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Hiding in Plain Sight—Med Mal Lawsuits and the Missed Cancerous Oral Lesion

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Ask any experienced plaintiffs lawyer if they ever handled a dental malpractice case, and the answer is almost always in the negative. Unfortunately, many lawyers have concluded that the potential damages are not enough to make dental malpractice cases worth pursuing. But while that might be true in some circumstances, there is a subset of lucrative cases that are hiding in plain sight of not only the lawyer, but also the medical practitioner. In these cases, a dentist, dental specialist or ears, nose and throat (ENT) doctor failed to consider what appeared to be a benign oral lesion as a potentially far more serious finding.

About 54,540 new cases of oral cavity or oropharyngeal cancer (back of the throat, including the base of the tongue and tonsils) will be diagnosed in the United States this year, according to the American Cancer Society. About 11,580 people in the United States will die from oral cavity or oropharyngeal cancer in 2023.

Cancers of the oral cavity, including the tongue, will be visible in their earliest manifestation to the trained professional but too often are negligently dismissed as benign. Where there is a delay in diagnosis and treatment, the outcome for the patient can be catastrophic. According to the American Society of Clinical Oncology, if oral or oropharyngeal cancer are diagnosed at an early stage, the overall five-year survival rate is 85%. If the cancer has spread to surrounding tissues or organs and the regional lymph nodes, the overall five-year survival rate is reduced to 68%. If the cancer has spread to a distant part of the body, the overall five-year survival rate drops precipitously to 40%.

Theories of liability in plaintiffs' oral cancer litigation include failure to diagnose the cancer, failure to perform a biopsy, and failure to refer a patient to a specialist. The biggest challenge to successfully litigating a failed oral cancer diagnosis case is causation and the contributory behavior of the patient.

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This article provides a brief overview of oral cancer, including the risk factors and early signs. It discusses the standard of care for general dentists, dental specialists and ENT physicians in evaluating patients with suspected oral lesions, and the differential diagnosis that must be considered by the dentist with every suspicious lesion. The article addresses what can go tragically wrong when proper diagnosis and treatment are delayed and offers practice tips for litigating these complex cases.

A Brief Overview of Oral Cancer

The most prevalent type of oral cancer is squamous cell carcinoma. Squamous cells are described by the American Cancer Society as "flat, thin cells that form the lining of the mouth and throat." Oral cancer develops when the

squamous cells mutate and grow abnormally. Risk factors for oral cancer include:

- Tobacco use of any kind, including "smokeless" tobacco products, such as chewing tobacco
- Alcohol use
- Family history of head and neck cancer
- Personal history of cancer
- History of previous head/neck radiotherapy
- Complaints lasting longer than two-four weeks
- Immuno-compromised, e.g., patients who have had transplants and are on anti-rejection medications are at increased risk for developing cancerous oral lesions
- Patients over age 40 are considered at higher risk for oral cancer

Early signs of oral cancer include:

- Persistent red or white patch on the inside of the mouth
- Nonhealing ulcer
- Progressive swelling/enlargement
- Unusual surface changes
- Sudden tooth mobility without apparent cause
- Unusual oral bleeding
- Prolonged hoarseness
- Standard of Care

In general, the standard of care for general dentists and specialists requires:

-A complete medical and social history. Every practitioner, whether a general practitioner or specialist, must take his/her own thorough history of each patient. It is not acceptable to rely on any previous histories, and the history must be updated at each subsequent visit.

-General dentists must conduct a complete and thorough oral cavity examination, which includes visual inspection and palpation of the head, neck, oral and pharyngeal regions. The oral examination must include the oral cavity and its structures including the tongue, lymph nodes, muscles of mastication, temporomandibular joint and sinuses.

-General dentists must repeat the dental hygienist examination of the oral cavity.

-Dental specialists are also dentists, and they must also conduct a complete oral examination and cannot rely on the referring general dentist's oral cavity examination. Just because a specialist, such as an endodontist, may be focused on a specific problem for which the patient has been referred, such as the need for an extraction or root canal, does not excuse the specialist from the standard of care to screen for oral cancer.

-Written documentation and/or clinical photos describing the lesion must be included in the patient's chart. Examples of how practitioners should document/describe lesions are shape, size, color, consistency or induration.

-When there is a suspicious lesion, the dentist or specialist must consider cancer in the differential diagnosis until proven otherwise.

Differential Diagnosis

The differential diagnostic algorithm for every suspicious lesion begins with listening to the patient's history. Practitioners should ascertain how long a lesion has been present, whether it has changed in size or character, the symptoms associated with it (e.g., pain or swelling), whether there are any associated constitutional symptoms, and whether there is any historical reason for the lesion.

A complete clinical examination should be performed, and where appropriate, the general dentist may refer the patient to a specialist.

According to the Oral Cancer Foundation: "Any oral lesion that does not regress spontaneously or respond to the usual therapeutic measures should be considered potentially malignant until histologically shown to be benign. A period of two-three weeks is considered an appropriate period of time to evaluate the response of a lesion to therapy before obtaining a definitive diagnosis."

Diagnostic tests include a biopsy, radiographs and laboratory examination.

Biopsy methods include:

- Exfoliative cytology (cell scrapings)
- Fine needle aspiration
- Incisional biopsy (removal of a representative sample of the lesion)
- Excisional biopsy (complete removal of the lesion)
- Radiographic modalities include:
- Computer tomography (CT) scan
- Magnetic resonance imaging (MRI)
- Routine dental radiographs

A complete blood count (CBC) and liver function tests can also aid in the diagnosis of oral cancer.

What Can Go Wrong

Problems start with an incomplete medical history leading to a flawed differential diagnosis. We repeat: Every general practitioner or specialist must obtain his/her own thorough medical history of the patient. Not all patients are

medically sophisticated or have good recall of their medical history. It is incumbent upon the professional to tailor the history-taking from the patient to secure all relevant information. The medical history must also be updated at every subsequent visit. The failure to obtain a complete and accurate medical history is a deviation from accepted standards of care. In addition, the specialist should never rely solely on the history provided by the referring dentist.

Cases that begin with an inadequate medical history often end with focused treatment and attention on an area that has nothing to do with the source of the patient's medical condition and a delayed diagnosis.

Causation and Damages

Unfortunately, our firm has seen a number of cases where failure to diagnose and delayed diagnosis of oral cancer have led to progression of the disease, radical surgery, the need for radiation therapy, and permanent loss of functionality (e.g., difficulty speaking and swallowing) due to the need for "mutilating" surgery, including near total glossectomy (surgical removal of more than half of the tongue). A tumor of the tongue that is timely diagnosed will generally only require a partial glossectomy, instead of more radical surgery and result in less dysfunction of speech and swallowing. Where there is a delayed diagnosis and the tumor spreads and results in a near total glossectomy, these patients will face a lifetime of liquid nutrition and pureed food because delayed diagnosis necessitated a near total glossectomy. Our clients also have lost their earning capacity and occupations because they could not overcome the physical and speech-language impairments of radical surgery.

Strategies for Countering Common Defenses

The patient's compliance or social habits (e.g., use of tobacco products) will always be front and center in defense of these claims, and counsel must be prepared to counter these "go-to" defenses. In addition, the doubling time of the most common oral cancers results in a rapid spread of the cancer and will be another argument in defense of a "delay in diagnosis" claim. When the dentist on trial resorts to the "blame the patient" defense, this is best countered by demonstrating the lack of an adequate history regarding tobacco and alcohol use. Patients who use smokeless tobacco will often respond in the negative to a question of "Do you smoke?" A social history must specifically include the use of all types of tobacco. A dentist or specialist must consider the risk factors when evaluating an oral lesion. In a high-risk patient there must be heightened vigilance and concern about any suspicious lesions. Every defendant will agree at deposition that patients who smoke are at increased risk for the development of oral cancer. Regarding causation, in failure to diagnose cancer cases we work in reverse. We look at the staging of the tumor and determine whether timely intervention would have changed the outcome. Many clients call a lawyer after meeting with a cancer specialist. The specialist will tell the client that had the tumor been diagnosed earlier in time the outcome would have been different. But never assume that the cancer specialist will agree to testify or offer an opinion on causation. Rather, retain your own independent causation expert in all cases. The best you can realistically expect is for the treating cancer specialist to provide a report of his/her treatment, but this testimony can be very effective and dramatic damages testimony.

Required Experts

When building a dental malpractice oral cancer case, plaintiff's counsel must use multiple experts on a variety of matters, including standard of care, medical causation, future medical care, emotional distress and economic losses. While required experts will vary depending upon the circumstances of each case, experts generally include:

- Oral/Maxillofacial surgeons
- Otorhinolaryngology/Head and Neck surgeons
- Endodontists, periodontists, dentists and other dental practitioners
- Radiologists'
- Vocational experts
- Psychologists for forensic psychiatric evaluations
- Forensic economists

Final Thoughts

Oral cancer cases are complex cases, and best practice demands that they be handled by attorneys with extensive medical and legal knowledge and significant trial experience. Like all medical malpractice lawsuits, oral cancer lawsuits have the potential to transcend individual clients and play a crucial role in identifying and rectifying safety issues, which benefits all patients.

While it might be tempting to dismiss the next potential client who calls your office with a "dental malpractice case," we urge you to take the call. You may find an oral cancer case hiding in plain sight on the other end of the phone line. **Ezra Wohlgelernter** *is a co-founding shareholder at Feldman Shepherd Wohlgelernter Tanner Weinstock Dodig. He can be reached at ezra@feldmanshepherd.com.*