PALLIATIVE CARE NETWORK OF WISCONSIN

FAST FACTS AND CONCEPTS #430
ORAL CARE: FOCUSED HISTORY AND EXAMINATION IN PATIENTS WITH SERIOUS ILLNESS

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Background: Patients nearing the end of life from an underlying illness are vulnerable to oral complications (1,2). While these symptoms may impact a patient's quality of life, they are easy to overlook (3). A focused oral history and examination can expedite diagnosis and symptom control (4). This *Fast Fact* offers a practical approach to the oral history and examination in patients with life-limiting illnesses.

Initial history: In patients who are lucid, utilize a concise screening question such as "*Do you have pain or discomfort in your mouth*?" Follow up questions include pain location, character, and whether it worsens with hot or cold foods/liquids (5). Inquiring about dentures, oral bleeding, dryness, sense of taste, odor, and difficulties chewing/swallowing is also recommended (5,6). Mucositis pain can occur in any patient treated with chemotherapy, but it is especially common when patients with head and neck cancer are treated with chemo-radiation. Inquire about the most recent dose of chemotherapy and/or radiation therapy as appropriate (5). When patients are not able to verbalize their symptoms (e.g., dementia, aphasia) tools such as the PAINAD scale can assess for generalized pain and thereby target those who would benefit from a more involved oral evaluation (6,7). See *Fast Fact #126.*

Preparation for the oral cavity examination: Gauze, a penlight, a wooden tongue-depressor, and a pair of gloves will suffice for the initial evaluation for most patients (8). For those who are unable to tolerate the exam (e.g., delirium, agitation), it is best to delay until they can, or they are more sedated. Avoid using excessive force, hard metal devices to pry the mouth open, or inserting their own finger in an to avoid injury. Plastic finger-guards or a silicone dental prop may be helpful, although they are not readily available in most non-dental clinical settings (9,10). If unable to complete a necessary oral examination, referal to an otolaryngologist or dentist may be necessary (see below).

Initial oral examination: Evaluate odor, dryness, oral hygiene, presence of prosthesis, food particles, and any active bleeding or dried blood (8). The presence of a facial droop sparing the forehead muscles with loss of sensation could signal a cerebrovascular accident (CVA); unilateral facial droop involving forehead muscles with preserved sensation usually indicates Bell's Palsy; unilateral shooting/lancing pain from palpation may signal trigeminal neuralgia (11). The Brief Oral Health Status Examination (BOHSE) is a validated tool for oral examination (12). Although it was developed for nursing home residents, it can be applied reliably in other clinical locations for at risk patients (e.g., patients with head and neck cancer) in about 2-3 minutes (12,13). It evaluates 10 oral anatomical structures and rates them on a 3-point scale with 0 being normal, 1 being lower and 2 being higher level of structural disease status.

- Lymph Nodes: check tonsillar, sub-mandibular and sub-mental nodes for symmetry, enlargement, consistency, and tenderness. Small, moveable, soft, mildly tender, and symmetrical enlargement is more indicative of a viral illness whereas hard, indurated lymph nodes may denote malignancy.
- Lips: visualize for dryness, chapping, redness at corners, bleeding, patches, or ulcers.
- Dentures: remove and check for cleanliness and fit. Poor fitting dentures can impact oral intake.
- Tongue: evaluate for fissuring, redness, red or white patches, ulceration, and saliva production.
- Cheek, floor/roof of mouth: check for dryness, swelling, induration, masses, and aphthous ulcers. White confluent plaques that do not scrape off with a tongue depressor easily often denote thrush.
- Gums: check for bleeding, friability, swelling, tenderness, sores, and white patches.
- Teeth: look for chipped, missing, or broken teeth, decays, fillings, or sharp edges.
- Uvula, tonsils, and posterior pharyngeal wall: check for swelling, redness, mucositis, or abscess.

Management of common causes of oral discomfort (4,6): Certain oral conditions are common enough among patients with life-limiting illness to warrant a brief description of targeted management options.

- Thrush, secondary to *Candida albicans*, can elicit dysgeusia and oral dryness. A 7–14-day course of oral fluconazole (initial dose 200 mg, subsequent 100 mg/day) resolves most cases. Clotrimazole

troches or topical nystatin 4-5 times/day for 7-14 days can resolve more mild cases. Advise patients to soak dentures in nystatin solution for 24 hours at least twice to prevent recurrence (14).

- Mucositis from chemoradiation – *"Magic mouthwash(es)"* are a mixture of various proportions of lidocaine, nystatin, diphenhydramine, famotidine, and/or magnesium hydroxide. They are used as a swish and spit for oral pain or a swish and swallow for pharyngeal or esophageal mucositis. Once daily doxepin rinses have shown analgesic benefit (15,16). Topical opioids, anti-inflammatories, cryotherapy, sucralfate, growth factors, and photo-biomodulation have also been described (17).
- Oral Dryness – regular use of a non-alcohol-based mouthwash and/or oral lozenges may alleviate oral dryness. For patients who underproduce saliva (e.g., salivary gland damage from radiation/chemotherapy) oral saliva supplements are available.
- Aphthous ulcers: triamcinolone 0.1% in orabase; dexamethasone elixir swish and spit; viscous lidocaine; and amlexanox 5% paste have been shown to safely reduce pain in the short-term (18,19).
- Swallowing problems / tongue paralysis - referral to a speech therapist may be warranted.

Referral to a dentist or otolaryngologist: Patients with intractable oral bleeding from a dental cause or gingival necrosis from a recent radiation treatment may benefit from an urgent dental consult. Similarly, patients with infection of bilateral submandibular space (Ludwig's angina), acutely painful tonsillar and retropharyngeal abscess may require an urgent ENT consult. More routine or non-urgent reasons for consultation including tooth extraction prior to chemo-radiation initiation, long-standing post radiation dentition concerns, temporomandibular joint issues, and ill-fitting dentures (20).

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