G54 Failure to Diagnose Oral Cancer Is Not Always Malpractice

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The goals of this presentation are to: (1) provide the attendee with information as to the reasons and length of delay in oral cancer diagnosis in a major tertiary cancer center, from the standpoint of both the patient and the practitioner; and, (2) relate, by way of a case report, what can go wrong when a cancer is missed at the very earliest stages and how this can lead to erroneous legal conclusions.

This presentation will impact the forensic science community by informing attendees that the incidence of oral cancer is increasing and the general principles of cancer treatment, across all disease sites, is that early diagnosis improves survival rates; however, in order for an oral cancer to be diagnosed, it must "declare itself" by being detectable. Additionally, both the patient and practitioner have responsibilities in the diagnostic process. Practitioners and experts should be aware of reasons for not detecting oral cancers and the regulatory and legal ramifications of not being cautious in assessing cases of apparent misdiagnosis.

A general principle of oral squamous cell cancer management is that early detection results in increased survival and decreased morbidity. Delay to diagnosis occurs in all stages of oral cancer but is more frequently seen in single patients, non-smokers, and those with Stage IV (advanced) disease. With the increase in cases of oropharyngeal cancers related to human papilloma virus rather than tobacco abuse, it is likely that delay in getting these patients diagnosed will continue to be a problem. In a review of an institution's database containing more than 26,000 oncology patients, delay to diagnosis could be divided into two parts: (1) primary delay, where the patient delays presenting to a healthcare practitioner; and, (2) secondary delay, where this first point of contact does not immediately diagnose the condition.

This present case details a situation in which a general dental practitioner failed to diagnose an odontogenic carcinoma, providing the patient with a diagnosis of apthous ulceration. The patient did not keep all follow-up appointments and ultimately the condition progressed. Once the condition "declared itself" and became clinically obvious to the general dentist, he took photographs, radiographs, and ensured that the patient was seen immediately by an oral surgeon who equally quickly referred the patient into the provincial cancer system.

The patient ultimately complained to the Dental Regulatory Authority (DRA) and the dentist, without benefit of counsel or expert assistance, pled guilty to "failure to diagnose." After he realized a long suspension was imminent, he retained a lawyer and an expert. This became problematic for all parties involved.

By reviewing the records of the case, the general community standard in diagnosing the far more common squamous cell cancer of the oral cavity, and undertaking a prospective study of 100 patients, the defense posited that the practitioner had not committed an error in this particular case. At this study's institution, in the past 30 years more than 14,000 head and neck cancers have been treated in the clinic. Of these, precisely two were odontogenic carcinomas. The prospective study revealed the median time for patient-related delay to diagnosis and practitioner-related delay to diagnosis was approximately 5 weeks and 13 weeks, respectively. Furthermore, the patient, who later became a patient (and one of the two cases with this condition at this study's institution), had successful management that was identical to the treatment the patient would have received had there been a prompt diagnosis weeks earlier. In the interim, the general dentist, presumably assuming he was not being diligent, had started taking biopsies of many variants of normal — unwittingly alarming a large number of otherwise well people.

Many issues came to bear in the defense of this individual including factual errors the defendant had previously agreed were true that were later found to be untrue and errors uncovered by the defense team. Despite the prior plea arrangement, the DRA, whose conduct was very reasonable throughout the process, recognized the importance of these new issues as well as information brought to the table by the defense and agreed to a grossly diminished penalty that was accepted by the dentist.

While failure to diagnose is not encouraged, it is important that experts realize that cancers must be of a certain size and exhibit clinical features that sufficiently raise the index of suspicion of the treating person. Additionally, it is prudent to retain competent legal advice and obtain the input of an expert in the field prior to entering into plea arrangements with DRAs or anyone else.

Oral Cancer, Misdiagnosis, Malpractice