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Case Report

The Importance of The Dentist – Patient Relationship in Oral Cancer Treatment

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ABSTRACT

Background: There are many instances in oral cancer cases in which a lack of patient cooperation was found to be a hampering factor in the overall case management. A good relationship between dentists and patients should therefore be built in conjunction with other treatment modalities. **Case Report:** Three complete oral cancer cases with dentist–patient relationship problems are presented. One of the common basic ways to build a good relationship is through communication and empathy. A relationship is also influenced by psychological distress, experience from previous treatments, socioeconomic factors, the healthcare system, time constraints, and belief. **Conclusion:** No single intervention strategy can improve the compliance of an oral cancer patient. An assessment of patient knowledge and understanding of the regimen along with clear and effective communication and trust in the therapeutic relationship are important in the overall patient management.

Keywords : compliance, oral cancer, perception

Background

Oral cancer is the sixth most common cancers worldwide.[1] Until now, there is no national data on the epidemiology of oral cancer in Indonesia. However, there were 95 patients in the West Java province diagnosed with oral cancer from 2014 to 2015.[2] In Cipto Mangunkusumo Hospital, the nasopharyngeal cancer prevalence was 28.35% between 2000 and 2005 with trends increasing 2.6-fold and a predominance among males.[3] An oral cancer diagnosis is mainly based on histopathologic appearance. Smoking, drinking alcohol, and betel quid chewing are the known risk factors in Indonesia.[4] Kretek cigarettes, traditional alcohol drinking, and different types of betel quid chewing are still cultural habits in the country.[5] Moreover the type of traditional alcohol are certainly different from conventional alcohol products such as beer, wine, and etc. No study has done to compare the effect of traditional and conventional alcohol drinking.

Despite many studies, healthcare providers still have questions about the cooperation of oral cancer patients. Some patients do not take their medication, and others do not have a positive attitude towards the treatments. This might be due to the fact that most Indonesian people still have the perception that cancer is a deadly disease that is incurable, unstoppable, and comes with a high

cost for treatment.[6,7] There are also still many negative attitudes from patients that do not seem to have a valid reason behind them.[8–11]

To the best of our knowledge, no literature exists on serial cases of oral cancer patient perception and compliance with dentist instructions in Indonesia. This paper will discuss several factors that influence the dentist–patient relationship in three oral cancer cases. At the end of this case report, the factors that contribute to a good dentist–patient relationship will be discussed.

Case Report 1

First visit. A 55-year-old male came to Trisakti Dental Hospital complaining of continuous dull pain in his upper left gingiva that started six months ago. He also had difficulty speaking and chewing. The pain history started with swelling and sharp pain in his infected tooth. The dentist prescribed antibiotics and analgesics to relieve the pain and performed a tooth extraction one week later. The pain still persisted after the extraction. The patient changed dentists often and took many medications without prescriptions, such as lincomycin, ciprofloxacin, mefenamic acid, natrium diclofenac, and dexamethasone, for six months without any improvement in the symptoms. The patient had a kretek smoking habit of one pack per day since junior high school. No alcohol consumption and no relatives with malignancy were found in the patient history.

The patient had gained weight five months prior to the visit to our hospital. Lethargy and moon face were found on physical examination. Palpation of the left submandibular lymph node revealed that it was hard and painful. The upper left gingiva of the edentulous 25 region was ulcerated with a corrugated texture, erythematous, and covered by white pseudomembranous lesions. An erythematous area was found after the pseudomembranous was scraped off. A panoramic radiograph showed a 11 x 4 mm radiolucency between tooth 25 and 26 reaching to the base of the left maxillary sinus (figure 1a and 1b).

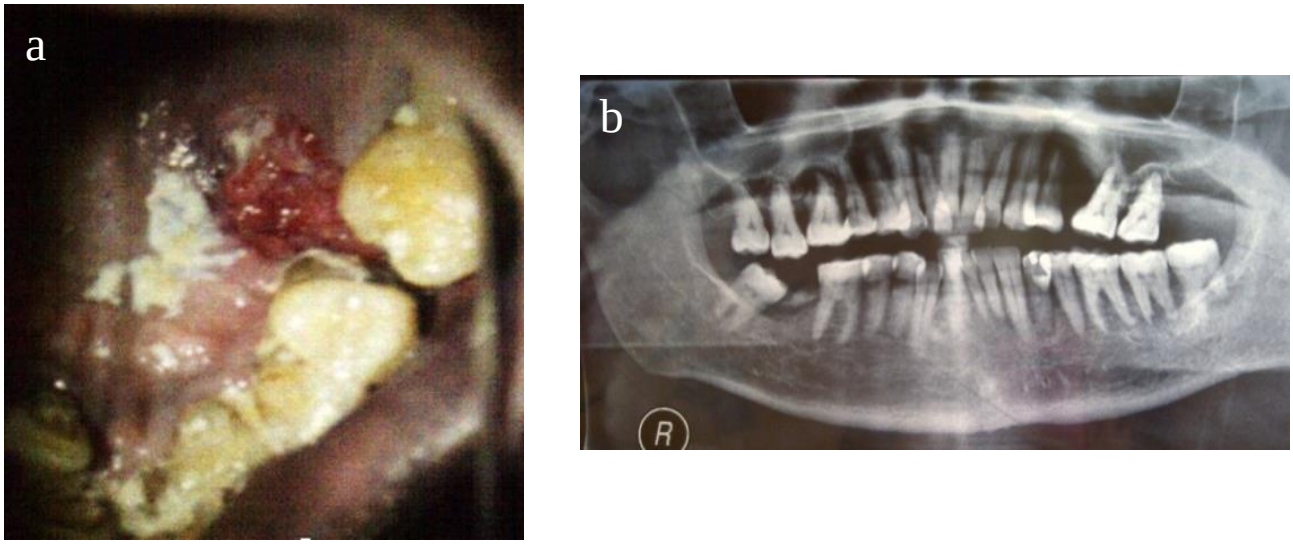


Figure 1. Clinical presentation of oral cancer. First case showed ulcerated lesion on palato-gingival of #25 (a) and radiolucency between #21-#27 (b).

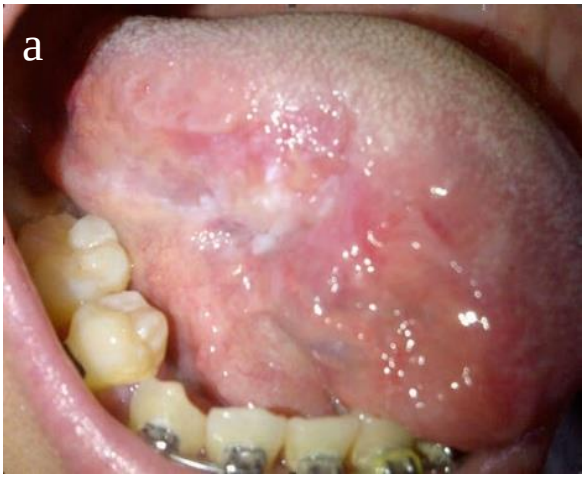
The clinical diagnosis of acute pseudo-membranous candidiasis and oral squamous cell carcinoma arising on the upper left gingiva 25 was made by an oral medicine specialist. Nystatin was given for two weeks to eliminate the fungal infection. The patient was instructed to stop all previous medications and was scheduled for biopsy.

One week later, the patient did not come to the dental hospital for further treatment. The patient informed our hospital that he refused to come and receive any treatment at our facilities. Moreover, he was still taking several medications from a previous dentist but had stopped smoking. We explained the possible risks of his disease and urged him to seek intensive treatment in another hospital.

Second visit. Patient informed that two weeks before, the patient went to a government hospital for a biopsy and an extraction of tooth 26. The biopsy showed severe differentiation of oral squamous cell carcinoma. A CT scan showed third-stage oral squamous cell carcinoma. Patient weight loss was significantly more than 10 kg, and painful symptoms persisted with no relief from common analgesic medication. The patient was referred to an oncologist. From the information taken by hospital staff, the patient passed away four months later during chemotherapy treatment and showed severe depression from a long-term history of pain.

Case Report 2

First visit. A 22-year-old female referred by general dentist with unknwon oral lesion. Patient came to the dental hospital two years ago with complaints of soreness on the right lateral border of the tongue near tooth 46. There was no risk factor for oral cancer in the patient history. Intraoral examination revealed a white patch with striae on the right lateral border of the tongue with a single ulcer, no induration, and tenderness on palpation (figure 2a and 2b). Biopsy results showed a band of lymphocyte and liquefaction degeneration. The diagnosis was consistent with lichen planus without dysplastic changes. The treatment was a tongue frenectomy to eliminate the irritation and topical clobetasol three times a day for three months. The lesion improved clinically and subjectively, and the patient regularly attended check-up appointments every six months.



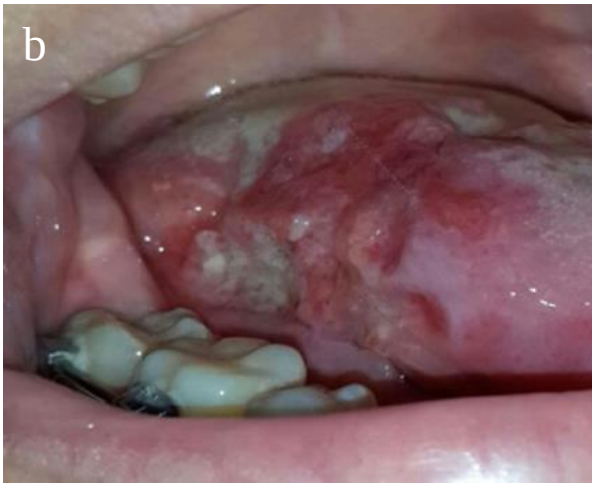


Figure 2. Second case showed white patch on lateral right border of the tongue without ulceration (a) and ulcerated with white patch several years followed (b).

Second visit. One year later, the patient came in with white striae surrounded by a red ulcer and induration of the margin. Clinical VELscope® (Visually Enchanced Lesion scope; LED Dental Inc., Burnaby, BC, Canada) fluorecence showed a loss of fluorescence. A second biopsy was taken and the results still showed no dysplastic cells. Treatment with clobetasol was continued for three months.

Third visit. Three years after the first diagnosis, the patient came in with more pronounced pain and limited mobility of the tongue. The lymph node was palpable on the right side. Intraoral examination showed a red ulcer with an indurated margin. A third biopsy showed moderately differentiated squamous cell carcinoma. The patient was referred to an oncologist and passed away while receiving radiation therapy.

Case Report 3

First visit. A 52-year-old female referred by general dentist with unknown oral lesion. Patient came in with complaints of soreness on the left buccal mucosa. Intraoral examination revealed a whitish lesions with an erythematous background on the gingiva and buccal mucosa in the last four months. The clinical diagnosis was erosive oral lichen planus. Stress on the job was found to be a risk factor. A biopsy was conducted with results that were consistent with the clinical diagnosis. Topical clobetasol was given as a treatment.

Second visit. Eleven months after the diagnosis, the oral lesion become worse. The patient complained of pain in the left cheek. Intraoral examination revealed more prominent whitish lesions with erosion, advancing to the buccal gingiva of tooth 46. A second biopsy was conducted that showed invasive moderately differentiated squamous cell carcinoma. The patient was referred to an oncologist (figure 3a and 3b).

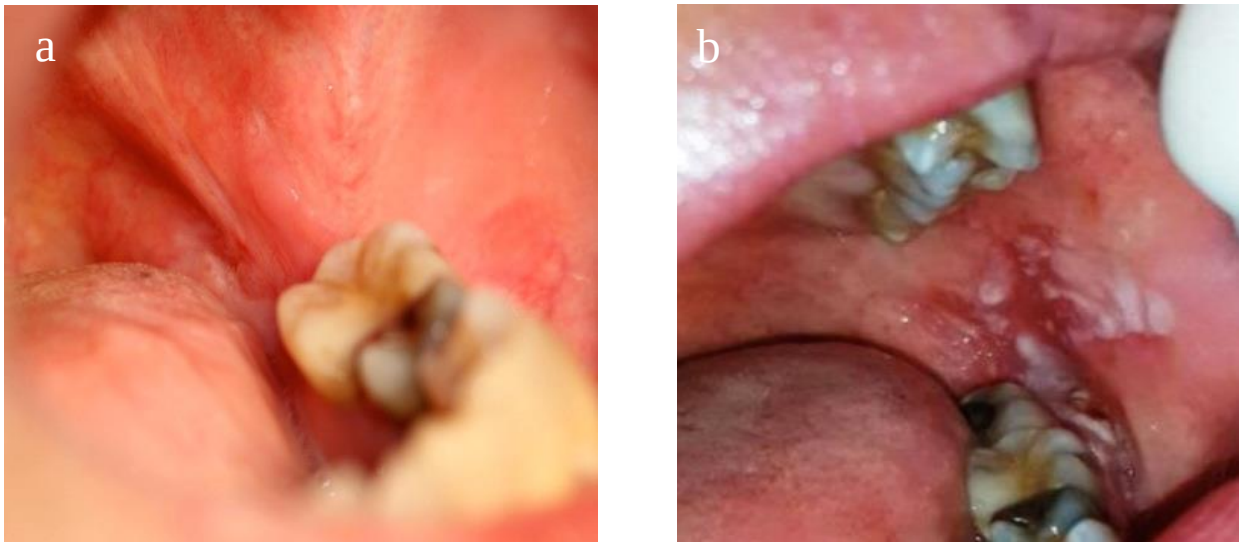


Figure 3. Third case showed fine thin white patch on left buccal mucosa near #27 (a) and erosion with white patch at the retromolar region (b).

Table 1. Patient background from each case

	Case 1	Case 2	Case 3
Gender	Male	Female	Female
Age (years)	55	22	52
Marital status	Married	Single	Married
Personal background			
- Job	Entrepreneur	Student	Headmistress
- Income (USD)	750 - 1100 USD	None	> 3700 USD
Early symptom(s)	Pain in tooth 25	Soreness on the right lateral border of the tongue	Soreness on the left buccal mucosa
Risk factor of oral cancer	Smoking	None	None
General dentist Diagnosis	Misdiagnosed as tooth pain	Unknown diagnosis	Unknown diagnosis
Treatment	Inappropriate treatment	Referred to oral medicine specialist	Referred to oral medicine specialist
Attitude towards oral medicine specialist	Reluctant to follow instructions and treatment	Followed instructions and treatment	Followed instructions and treatment
Regular visit	No	Yes	Yes

Discussion

One common basic way to build a good relationship is through communication and empathy.[12] In all three cases, the same oral medicine specialist tried to build a good relationship with the patient through communication within all visits. Psychological factors, socioeconomic factors, a support system, and patient beliefs were the strong points to build the relationship.

A high level of psychological distress, including worry, anxiety, and depression (whether subclinical or clinical), is common among oral cancer patients. This condition usually occurs from the beginning of the diagnosis to months after the conclusion of treatment. Studies have shown that there is a link between the psychological and physiological features of cancer risk and progression through the activation of the hypothalamic–pituitary–adrenal axis in chronic stress responses and depression. This impairs the immune response, which contributes to the progression of cancer.[13] A study by Gagliese *et al.* (2007) showed that depression is highly prevalent among advanced cancer patients with pain. Patients in the first and third case showed indications of depression prior to and during the course of the

of the cancer treatment.[14] High psychological distress is shown to hamper communication between patients and health providers, as was shown in the case of the first patient.

Several studies have found that patients with a high socioeconomic status show better compliance with the instructions of health providers.[15] In these case reports, socioeconomic status consisted of educational level, annual income, and access to healthcare. The high family socioeconomic status from patient number two helped her to cooperate and show better compliance with the treatment. On the contrary, the low socioeconomic status of patient number one led to difficult access to early patient care. This resulted in other problems, such as a long waiting time for appointments and difficulties in getting prescriptions, all of which increased the patient's psychological tension and jeopardized the patient's trust in the dentist and the entire treatment process.[15] The lack of trust that was shown in the first case resulted in bad case management. The patient continued using his old medications, which worsened his condition. It has been shown that the uncontrolled use of corticosteroid medications for a long period can make cancer progression more severe.[16] The early detection of oral cancer and proper counselling from the previous dentist should have helped the patient in receiving the subsequent oral cancer treatment provided by the specialists.[17]

Another factor that indirectly relates to patient compliance is belief. A patient's belief about illness and treatment are interconnected.[18] A higher level of compliance can be achieved when the patient feels susceptible to the disease,[19] believes that the disease could pose severe consequences,[20] and believes that the therapy will be effective or perceives benefits from the therapy.[21]

Although the article indicated the factors that considered important in dentist-patient relationships, some limitations hindered the author to have a strong conclusion. No psychological screening was done in the course of the treatment, and appointment time was too short for building patient's trust, thus developing good relationship. All patients in this case report had signed informed consent documents from Dental Hospital of Trisakti University which allow the authors to publish their cases.

Conclusion

While no single intervention strategy can improve the compliance or adherence to instructions of all patients, most studies agree that a good dentist–patient relationship is an important factor in overall patient management. Psychological factors, socioeconomic factors, and patient beliefs have to be recognized by dentists to build a good relationship with oral cancer patients.

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