



The practice of oral medicine in the United States in the twenty-first century: an update

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Objective. The aim of this study was to describe the practice characteristics of Oral Medicine trained dentists in the United States.

Methods. This study was a cross-sectional survey of members of the American Academy of Oral Medicine. Patient demographic characteristics, referring providers, medical comorbidities, diagnoses, and practitioner information were collected during a 5-day practice week. The survey was open during the years 2011 and 2012.

Results. Information from 916 patients was entered by 74 practitioners from 20 states. The mean number of practitioners seen before consulting Oral Medicine providers was 2.2, and patients had experienced symptoms for 16.8 months before the initial encounter. Common chief complaints were nonulcerative mucosal lesions, orofacial pain, and dry mouth. Patients with cardiovascular disease were at a higher risk of developing lichenoid lesions, and those with psychiatric conditions were at higher risk of reporting burning mouth symptoms.

Conclusions. Diagnoses and procedures performed by Oral Medicine practitioners complement practice characteristics of general and specialty dentists in the United States. (*Oral Surg Oral Med Oral Pathol Oral Radiol* 2015;119:408-415)

The field of Oral Medicine is defined as the oral health care of patients with medically complex conditions and the diagnosis and primarily nonsurgical management of medically related conditions affecting the oral and maxillofacial complex.¹ Oral Medicine is considered a distinct specialty of dentistry in many parts of the world and includes the management of oral and maxillofacial manifestations of mucocutaneous disease, orofacial pain, and salivary gland dysfunction, as well as the dental management of patients with complex medical disorders.² The practice of Oral Medicine in the United States dates to 1945, with the establishment of the American Academy of Oral Medicine (AAOM). Contributions of Oral Medicine to oral and medical care include an improved understanding of the etiopathogenesis of oral mucosal lesions and the testing of new therapies; the description and development of novel treatments for disorders causing orofacial pain; and the acquisition of deeper knowledge regarding the genetic basis of oral cancer, among others.³⁻⁹ In addition, the field of salivary diagnostics and biomarkers has progressed over the past decade to provide insight into the

detection and management of select oral and systemic diseases.¹⁰ Recent statistics demonstrate a growing population suffering from oral diseases, including oral cancer and systemic conditions affecting the oral and maxillofacial region, chronic oral mucosal disorders, and chronic disabling diseases.¹¹

In response to these growing oral health and medical needs, the scope and demand for Oral Medicine services has developed substantially. A study performed in 1996 reported that most persons diagnosed and managed in Oral Medicine clinics had medically compromising conditions, oral mucocutaneous lesions, or chronic orofacial pain conditions.¹² A follow-up 2001 publication, based on national epidemiologic survey data, forecasted an increased need for Oral Medicine services in the United States.¹³ A more recent international survey of Oral Medicine practitioners regarding their practice and training (distributed in 2010) suggested that more than 88% of respondents considered management of oral mucosal disease, salivary dysfunction, oral manifestations of systemic diseases, and facial pain within the definition and scope of Oral Medicine practice.² The present represents a follow-up study to the original 1996 publication addressing Oral Medicine practice in the United States. This study provides information about how this

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Statement of Clinical Relevance

The practice of Oral Medicine in the United States includes diagnoses and procedures that complement other disciplines of dentistry and medicine. This study reflects the current practice of Oral Medicine in the United States.

field is being practiced among other areas of dentistry and medicine in the current decade and describes contemporary changes in the conditions being referred to Oral Medicine practitioners.

OBJECTIVE

The main objective of this study was to identify clinical services provided by members of the AAOM, including diplomate members, and describe oral medicine practice characteristics. Among these, we collected information on the most frequent encountered diagnoses, the number of health care providers seen before consultation, type of chief complaint and length of time patients experienced the complaint before Oral Medicine consultation, the anatomic orofacial distribution of the chief complaint, and the types of referring doctors. Our group also intended to evaluate the association between systemic and oral diseases in this patient population. Thus, we explored the association between medical comorbidities and common Oral Medicine diagnoses.

METHODS

A prospective survey of Oral Medicine practitioners was implemented to include significant practice and patient characteristics, based on previous publications that addressed broad clinical areas.^{2,14-17} The study protocol was approved by the University of Kentucky Institutional Review Board (11-0071-X2 B), and distributed electronically to active members of the AAOM (March 2011-June 2012) and to the attendees of two AAOM annual scientific meetings (2011 and 2012). The electronic version used standard polling software (Zoomerang, Palo Alto, CA) and a link posting on the AAOM website. All providers were asked to record the following patient information for a 5-day practice week (consecutive patients notwithstanding degree of complexity): demographic characteristics, medical comorbidities, visit diagnosis (International Classification of Diseases, ninth revision [ICD-9]), referral source, presenting symptoms, anatomic location, procedures (current procedural terminology [CPT], current dental terminology [CDT]), number of practitioners seen before consultation, and duration of the chief complaint. Practitioner-specific questions included the number of days designated for clinical practice per month, location of practice, and setting (dental school, hospital, multiple locations, or private practice only). Each participant was requested to complete the survey without providing any patient identifiers and only once from the primary practice location. Responses to the survey were forwarded to the AAOM executive director, who reviewed the data for anonymity before saving in a firewall- and password-protected database accessible only to the study team.

The primary unit of analysis was the individual patient. Practitioner information was used to characterize the distribution of respondents. Data were analyzed with descriptive statistics and bivariate analysis (Chi square) to explore the associations between systemic diseases and Oral Medicine diagnoses. All analyses were done in Stata version 12.0 (Statacorp LP, College Station, TX).

RESULTS

Information from 916 patients was entered by 74 practitioners from 20 states, for a return rate of 15% (Table I). Sixty-two (83.3%) providers were certified by the American Board of Oral Medicine. The mean number of clinical practice days per month was 10 (95% confidence interval [CI]: 8.7-10.26). Forty-six percent of respondents practiced mainly at a dental school faculty practice, and 31% practiced mainly at a hospital setting. Eighteen percent practiced in combined settings, and 5% were in private practice in an ambulatory setting. The characteristics of referring providers to Oral Medicine services are described in Table II. The majority of referrals (67.5%) to Oral Medicine clinicians originated from general dental practitioners and physician specialists. Among the physician specialists, 41% were otolaryngology specialists, 24% were hematologists, oncologists, or radiation oncologists, 22% were rheumatologists, and 13% were dermatologists.

A total of 596 (65.1%) females and 313 (34.17%) males were entered into the survey. The mean age was of 57 years (standard deviation [SD]: 17.3; 95% CI: 55.5-57.8). The majority of patients (74%) were Caucasian, followed by African Americans (12.8%) and Hispanics (8.8%). Patients had seen, on average, 2.2 (95%CI: 2.09-2.31) practitioners before consulting the current clinician and had experienced orofacial symptoms for a mean of 16.8 months (95% CI: 15.4-18.3). The most frequent reasons for consultation were oral lesions (mass/white/red) ($n = 313$), orofacial pain ($n = 113$), dry mouth ($n = 85$), burning mouth ($n = 85$), and oral ulcers or sores ($n = 79$) (Table III). Thirty-five percent had symptoms in two or more intraoral or extraoral locations. Common intraoral locations were the tongue and gingiva (cumulative proportion of combined tongue and gingival sites: 28.6%), followed by teeth (10%), buccal mucosa (7.8%), and lips (5.3%). Eight percent of the subjects reported extraoral location of symptoms (facial, cervical, temporomandibular, and salivary).

Table IV describes the distribution of clinical diagnoses, and Table V describes the reported procedures performed in Oral Medicine clinics. The most common diagnosis was oral lichen planus (16.6%), followed by disturbances of salivary gland function (7.1%). Reported procedures were most often

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