Miss Joanna Christou
Elective report 2013

ORAL MEDICINE

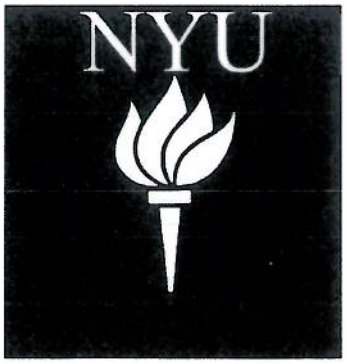
Bart's and The London SMD

Medical elective 2013

International variations and similarities in referral patterns and diagnosis between North America and the UK

16-04-2013 to 06-06-2013

Miss Joanna Christou



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Summary

I attended two oral medicine units in New York and Boston, and attend the American Academy of Oral Medicine (AAOM) scientific meeting, before returning home to my base unit in London to complete 4 weeks of oral medicine experience. This was a great opportunity for academic and self-development. In previous years, peers from my cohort have visited both the oral medicine units in New York and in Boston. They reported that it was a great learning experience and encouraged me to visit the units. The earliest opportunity for me to do this was during my medical degree elective period.

The itinerary for my visit to the US included:

16-04-2013 to 24-04-2013 New York University, New York

24-04-2013 to 28-04-2013 American Academy of Oral Medicine meeting, San Antonio, Texas

28-04-2013 to 08-05-2013 Brigham and Women's Hospital, Boston

I found everyone to be welcoming and helpful in allowing me to achieve the aims set out for this project. During my visit I was able to spend time observing a variety of clinics, attend meetings, grand rounds, educational meetings and MDT's. I met the majority of faculty staff within each unit and spent time with the juniors which expanded my understanding of the training in each region. I spent time in the pathology labs viewing slides from patients we had seen in the clinics and was exposed to some new approaches to managing oral mucosal disease and facial pain.

Each unit has their own fund raising activities which also act to increase the profile of the speciality in the local area. I was lucky that NYU were carrying out one such event during my visit. It was a privilege to be involved in this. It added an extra dimension to my experience and enabled me to give back directly to the team in return for hosting me.

Aims and objectives

In order to obtain further experience in oral medicine I sought to undertake a tri-centre study of the case mix between New York University, Brigham and Women's Hospital and the Eastman Dental Hospital. I had had the pleasure of meeting some of our American colleagues previously at international meetings and I was excited to be able to observe their work. Also, I had recently become aware of the proposed international standardisation of training pathways for trainees in oral medicine. As such, the proposed outcome of this visit was to profile the case mix of number of patients, diagnoses and treatment provided. Additionally I wanted to gain a further understanding of the differences in training pathways between the US and the UK by looking at training opportunities for juniors. The aims proposed for this project included the following:

1) To compare the US privatised healthcare system to the UK National Health Service (NHS) and understand how oral medicine services are organised in the US vs. the UK;
2) To investigate the prevalent oral mucosal diseases managed by oral medicine specialist units in the US and the UK and try to understand why the case mix variation exist;
3) To learn differing management options offered to the patients;
4) To map international oral medicine practice and exposure for trainees.

These aims would be achieved by the following objectives:

1) Attend clinics
2) Participate in academic activity, such as grand rounds, MDT's, pathology meetings
3) Collate the data log of unit activity to compare the case mix
4) Speaking with international colleagues
5) Research existing training pathways for oral medicine in the UK and the US
6) Understand the nature of the US privatised system and compare health outcomes between the US and the UK

In addition to the above, I was fortunate that the American Academy of Oral Medicine was hosting their annual meeting in San Antonio, Texas during the intended time frame of my visit. This enabled me to spend time with oral medicine colleagues throughout the United States of America with whom I potentially would not have had the opportunity to otherwise meet. Moreover, I was able to attend the lectures provided by the AAOM and learn about the current research areas of interest from oral medicine professors across the US and compare this to the current research being undertaken in the UK.

The remainder of this report will address the following topics:

- Comparing healthcare in the US vs. the UK

- Report on difference in case mix in oral medicine observed at the three units
- Report on training pathways and opportunities for oral medicine juniors

In the appendix an activity log, including photographs, and some patient case discussions can be found. Permission was sought for the sharing of these photographs and patient data for the purpose of this report.

Healthcare in the US vs. the UK

When the World Health Organisation issued its first global comparison of healthcare systems the overall performance ranked the healthcare as 9th and 17th in the UK and US respectively. This is despite a greater percentage of GDP and expenditure per capita in healthcare in the US. France took the number one spot.

In the UK the government grants the right to free healthcare for all citizens through the NHS which is funded by taxation. The NHS was established in 1948 and prior to this health was a luxury and not a human right. The pool of government funding is divided into strategic health authorities, of which there are 10 in the country and then further divided into local trusts which includes all its doctors, dentists, pharmacists etc. The local primary care trust is responsible for identifying the needs of its community for which it provides healthcare. Both emergency and elective treatment is available. For the individual, accessing health it typically via the primary care physician for which referral to secondary or specialist centres can be made. Alongside this, the private healthcare system is growing with more insurance schemes. The vast majority of physicians work partly in the NHS and within the private health system. The private system in the UK offers primarily the advantage of reduced waiting times. Today, the NHS is still one of the largest employers in the world.

The US does not offer universal healthcare for all through the government. Private companies are promoted in taking responsibility for providing health. 80% of the population have health insurance. Individuals are either given a healthcare plan by employers or they self-fund. There is some government sponsored healthcare. Accessing health is typically via the primary care physician although a greater proportion of patients will directly seek help from a specialist.

In reality, both countries are under pressure to get more value out of the healthcare system and could learn from each other. The US has better analysis of their healthcare spending whereas the UK has a better system of electronic records which are easier to share between sites and doctors. Americans are shocked at the stories fed through the media

regarding waiting times in the NHS and British people cannot understand that requiring blood pressure medication, for example, means you'll only receive them if you can afford it.

During my time in the US, I found it uncomfortable to see the finances of healthcare discussed at the consultation; that patients would have to choose treatment based on the cost. This seemed to be a natural part of the consultation process accepted by both the doctor and patients alike. I was able to learn about some of the differences between the health insurance schemes and the financial structure of healthcare. I experienced this first hand when one consultant asked me to call a pharmacist regarding a prescription for a drug, and I was totally unprepared to answer questions regarding the insurance status of the patient and which banding of insurance would therefore permit the patient to receive the medication.

Case mix in oral medicine

To demonstrate the nature of the differences between how patients are managed in the units, I will select a few examples of the commonly encountered conditions; Temporomandibular disorder (TMD), Burning mouth syndrome (BMS) and epithelial dysplasia.

TMD: For the first time I witnessed trigger point injections for the management of myofacial pain aka TMD. The patients receiving the injections recognised the short-term nature of the therapy but the symptomatic relief offered by the quick fix appealed to the patients. I observed this at both NYU and BWH. At EDH, a focus is placed on psychosocial and lifestyle modification to prevent anxiety leading to muscle tension. Although this can provide a more proactive approach to preventing future symptoms, it relies significantly on the patient coming on-board with the treatment plan which requires a lot of effort without immediate results. Equally, the use of a mouth guard for bruxism is something which in the UK we provide to protect the teeth from the sheering forces as opposed to relaxing the muscles which I have observed being discussed with patients during consultation in the US. At NYU they are very lucky to have a physiotherapist on the facial pain clinic once per month. She carries out exercises and education of patients directly within the clinic setting. At EDH we have a liaison psychiatrist and a psychologist who work within the team but at a different site and patients require a referral to be assessed and managed by those teams. From this experience it seems that all of these approaches are effective with every clinician that I've spoken to reporting good outcomes irrespective of the management approach used.

BMS: Each unit appears to run a comprehensive set of blood tests including haematinics, a screen for diabetes, and some also undertake zinc on a case by case basis. The explanation

offered for BMS is similar in each unit with a discussion on "sensitised" nerves creating sensations in the mouth. What I was surprised by was how accepting of this the American population seemed to be with patients drawing their own conclusions in saying "so, it's in my head" and then being happy to move on from there with the management. BMS is managed with a clonazepam mouth rinse which can be swallowed to help with sleep or expectorated if sleep is good enough already. In the UK, we really struggle to get patients on board with the concept of sensitive nerves and the fact that stress may play a role. At EDH we typically offer a tricycylic antidepressant combined with lifestyle/stress management which may include psychological support in the form of pain management or simply information provision on the condition. I think this boils down to health belief models within the UK vs. the US with the latter population being much more accepting of concepts like BMS.

Epithelial dysplasia: The management of this condition was very similar in the units I visited but the diagnostic approach varied. At NYU I was able to observe the use of the Velscope for the detection of epithelial changes associated with dysplasia. In the US there is a lower threshold for the biopsy of suspicious lesions and patients on regular surveillance following a previous dysplasia diagnosis then undergo further biopsies at closer intervals. I presume this is due to the litigious nature of medical practice within the US. Management of dysplasia at EDH assumes that mild or potentially moderate dysplasia is reversible and as such, not all dysplastic cases need surgical intervention. In most cases, patient education on risk factors along with prescription of an antioxidant such as vitamins ACE and selenium are first issued. The patient is closely followed up and serial biopsy may be performed based on clinic findings. If a patient has a severe dysplasia on biopsy, a history of cancer or there are risk factors present, then surgical intervention would be advised at an earlier stage. Diagnosis is based on clinic judgement alone with no adjuncts to diagnosis such as the ones I observed in New York. A case of dysplasia or malignancy detection from each unit is discussed in the appendix.

Regarding standardisation of oral medicine training, these examples above and clear difference in volume of patients, along with the set-up of each unit varying to such an extent means that overall, the experience of juniors in each unit is incomparable. I think it would be extremely tough if not impossible to approach standardisation of training in oral medicine. I think core concepts could be outlined in terms of how many patients a trainee should expect to see and what skills they should have to be considered proficient in the practice of oral medicine (i.e. History taking, diagnostics, etc) but this could only be written in a vague manner which ultimately would not change the experience that a junior would have and thus would not result in its desired standardisation.

Oral medicine training pathways

In the US, oral medicine training programs are available at 8 different units across the country. The units include:

- Harvard university, Boston
- University of California, San Francisco
- Carolinas medical centre
- University of Pennsylvania
- University of Washington
- University of Southern California
- UBC dentistry medicine-oral pathology postgraduate hospital
- University of Toronto

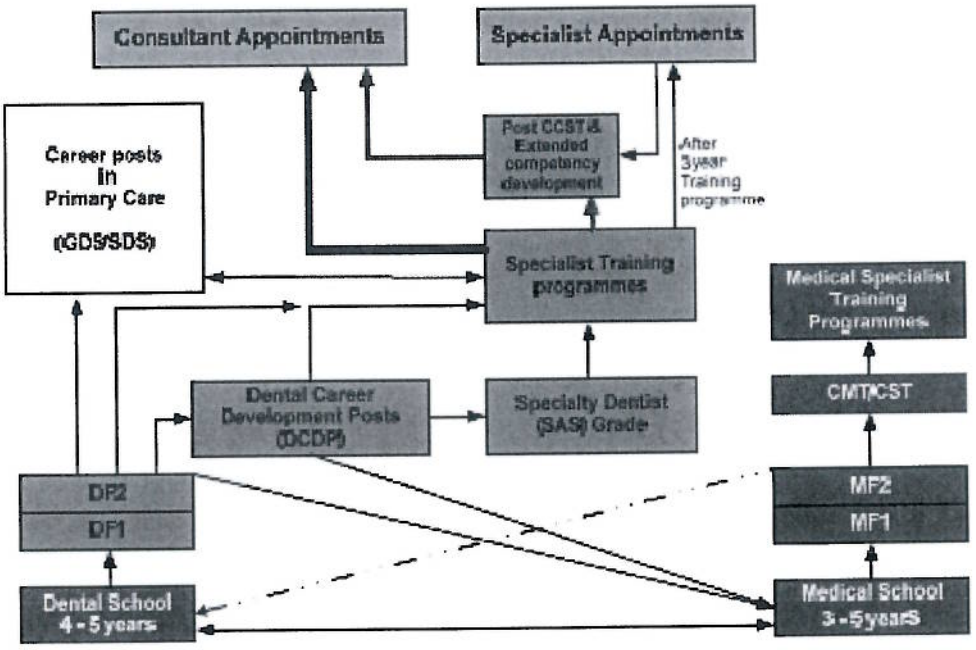
Each training program involves a "minimum of 24 months of training, and lead to a Certificate in Oral Medicine". The program is typically entered directly after the DDS or following a general practice residency (GPR) year. Each of the programs is hospital based and involves training in the management of medically-complex dental patients, oral pathology, oral radiology, as well as mucosal disease, salivary gland disease and facial pain. Some of the programs offer additional training towards a master's or doctoral degree, in addition to the clinical certificate. Oral medicine in the US is not accredited with specialty status with the American Dental Association.

In the UK the training is undertaken in NHS hospitals. There are 17 oral medicine specialist units in the UK located as follows:

- Eastman, London
- QMUL, London
- GKT, London
- Bristol
- Cardiff
- Birmingham
- Cork
- Dublin
- Belfast
- Liverpool
- Leeds
- Sheffield
- Manchester
- Newcastle
- Edinburgh

- Glasgow
- Dundee

To enter an oral medicine training program in the UK, a minimum of 2 years foundation training should follow the initial dental qualification (BDS). The foundation training is based in primary and secondary care setting, with completion of the MJDF or FDS as "useful indicators" that this level has been achieved, although not essential requirements. Oral medicine training is undertaken in the NHS hospital setting. Previously the entry pathway included both medical and dental undergraduate degrees with registration with the GMC and GDC respectively. In 2010 the specialist training pathway changed to include an entry point for dentally qualified individuals registered with the GDC only. Taken from copdend.org, the training pathway for oral medicine in the UK can be seen below. It includes both a single (with a 5 year training program) and double (with a 3 year training program) qualified pathway towards certification as a specialist.



Acknowledgements

My greatest thanks to the following consultants for their teaching and encouragement during the course of my visit:

Dr Ross Kerr, NYU

Dr Romero, NYU

Dr Nathaniel Treister, BWH

Dr Sook Bin-Woo, BWH

Dr Mark Lerman, BWH

Dr Tim Hodgson, EDH

Appendix

1: Diary of daily activity

Day 1: 17-04-2013

08:00 Met Professor Kerr in NYU for the multidisciplinary tumour board at Bellevue Hospital Centre. Present at the meeting were H&N surgeons, ENT surgeons, oncologists, radiologists, speech and language therapy and oral medicine clinicians. Residents presented cases and they were discussed at length and treatment planned. The meeting was a lot larger than what I have experienced in the UK.

09:30 Clinic with Professor Kerr including private patients.(* See appendix 2)

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
M	59	Rev	Carcinoma in situ LLQ	Resection 4/12 previously	Rev 2/12
F	41	Rev	Moderate dysplasia R tongue	Risk factor advice	Rev 4/12
F*	86	Rev	Dysplasia R tongue	Reassurance	Rev 4/12
F	85	Rev	Hyperkeratosis ULQ	Reassurance	Rev 4/12

14:00 Clinic with oral medicine international residents and undergraduate students.

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	75	Rev	Unknown- burning and dry mouth	Anti-fungals, B12 recommended	Rev 2/52
M	55	Rev	Pleomorphic adenoma	Review following biopsy 1/52 previously	Rev 1/12
F	74	Rev	Unknown- multiple white patches	Reassurance	Discharge
F	34	Rev	Lichenoid changes	Triamcinolone, biopsy	Rev 2/52
M	54	Rev	Moderate dysplasia	Reassurance	Rev 3/12

Day 2: 18-04-2013

09:00 Pathology teaching in the lab looking at slides of cases from the week with Dr Phalegn.

10:00 Facial pain clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	47	Rev	Unknown-headache + burning since XLa	Topical lidocaine and capsicain. Indomethacine.	Rev 2/12
F	65	Rev	Myofacial pain and TMJ capsulitis	Celecoxib	Rev 2/12
F	46	New	Myofacial pain. Traumatic neuroma.	Amitriptyline.	Rev 1/12

14:00 Facial pain/TMD clinic.Physiotherapist present.

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	69	New	TMD	MRI. PT exercise and massage. Bite guard.	Rev 3/12
F	43	New	TMD	PT exercise. Bite guard.	Rev 3/12
F	49	New	Chronic paroxysmal hemicranias	Indomethacine. Referral to neurologist.	Rev 2/52
M	41	Rev	TMD	Bite guard day and night	Rev 6/52

Facial pain team. From Left to right:

Dr M. Romero *Assistant Professor.* Dr A. Bin-Nabhan *International resident.* Dr R Phull *Faculty.*

Dr R Alghamdi *International resident.* Dr E Alam *International resident.* Dr Joanna Christou

Day 3: 19-04-2013

09:00 Tour of the hospital. Student research day with 150 poster presentations.

13:00 William Maixner guest lecturer on Complex persistent pain conditions.

14:00 Project planning and work with Dr Kerr

Day 4: 21-04-2013

11:00 4 mile charity walk to raise money for oral cancer. This is the 8th NYC oral cancer walk. There were 600 people participating in the walk. Over $50,000 was raised for the charity which is led by Dr Ross Kerr.

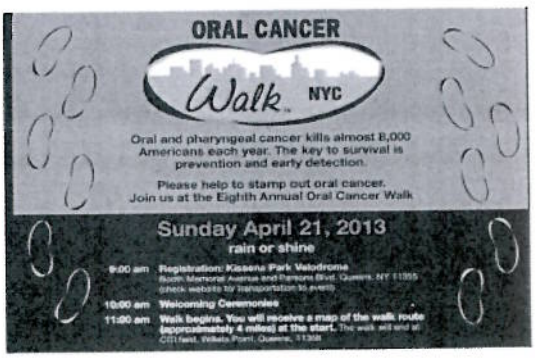
Charity walk in Queens. From left to right:

Dr R NiRiordain

Dr Joanna Christou

Dr Ross Kerr

Dr Leila Khamashta



Day 5: 22-04-2013

Worked on obtaining and collating data for this project.

Day 6: 23-04-2013

Worked on obtaining and collating data for this project.

Day 7: 24-04-2013

Took flight to San Antonio, Texas for the AAOM conference.

Day 8: 25-04-2013

08:00 Liver disease- Medical perspective. Dr Vincent Speeg.

08:45 Liver disease- Oral manifestation and impact on dental management. Dr Joel Napenas.

09:45 Sjogrens syndrome update. Dr Troy Daniels.

10:30 Lupus- Oral manifestations and impact on dental management. Dr Catherine Kowalewski.

12:00 Jonathan A. Ship diplomats lecture. Dr Sook-Bin Woo.

14:00 Oral medicine residents meeting. I had the opportunity to meet with residents from all over the United States. They were from the University of Southern California (Los Angeles, California), Carolinas Medical Centre (Charlotte, North Carolina), University of Washington (Seattle, Washington) and University of British Columbia (Vancouver, Canada). They were all qualified in dentistry, having completed general practice residency (GPR) training and are now in their residency program for oral medicine. One of the residents was dual-qualified and the others were dentally qualified. We talked extensively about the differences in training pathways between the US and the UK. The greatest difference being that the oral medicine residency in the US includes special care dentistry, oral pathology and radiology. Additionally, oral medicine is not recognised as a speciality in the US.

Oral medicine residents meeting

15:00 Oral complications of cancer therapy. Dr Michael Brennan.

18:00 New member reception

Day 9: 26-04-2013

08:20 Role of HPV in head and neck cancer. Dr Gypsyamber D'Souza.

09:10 Update on treatment of oropharyngeal carcinoma. Dr AthanassiosArgiris.

10:15 Update on cell based assessment of oral cancer. Dr John Devitt.

11:00 Update on stem cell transplantation. Dr Cesar Freytes.

11:45 Oral implications of stem cell transplantation. Dr Mark Schubert.

18:30 Presidents reception and award ceremony

Day 10: 27-04-2013

08:00 Complex neuropathic pain conditions- Pharmacologic management. Dr David Sirois.

08:45 Update on HIV. Dr Lauren Patton.

10:00 Pathophysiology of chronic steroid use. Dr Sara Ahmadi.

10:30 Evidence to support the use of replacement steroid therapy. Dr Mark Schifter.

11:00 Panel discussion on steroid prophylaxis in dentistry.

11:15 Osteonecrosis from new bone-modifying agents. Dr Cesar Migliorati.

12:00 Case report award presentations

Bilateral facial paralysis secondary to large diffuse B cell lymphoma. Dr Juan Bugueno

Oral ulceration following full facial transplantation. Dr Anna Yuan

Pyostomatitisvegetans in a patient with ulcerative colitis. Dr Christine Nadeau

16:00 Management of patients with dry mouth. Dr VidyaSankar.

19:00 Closing reception and dinner

Day 11: 28-04-2013

Took flight to Boston for externship at Brigham and Women's Hospital.

Day 12: 29-04-2013

08:30 Dr Sook-Bin Woo- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	57	Rev	Previous SCC 2y ago. Today candidiasis.	Nystatin	Rev 4/52
F	62	New	BMS	Clonazepam m/w QDS Psychology for anxiety	Rev 4/52
F	54	New	BMS	Clonazepam m/w QDS	Rev 4/52
F	56	New	OLP	Reassurance. Advised to check thyroid status	Rev 3/12
F	63	Rev	Proliferative leukoplakia	Biopsy	Rev 2/52
F	49	New	Healthy mouth	10y hx bisphosphonate use- ?BRONJ	Discharge
F	67	New	Actinic keratosis	Topical steroid, antifungals, rev for bx	Rev 2/52
F	68	Rev	Erythroleukoplakia	Bx	Rev 2/52
F	48	New	BMS	Clonazepam m/w QDS	Rev 4/52

14:00 Resident's clinic with Dr Anna Yuan

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	69	New	Due for bone marrow transplant	Dental assessment. OHI and FMSC+P	Discharge
M	25	New	Due for bone marrow transplant	Dental assessment. Full mouth Xrays.	Discharge
M	63	In patient	Myelofibrosis – oral mucositis	Antihistamine/anti-inflammatory m/w	Rev 1/7
M	53	In patient	AML – oral mucositis	Antihistamine/anti-inflammatory m/w	Rev 1/7

Day 13: 30-04-2013

09:00 Dr Mark Lerman- Oral medicine clinic(* See appendix 3)

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F*	68	New	Likely SCC	Bx	Rev 1/52

F	67	New	BMS	No tx- pt choice	Discharge
M	75	Rev	OLP	Dexamethasone m/w	Rev 1/1

14:00 Dr Sook-Bin Woo- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
M	49	Rev	Leukoplakia	Monitor	Rev 1/1
F	81	Rev	OLP	Dexamethasone m/w	Rev 3/12
F	64	Rev	BMS	Reassurance, increase fluid intake	Rev 6/12
F	67	Rev	BMS	Psychology, increase fluid intake	Rev 6/12
F	48	New	Exfoliativechelitus	Vaseline, stop lip licking, increase fluid intake	Discharge
M	66	Rev	CML- dental assessment	To see dentist for LL5 periapical infection	Discharge

I also attended the pathology lab to review patient slides with Dr Sook-Bin Woo.

Day 14: 01-05-2013

08:00 Grand round. Cases presented by juniors including likely SCC and red/white proliferative lesions.

09:00 Oral medicine seminar led by Dr Nathaniel Treister.

- Residents presentation on human herpes viruses
- Drugs presentation
- Update on recent publications of interest.

13:00 Dr Stephen Sonis- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	67	Rev	OLP	Fluocinamide	Rev 1/1
F	61	Rev	OLP	Dexamethasone m/w	Rev 1/1
M	71	Rev	OLP	Monitoring	Rev 6/12
F	67	Rev	OLP w dysplasia	Monitoring	Rev 3/12
F	72	New	Xerostomia	Pilocarpine, SCA	Rev 6/52
F	54	New	Secondary sjogrens synd.	Xylimelts, biotene spray	Rev 6/12

Day 15: 02-05-2013

08:30 Dr Nathaniel Treister- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
M	41	Rev	BMS, TMD	Trigger point injections	Rev 2/12
M	62	Rev	Post-irradiation trismus	PT, stretch exercises, Dyna splint	Rev 1/52
F	58	Rev	BMS	Clonazepam m/w, gabapentin	Rev 2/12
M	61	In patient	Brain abscess ?odontogenic origin	Dental assessment- NAD	Discharge from OM
F	76	In patient	AML- recent XLa, c/o post-op pain	Dental assessment- NAD	Discharge from OM

13:00 Dr Nathaniel Treister- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	65	Rev	OLP	Dexamethasone m/w	Rev 1/1
M	53	Rev	GvHD	Tacrolimus, clobetasol	Rev 3/12
M	31	Rev	Coxsackie virus	Supportive	Discharge
M	67	New	BRONJ	Peroxydyl m/w	Rev 6/12
M	30	New	Frictional keratosis	Reassurance	Discharge
F	67	Rev	OLP + dysaesthesia	Clobetasol, clonazepam, fluconazole	Rev 3/12
F	27	Rev	Crohn's	Intralesional triamcinolone	Rev 2/52
M	64	In patient	AML- chemox induced mucositis	Caphisol, lidocaine m/w	Rev 1/7
M	64	In patient	Myelofibrosis- chemox induced mucositis	Antihistamine/anti-inflammatory m/w	Rev 1/7
M	34	In patient	# teeth after Boston marathon bombs	XLa	Rev 1/7
M	81	In patient	Pharyngeal abscess ?odontogenic origin	Dental assessment- NAD	Discharge from OM

Day 16: 03-05-2013

08:30 Dr Nathaniel Treister- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	55	Rev	BMS	Clonazepam m/w	Rev 3/12
F	58	New	OLP	Dexamethasone m/w	Rev 6/12
M	27	New	BMT for ALL-GvHD	Clonazepam m/w, tacrolimus, pilocarpine	Rev 1/12
F	39	New	ROU	Dexamethasone m/w, pentoxyphyline	Rev 1/12

13:00 Dr Nathaniel Treister- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
M	66	Rev	Post-irradiation trismus	Dynasplint, fibrous band release surgery	Rev 1/12
F	55	Rev	BMS	Clonazepam m/w	Rev 1/12
F	52	Rev	OLP	clonazepam m/w, clobetasol, intralesional triamcinolone	Rev 3/12
F	22	Rev	GvHD	Clonazepam m/w, tacrolimus, dexamethasone m/w, clobetasol	Rev 2/12
M	59	In patient	BMT for AML – mucositis	Caphisol	Rev 1/7
M	53	In patient	AML – oral mucositis	Antihistamine/anti-inflammatory m/w	Rev 1/7

Day 17: 20-05-2013

09:00 Dr Tim Hodgson- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
M	13	Rev	Erythema multiforme	Azathioprine, betnesol, cultivate	Rev 3/12
F	33	New	OLP	Betnesol, difflam	Rev 3/12
F	21	Rev	ROU	Betnesol	Rev 6/12
M	38	Rev	OLP	Flixonasenasules, flixonase spray, cultivate ointment, difflam	Rev 6/12
F	70	Rev	Xerostomia	Salivix pastilles, bioextra gel	Rev 6/12

F	84	Rev	Secondary sjogrens	Salivix pastilles	Rev 6/12

14:00 Dr Tim Hodgson Oral medicine clinic (* See appendix 4)

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F*	54	New	Likely SCC of lip	Biopsy	Rev 1/52
F	42	New	Lichenoid reaction	Monitoring	Rev 6/12
M	35	New	Fibroma	Excisional biopsy	Rev 3/52
F	36	New	Subjective halitosis	Reassurance	Rev 3/12

Day 18: 21-05-2013

09:00 Dr Tim Hodgson- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	39	New	OLP	Biopsy	Rev 3/52
F	58	New	Healthy mouth	Reassurance	Discharge
F	67	New	Median rhomboid glossitis	Oral microbiology swab	Rev 6/52
F	15	New	Fibroma	Excisional biopsy	Rev 3/52

Day 19: 22-05-2013

09:00 Dr Tim Hodgson- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	50	New	BMS	Reassurance	Rev 3/12
M	63	New	White patch ?leukoplakia	For biopsy	Rev 3/52
F	46	New	OLP	Flixonase spray, difflam, for biopsy	Rev 3/52
F	79	New	Fibroma	For excision	Rev 3/52

14:00 Dr Tim Hodgson- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
M	67	New	Mediam rhomboid glossitis + pseudomembranous	Fluconazole, nystatin, corsodyl, denture hygiene, inhaler	Rev 6/52

			candidiasis	hygiene	
F	71	New	BMS	Reassurance	Rev 6/12
M	70	New	BMS	Referral to psychology	Rev 3/12

Day 20: 23-05-2013

09:00 Dr Tim Hodgson- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	60	Rev	OLP + candidiasis	Betnesol, nystatin, difflam spray	Rev 3/12
F	47	Rev	Oral SLE	Flixonase nasules, diflam	Rev 3/12
F	52	Rev	MMP	Flixonase nasules	Rev 3/12
F	81	Rev	OLP + xerostomia	Cutivate ointment, corsodyl, salivix pastilles	Rev 1/1
M	81	New	White patch ? dysplasia	For biopsy, SCA	Rev 3/52

Day 21: 24-05-2013

09:00 Dr Tim Hodgson- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	56	Rev	OLP	Flixonase spray	Rev 4/12
M	83	Rev	OLP with dysplasia	SCA	Rev 9/12
F	35	Rev	OSMF + mucocoele	Paan + SCA	Rev 1/12
F	27	Rev	RAS	Flixonase nasules, difflam spray, corsodyl	Rev 3/12
F	39	Rev	OLP	SCA	Discharge
F	72	Rev	MMP	Dapsone, doxycycline, betnovate, flixonase, corsodyl	Rev 4/12
F	14	New	Frictional keratosis	Reassurance	discharge

14:00 Dr Tim Hodgson- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	50	New	White patch	For biopsy	Rev 3/52
F	62	New	Viral papilloma	For biopsy	Rev 3/52
M	39	Rev	Secondary sjogrens syn.	Salivary substitutes, fluoride m/w and t/p	Rev 6/12
F	43	New	Diabetes insipidus	Endocrinology referral	Rev 4/12

Day 22: 28-05-2013

09:00 Dr Tim Hodgson- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	82	New	Candidiasis	Nystatin, corsodyl	Rev 1/12
F	74	Rev	OSMF	Betnesol, difflam	Rev 3/12
F	64	New	ROU secondary to vit B deficiency	Flixonase spray, difflam spray	Rev 3/12
M	45	New	Vascular malformation	MRI to identify feeding vessels	Discharge to OMFS
F	27	New	Amalgam tattoo	For biopsy	Rev 3/52

12:00 Clinicopathological meeting.

MDT with oral medicine and oral pathology to discuss recent cases of academic interest. 5 cases presented and discussed as a group.

14:00 Dr Tim Hodgson- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
M	49	New	BMS	Reassurance	Rev 3/12
F	82	New	Denture trauma	Reassurance	Discharge
F	58	New	Keratosis	SCA	Discharge

Day 23: 29-05-2013

09:00 Dr Tim Hodgson- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	65	New	Lichenoid reaction	For biopsy	Rev 3/52

F	61	New	Stomatitis nicotina + keratosis	For biopsy, SCA	Rev 3/52
M	52	New	FEP	For biopsy	Rev 3/52
M	34	New	FEP	For biopsy	Rev 3/52
F	34	New	RAS	Betnesol, difflam, bloods	Rev 3/12

14:00 Dr Tim Hodgson- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	55	Rev	SCC	Ref OMFS	Discharge
F	52	New	Frictional keratosis	Reassurance	Discharge
F	40	New	OLP	For biopsy, betnesol	Rev 3/12
M	51	Rev	Friction and smokers changes	SCA	Rev 6/12

Day 24: 03-06-2013

09:00 Dr Tim Hodgson- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	59	New	Likely mandibular lymph node	For USS	Rev 4/12
M	35	Rev	RAS minor	Thalidomide, flixonase nasules	3/12
F	33	New	BMS	Reassurance	Discharge
F	43	New	BMS	Reassurance	Rev 3/12
M	25	New	Mucocoele	For excision	Rev 3/52

14:00 Dr Tim Hodgson- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	53	New	BMS	Nortiptyline, CBT, difflam spray	Rev 6/12
M	56	New	OLP	Difflam, flixonase spray, for biopsy	Rev 3/52
M	17	New	ROU secondary to iron deficiency	Flixonase spray, difflam spray, bloods,	Rev 3/12

				iron replacement therapy	
F	47	New	BMS	Reassurance	Discharge

Day 25: 04-06-2013

09:00 Dr Tim Hodgson- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
M	44	New	RAS minor	Betnesol, difflam, bloods	Rev 3/12
F	36	New	OLP	Betnesol, for biopsy	Rev 3/52
F	35	New	?foreign body reaction	For biopsy	Rev 3/52
M	49	New	FEP	For excision	Rev 3/52
F	58	New	Altered facial sensation	Reassurance	Discharge

14:00 Dr Tim Hodgson- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	42	New	Erythema multiforme	Flixonase nasules	Rev 6/12
F	45	New	Amalgam tattoo	For biopsy	Rev 3/52

17:00 London Oral medicine group

"Psychology, psychiatry and physiotherapy- a multidisciplinary approach to oral medicine and facial pain". An evening of presentations by the team at EDH on their role in managing the patients we refer to them for facial pain (mainly TMD and BMS) and other conditions such as halitophobia. Consultants, specialists and juniors in training attended from all the oral medicine units across London.

Day 26: 05-06-2013

09:00 Dr Tim Hodgson- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
M	38	New	FEP	For biopsy	Rev 3/52
M	42	New	RAS minor	Prednisolone, flixonase	Rev 2/12

				nasules, corsodyl	
F	37	New	TMD + BMS	Reassurance	Rev 3/12
M	53	New	Leukoedema + frictional keratosis	SCA	Discharge

14:00 Dr Tim Hodgson- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
M	43	New	OLP	Betnesol, for biopsy	Rev 3/52
M	62	New	FEP	For biopsy	Rev 3/52
M	42	New	Resolved thermal trauma	Reassurance	Discharge
F	37	New	OLP	Betnesol, for biopsy	Rev 3/52

Day 27: 06-06-2013

09:00 Dr Tim Hodgson- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
M	19	New	White patch	For biopsy	Rev 3/52
M	23	Rev	Oral Crohns disease	Azathioprine, trimovate, intralesional corticosteroids, betnesol	Rev 3/12
M	53	Rev	Red patch	SCA, reduce etoh	Rev 4/12
F	25	Rev	Possible Behcets	Azathioprine, flixonase nasules, vibramycin m/w, corsodyl	Rev 2/12
F	83	New	OLP + frictional keratosis	Reassurance	Rev 3/12

14:00 Dr Tim Hodgson- Oral medicine clinic

Gender	Age	New/Rev	Diagnosis	Treatment	Follow up
F	54	New	Lichenoid reaction	For biopsy	Rev 3/52
M	53	New	Frictional keratosis	Reassurance	Rev 2/12

F	66	New	Kerstosis + candida	Nystatin, for biopsy	Rev 3/52

2. Cases of interest seen at NYU

Patient seen with Dr Ross Kerr.

Patient details: 86F, follow up for tongue dysplasia. c/o nil today.

PMH: Atrial fibrillation. Multiple cancers including melanoma, basal cell carcinoma and colon cancer. All detected in early stages and managed. Currently on serial surveillance with medical teams.

Meds: Warfarin.

Allergies: NKDA

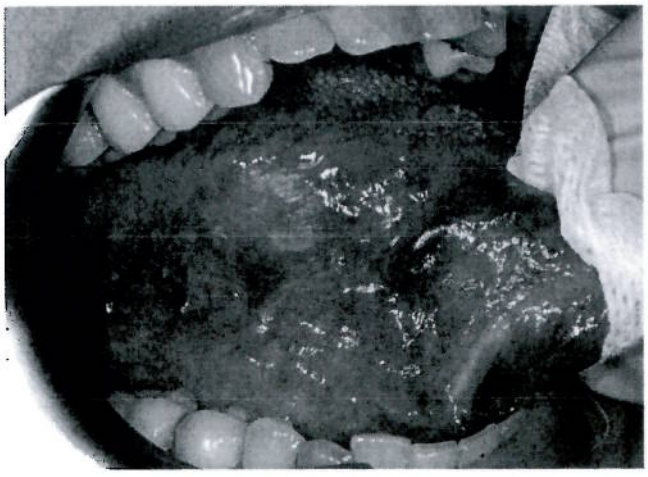
SH: Tobacco nil. Alcohol minimal.

OE: LN nil. TMJ nil.

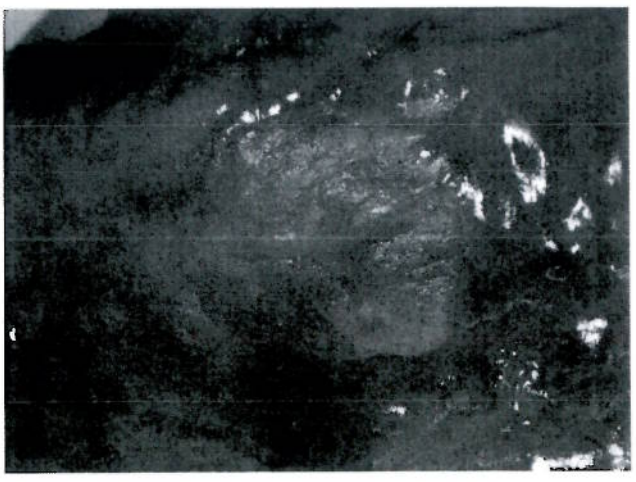
IO: Mucosa well lubricated. R ventro-lateral tongue homogenous leukoplakia. No speckling or ulceration. All other mucosal surfaces healthy.

Mx: Reassurance and close surveillance with regular biopsy.

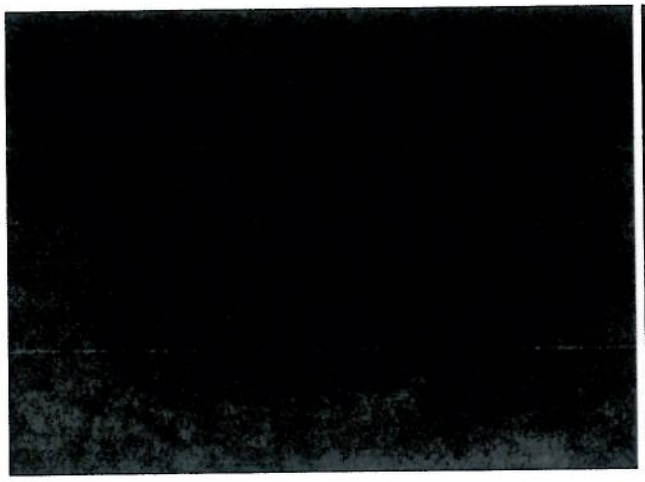
a) R tongue homogenous leukoplakia



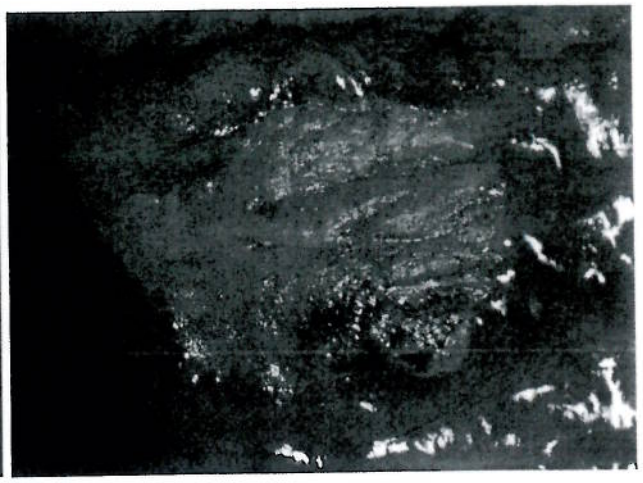
b) Closer view



c) Use of Velscope



d) Use of toluidine blue dye



This case was interesting for me as it was my first encounter of using the Velscope and toluidine blue dye in the clinical setting. Tolonium chloride (toluidine blue) is taken up preferentially by dysplastic tissue and thus aids the clinician in choosing the most appropriate biopsy site. From reading the literature it would appear that there is no evidence to suggest that the use of toluidine blue does not infer a higher detection rate as opposed to good clinical assessment alone. As such, its use may be limited to adding confidence to a clinician's judgement only. This, in my opinion, is a valid justification. Equally, the use of the velscope was a new experience for me and I was grateful to Dr Kerr and his patients for allowing to try using it.

3: Cases of interest seen at BWH

Patient seen with Dr Mark Lerman.

Patient details: 68F, 1y h/o "burning and tenderness in mouth" previously biopsy-confirmed OLP. Presents with daughter (who is a dentist) as symptoms worsening since January 2012. Current pain score 4/10. She describes that the symptomatic areas have migrated from the tongue to include the floor of mouth and gingivae on the right mandible. She now finds difficulty eating and reports weight loss attributed to reduced appetite following a family bereavement with death of her husband. Treatment to date includes betamethasone, tacrolimus, chlorohexidine and nystatin- all of which have not improved her symptoms.

PMH: T2DM, HTN, Lichen planus on skin confirmed by biopsy 10y ago.

Meds: Insulin. Topical oral preparations including betamethasone, nystatin, chlorohexidine.

Allergies: NKDA.

SH: Nil tobacco use, nil alcohol consumed. Retired, previously worked as a statistician. Patient lives in India and visits Boston for extended periods of time each year as daughter

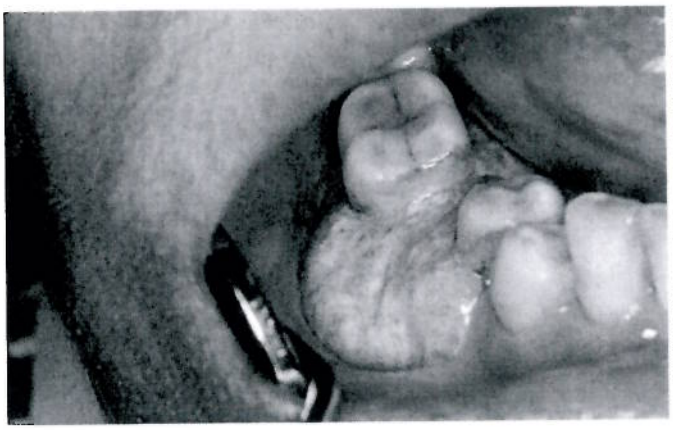
lives there. Parents deceased.3 siblings (a physician, a dentist and a lawyer; 2 in India, 1 in USA; all healthy).2 children (son; works in IT, healthy. Daughter; dentist, healthy; both live in USA).

OE: R submandibular non-tender, fixed lymphadenopathy x3.

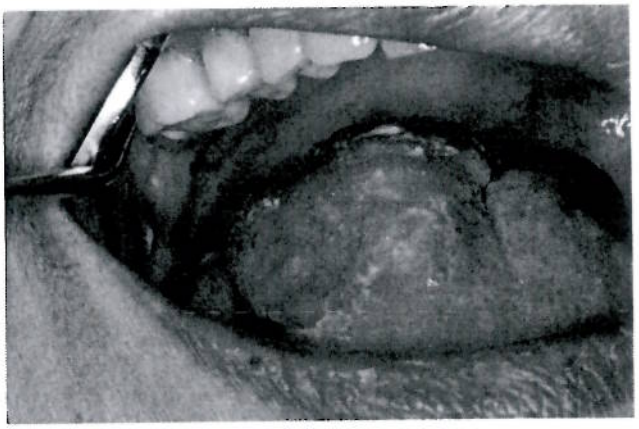
IO: 1-1.5cm indurated ulcer on the right dorso-lateral tongue with anterior peri-lesional erythema. Tongue was fixed. Edentulous ridge LR6 region was extensively ulcerated with granulation tissue extending onto the lingual alveolus and FoM. This area was firm to palpate. LR57 grade 2 mobile. Other mucosal surfaces showed some mild erosions and reticular striae.

Mx: 2 x biopsy with LA.

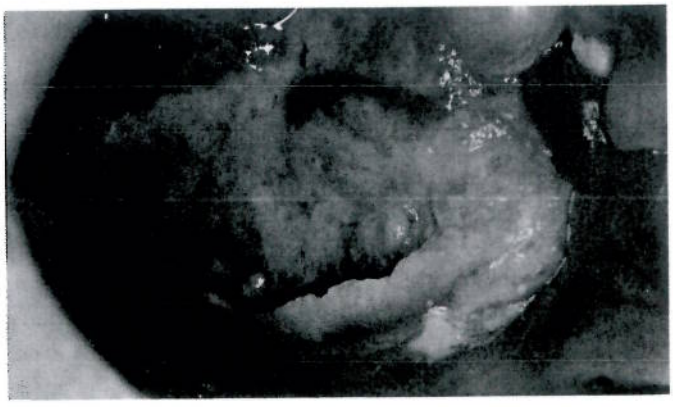
a) buccal attached gingivae



b) R lateral border of tongue



c) R FoM



Result: Histology confirms SCC of the alveolar mucosa and tongue. The patient was referred to cancer surgeons for further management.

This consultation was handled really delicately as the daughter, who is a dentist, had previously been managing this patient's ulcer and seemed to be in denial about the

situation. They had used topical tacrolimus, antifungals, steroids and found the symptoms to be progressing despite this management. The patient was aware of cancer as a potential diagnosis but did not think that this was the cause for her oral soreness. In addition, when the patient first started to describe her symptoms, she was vague and a poor historian, as such it initially appeared that her symptoms were more likely dysaesthetic in nature given the timing with the recent bereavement of her husband and report loss of weight due to reduced appetite. The patient was ambivalent about her symptoms and even wanted to cancel her appointment if it were not for her daughter who "forced" her to come.

Once a clinical assessment was undertaken and the diagnosis of oral cancer was suggested to them, they did not appear to accept the explanation offered. Despite this, the patient was happy to undergo a biopsy as advised by Dr Lerman. The biopsy was undertaken in the clinic and the results were available within the week. Unfortunately, I was not present at the time the patient received her biopsy results.

4: Cases of interest seen at EDH

Patient seen with Dr Tim Hodgson

Patient details: 56yo F, c/o 1year history of lip swelling with recurrent infections, previous biopsy of lip confirmed OLP as reported by the patient. Multiple infections of the lip have resulted in frequent courses of antibiotics. Patient is currently complaining of intermittent dull pain, dry lips and a white discharge. There is no specific intraoral complaint. Three are no other systemic symptoms reported. Patient is concerned regarding the possibility of cancer of the lip.

PMH: Asthma, fibromyalgia

Meds: Amitriptyline, ventolin inhaler, beclometasone inhaler, regular analgesia, eye drops

Allergies: Dust

SH: Lives with daughter who is a nurse, tobacco nil, alcohol nil. Born in Turkey and moved to the UK 12 years ago.

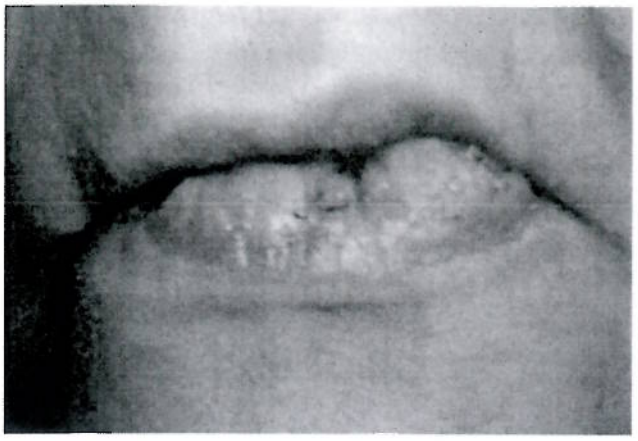
OE: LN nil, 2cm haemorrhagic and crusting lump on lower lip, firm and tender to touch, nodular on palpation

IO: mucosa well lubricated, mild reticluar white lines onbuccal mucosa bilaterally, no speckling, no ulceration.

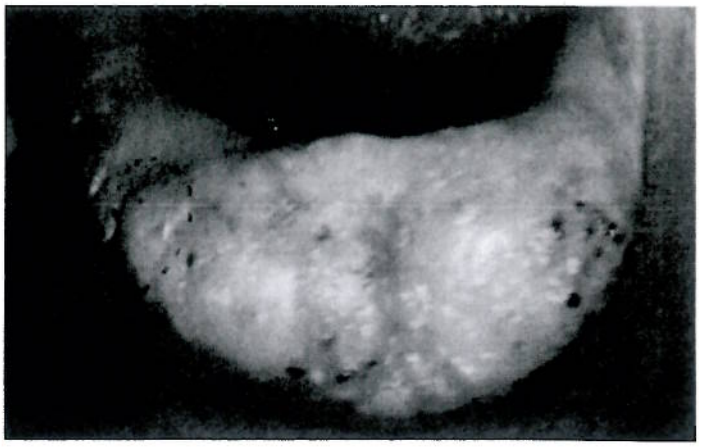
Biopsy was performed at that initial consultation. Results: Moderate dysplasia. But given the

clinical picture it was felt that the histology was representative of that region only and that likely epithelial invasion was present at other sites.

a) Extraoral view of lower lip



b) Closer view showing site of biopsy



The pictures above show a nodular lip swelling which was currently infected and haemorrhagic. The site of biopsy is marked on the photo above.

The patient was referred to OMFS for management of SCC. This case was a late presentation of a malignancy which had over the course of 1 year become recurrently infected. As such, biopsy of the lesion was difficult to undertake and asses histologically as there was significant inflammatory and infective components. Despite the pathology report showing only moderate dysplasia, due to the clinical appearance the patient was managed as SCC.