palate with multiple erythematous papules.

Case 7

Patient had a chief complaint of sensitivity in his tooth. Intraoral examination revealed nonscrapable, predominant erythematous patch interspersed with greyish white patch bilaterally at the commissures.

Case 8

Patient had a chief complaint of deposits in his tooth. Intraoral examination revealed diffuse greyish white patch throughout



Figure 1: Left buccal mucosa showing Oral Leukoplakia with a greyish white patch



Figure 3: Left buccal mucosa showing oral leukoplakia

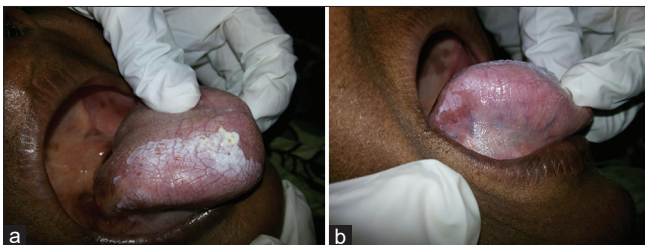


Figure 5: (a) shows distinct whitish leukoplakic patch on right half and anterior 2/3rd tongue. (b) showing extension of the patch beneath to floor of mouth

the left buccal mucosa interspersed with erythematous region and pigmentations.

Case 9

Patient had a chief complaint of pain in his tooth. Intraoral examination revealed diffuse erythematous inflamed palate and erythematous patches at commissures.



Figure 2: Bilateral blanching with hypo and hyper pigmentations with erythematous areas interspersed within. (a) showing OSMF involving right buccal mucosa. (b) showing OSMF involving left buccal mucosa



Figure 4: Left buccal mucosa showing well-defined rhomboidal-shaped leukoplakic patch



Figure 6: Showing palatal lesions in reverse smokers: Inflamed orifice of minor salivary glands on the palate

Case 10

Patient had a chief complaint of sensitive tooth. Intraoral examination revealed nonscrapable, diffuse grayish white patch on entire anterior 2/3rd of right half of tongue, appearing cracked mud. Within the

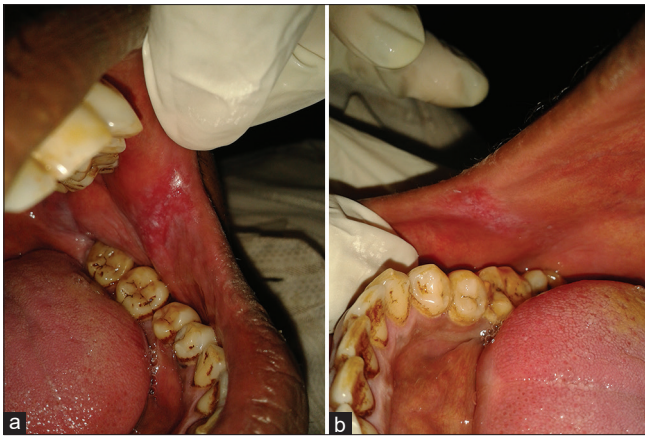


Figure 7: Erythroplakia. (a) showing erythematous patch involving left side commissure. (b) showing erythematous patch involving right side commissure

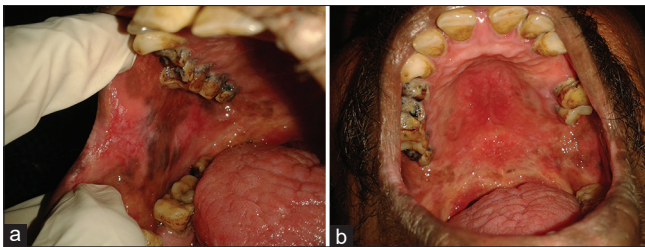


Figure 9: (a) showing erythroplakia involving right-side commissure. (b) showing palatal lesions in reverse smoking

diffusely spread lesion, a localized rhomboidal area of raised patch was noted.

Case 11

Patient reported with bleeding gums associated with difficulty in eating and drinking for three days. Two weeks back, the patient had visited another oral physician complaining of burning sensation and the patient was advised with an anesthetic gel. Intraoral examination revealed Wickham's striae bilaterally on the buccal mucosa and vestibular area with greyish white reticular striae and central erythematous zone. Generalized gingival desquamation was noted.

Case 12

Patient had a chief complaint of missing teeth. Intraoral examination revealed grayish white radiating lines with erythematous zones buccally in relation to the left side mandibular molar which was restored with amalgam.

Case 13

Patient reported with decayed tooth, with a known medical history of systemic lupus erythematosus (SLE) for 7 years and patient is under medications for the same. Intraoral examination revealed central zone of erythema surrounded by white striations. Immunofluorescence revealed the characteristic lupus band.

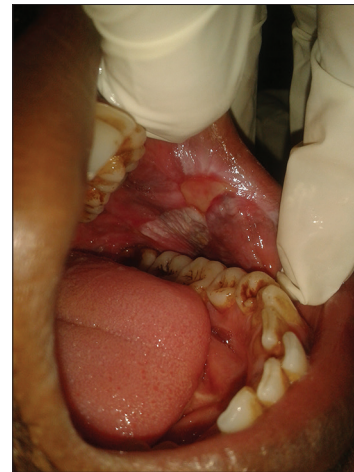


Figure 8: Showing erythroplakia involving left buccal mucosa



Figure 10: Leukoplakia patch involving right half of tongue with proliferative appearance

Discussion

A primary care physician should be responsible, humble, knowledgeable, and skillful to deliver an effective holistic care by inculcating the practice of effective communication of bad news, timely habit cessation counseling and compassionate care as a part of routine dental screening. Diagnosis of teeth alone should not be restricted. Also, if the soft tissue diagnosis is beyond the scope, then patients should be considered with empathy and should immediately be referred to a specialist, rather than not informing the patient regarding their oral pre-cancerous lesion/condition due to the physician's inappropriate attitude. As per WHO guidelines, palliative care should be incorporated into all the health sectors. A primary care oral/general physician should impart knowledge on palliative care and its principles to address each patient physically, psychologically, socially, and spiritually especially in screening high-risk cancer patients with a known habit history of carcinogens like tobacco.

This case series includes clinical intraoral presentations of all OPMDs except reports with Graft versus host disease,

Table 1: Illustration of the case series

Patient details	Tobacco history	History of Tobacco usage: Frequency and duration	OPMD diagnosis	Figure number
Case 1: 38/F	Positive	Chewing tobacco since 13 years.	Oral Leukoplakia, Oral Submucous fibrosis	Figure 1
Case 2: 51/M	Positive	Smoking tobacco since childhood and history of usage of gutka and pan masala since 17 years.	Oral Submucous fibrosis	Figure 2
Case 3: 18/M	Positive	Smoking since 3 years at a rate of 2-3 cigarettes/day	Oral Leukoplakia	Figure 3
Case 4: 49/M	Negative	Nil	Oral Leukoplakia	Figure 4
Case 5: 70/F	Negative	Nil	Oral Leukoplakia	Figure 5
Case 6: 40/M	Positive	Reverse smoking since 17 years, 2-3 packets per day.	Reverse Smoker's Palate	Figure 6
Case 7: 37/M	Positive	Cigarette smoking since 19 years, 1 packet/day	Erythroplakia	Figure 7
Case 8: 27/M	Positive	Smoking since 10 years, almost 2 packs/day	Erythro-Leukoplakia	Figure 8
Case 9: 48/M	Positive	Reverse smoking since 20 years with more than 3 packets/week	Erythroplakia + Reverse Smoker's Palate	Figure 9
Case 10: 47/M	Negative	Nil	Proliferative OL	Figure 10
Case 11: 32/F	Negative	Nil	Oral Lichen Planus with Desquamative gingivitis	Figure 11
Case 12: 47/F	Negative	Nil	Oral Lichenoid reaction	Figure 12
Case 13: 59/M	Negative	Nil	Lupus Patch	Figure 13

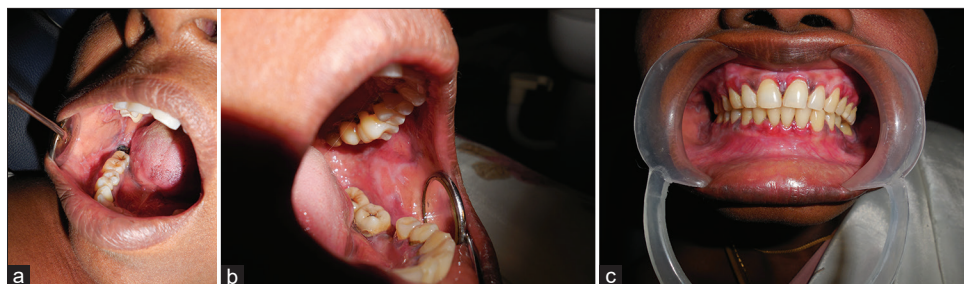


Figure 11: (a) showing reticular LP (Wickham striae) involving right buccal mucosa. (b) showing Wickham striae of left buccal mucosa. 11c showing desquamative gingivitis



Figure 12: Lichenoid reaction in relation to molar tooth restored with amalgam

dyskeratosis congenita, epidermolysis bullosa (bullous disease), and actinic cheilitis (chronic inflammatory condition of lip), since they seldom visit an oral physician seeking a cure. Table 1 illustrates the patient details and diagnosis of OPMDs.

Leukoplakia is a premalignant lesion or a pre-cancerous lesion described as “a predominant white lesion of the oral mucosa which cannot be defined as any other known lesion,” mainly

caused due to smoking.^[1] Leukoplakia typically presents with a cracked mud appearance, raised from the mucosa and always non-scrapable. Our report discussed three such cases without any history of tobacco, two among which presented on the tongue, one among which is a female, and one male patient among them with proliferative/verrucous leukoplakia. OL carries two-fold increased risk for malignant transformation.^[4] We reported two asymptomatic Oral Submucous Fibrosis (OSMF) cases with the habit of chewing betel quid with its variants. Studies have reported that physicians do not routinely examine their patients to identify early, suspicious oral lesions due to inappropriate attitude.^[6,7] Crissman *et al.* also reported that physicians delay diagnosis of oral malignancies because they get confused with other oral lesions of inflammatory, traumatic, or infectious origin which reflect their poor knowledge.^[8] Oral erythroplakia is a predominantly erythematous patch in the oral mucosa which has been identified with highest rate of malignant transformation.^[9] A heterogeneous appearance of grayish white patch with an erythematous component is termed as erythro-leukoplakia. Oral screening for erythroplakia should be an integral part of every oral soft tissue examination. Carter and Ogden stated that General Medical Practitioner's are less likely to examine patient's oral mucosa routinely and there is need for improved education, which again imparts the importance of a commitment toward society and compassionate care toward patients.^[10] Lichen planus (LP) is an autoimmune mucocutaneous disorder and has most



Figure 13: Lupus patch in a patient diagnosed with SLE

often been reported in middle-age with female predominance, presenting with vast features which includes reticular, erosive, plaque type, popular, bullous, etc.^[9] Our patient had a linear stria with annular presentation. Lichenoid reactions typically present with grayish black hyperpigmentation's either diffuse or appearing or as a pattern, which often gets misdiagnosed as LP. However, lichenoid reactions in oral mucosa definitely carry an underlying etiology. Our patient had a lichenoid reaction associated with an amalgam restoration. A case series from Netherlands reported the first malignant transformation in OLL. Oral lesions constitute 20% patients with systemic lupus. DLE associated squamous cell carcinomas is reported to be more aggressive than conventional cancer of lip. Palatal lesions in reverse smokers have a higher risk of developing into malignancies.^[9]

Author's Suggestion

A primary care physician should spend quality time to examine the entire oral cavity. Practice of medicine is compassionate, service, altruism, values, and trust worthiness. Currently, the face of Science has changed with the art fading away. Industrialization has fragmented a doctor's role and doctors are considered as commodities of the hospital and patient a means of revenue. This attitude has forced the doctors to increase patient volume with decreased compassionate care and empathy, which ends up at missing a potentially malignant lesion, miscommunication of patient's diagnosis, deficient or improper habit counseling and absence of commitment toward the profession and society. The time spent with the patient should not be judged in terms of revenue. It is a privilege to be a doctor, with obligation to community and Nation. Medicine is a societal service to humanity. Thus, the motto should be strived to prioritize patient care rather than time and money.

The author believes that Love and Empathy should come from within. Every primary care physician should be trained in palliative care and the principles of palliative care should be implemented into their routine practice to deliver a holistic care to each patient who is diagnosed with a potentially malignant disorder, thus ultimately aiming in prevention of oral cancer and improving the quality of life of patients.

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Conflicts of interest

There are no conflicts of interest.

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