their enrollees’ records and charges with those of patients not enrolled under their plans.

Beyond patient files
Aside from auditing the patient files, the third-party payer may also access the quality of the facility, the maintenance of the equipment, the level of difficulty patients on their plan encounter in obtaining appointment times, and the level of compliance with federal regulations during the course of the audit.

It is prudent that the dentist remains with the auditor at all times. It is worth the time to clear the calendar on the day of the audit and to stay with the auditor as patient and billing records are reviewed. Also, the staff of the dental practice should be prepared for the audit, and the dentist should discuss the procedures to be followed before the day it is conducted.

Because dental audits are becoming a routine part of doing business, dentists must protect their practice by preparing their office for an audit.

To prevent audit problems, dentists should make themselves aware of terms of any third-party contracts, keep the plan manuals in a safe place so the dentist can refer back to them, ensure each procedure performed matches the procedure billed and ensure that all patient records are organized and contain all relevant information on each patient.

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With a more thorough understanding of third-party audits and the third-party payer’s motivation for conducting them, dentists will be more likely to avoid costly mistakes.

Approximately one in three Americans will develop a malignancy in their lifetime. The chances of developing certain malignancies increase with age and several contributing risk factors such as tobacco and alcohol use. Notwithstanding significant decreases in death rates from heart disease, cerebrovascular disease and infections over the previous 50 years for many forms of cancer, death rates remain essentially unchanged during that same time period.

Squamous cell carcinoma (SCC) is the most common malignant neoplasm affecting the head and neck. Several variants of OSCC exist and histopathologic classifications for variants of OSCC include papillary, spindle cell, adenosquamous, their enrollees’ records and charges with those of patients not enrolled under their plans.

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Squamous cell carcinoma (SCC) is the most common malignant neoplasm affecting the head and neck. Several variants of OSCC exist and histopathologic classifications for variants of OSCC include papillary, spindle cell, adenosquamous,
and basaloid carcinoma; it is also possible to categorize types of OSCC based on clinical descriptors such as ulcerative, flat, polyoid and verrucoid.2 OSCC variants can have different growth patterns, ranging from small mucosal thickenings to large masses, and can appear endophytic or exophytic.

These tumors are erythematous to white to tan, frequently feeling firm on palpation. Conventional OSCC is composed of variable degrees of squamous differentiation, with well-differentiated cells closely recapitulating normal squamous epithelium but demonstrating some degree of basement membrane violation by nests of tumor cells, to poorly differentiated cells with more anaplastic-like appearances.

As a result of its complex exophytic papillary architecture, the papillary variant of SCC can be a challenge to accurately diagnose and histologic assessment of underlying invasion can be very difficult.3 Risk factors and pathogenesis for papillary SCC are unclear although human papilloma virus subtypes are thought to play a role in some cases.3

The purpose of this paper is to (a) present a rare case of papillary OSCC affecting the hard palate, and (b) describe the clinical and histologic features of this tumor in supporting the dentist’s role in early detection.

Case report
A 63-year-old female presented to the dental clinic at the Herman Ostrow School of Dentistry, University of Southern California with the chief complaint of a growth appearing on the roof of her mouth approximately two months prior to her presentation to our clinic. The patient’s past medical history included type II diabetes mellitus controlled with diet and exercise, and denial of any alcohol or tobacco use.

The remainder of her medical and social history was non-contributory; she was not taking any medications and a review of systems was unremarkable. Intraoral examination revealed a 3.5 cm exophytic mass in the anterior midline region of the hard palate (Fig. 1). The lesion appeared vascularized with ill-defined borders and no evidence of ulceration or erosion.

The patient had mild sensitivity upon palpation of the lesion. No cervical or submandibular lymphadenopathy was observed during the extraoral examination of the head and neck. Panoramic radiography revealed no abnormalities of the palatal area.

The patient was informed that a biopsy must be taken to obtain a definitive diagnosis; informed consent was obtained for incisional biopsy with local anesthesia. A representative wedge of tissue was removed and placed in 10 percent formalin for microscopic evaluation.

The biopsy site was cauterized to obtain postoperative hemostasis due to the high degree of vascularity. The biopsy site was closed with four 3.0 chromic gut interrupted sutures. Hemostasis was achieved, postoperative instructions were given and the patient’s postoperative condition was good.

The gross examination of the specimen consisted of a soft, tan papillary and friable mass. The histologic evaluation revealed a papillary variet...
Histopathologic evaluation revealed an exophytic, papillary proliferation of surface mucosa showing marked maturation perturbations. It included cellular and nuclear pleomorphism, prominent nucleoli, hyperchromatism, acantholysis, increased mitotic activity and abnormal mitotic figures, dyskeratosis and keratin pearls, and increased nucleo-to-cyttoplasmic ratios.

Invasive cords and islands of malignant mucosa were visualized and the associated connective tissue contained an influx of acute and chronic inflammatory cells. To evaluate whether the inflammatory infiltrates observed in the cancerous tissue were in response to superimposed fungal infection (because organisms such as Candida albicans are common oral inhabitants), periodic-acid Schiff staining was conducted and determined to be negative with appropriate staining of control tissue.

The patient was referred to the head and neck oncology group at the University of Southern California, Los Angeles County Hospital and Keck School of Medicine. Clinical work-up for staging was performed and computerized tomography scans of the head, neck, chest and abdomen were determined to be negative for metastatic disease; the lesion was staged at T2N0M0.

The patient underwent tumor resection with 1 cm margins and suprahoid neck dissection, with no radiation or chemotherapy. Her postoperative course was uneventful, and histopathologic analysis confirmed a diagnosis of papillary OSCC.

The dissected lymph nodes showed no metastatic involvement, confirming that the surgical margins were tumor free. There was no clinical evidence of recurrence at 6 months follow-up.

**Discussion**

The typical presentation for OSCC can be either a symptomatic or asymptomatic mucosal ulcer. These superficial ulcers often progress into symptomatic or asymptomatic exophytic or endophytic nodules with eroded or ulcerated surfaces, and can progress to direct invasion of the deeper structures resulting in a firm, non-movable mass.

However, OSCC often begin as white or red plaques of surface mucosa, making early clinical detection possible. If a leukoplakic or erythroplakic lesion appears in the oral cavity and does not heal within a few weeks, biopsy is recommended for definitive diagnosis, which may represent levels of histologically normal tissue (e.g., keratosis) to atypia, dysplasia, carcinoma in situ or overt carcinoma.

Papillary OSCC, such as the case presented here, is a variant of SCC as classified by the World Health Organization and can present as either in situ or invasive lesions.

Male predominance exists in OSCC cases, and the sites most commonly affected in order of prevalence are the larynx, nasal cavity and oral cavity.

The clinical appearance of papillary OSCC often mimics other variants such as verrucous carcinoma, which may represent levels of histologically normal tissue (e.g., keratosis) to atypia, dysplasia, carcinoma in situ or overt carcinoma.

Histologically, papillary OSCC shows cellular and nuclear pleomorphism, dyskeratosis, prominent nucleoli and increased nuclear-to-cyttoplasmic ratios, nuclear chromatin irregularities, prominent eosinophilic nuclei and increased mitotic figures with atypical formation. Perineural invasion can be seen in some lesions, presenting a positive correlation to metastatic potential.

In this case presentation, many of the aforementioned microscopic features of OSCC were evident without evidence of perineural invasion.

Early detection of OSCC, specifically stage I or II diagnosis, is usually associated with a favorable prognosis. Papillary OSCC in general has a 70 percent, five-year survival rate at any stage, and at T1 it carries a 100 percent survival rate compared to other variants, such as basaloide (40 percent, two-year survival), adenosquamous (55 percent, two-year survival), and spindle cell (80 percent, five-year) carcinomas.

Most reported cases of papillary SCC exhibit a mean diameter of 1 to 1.5 cm. Our patient presented with a relatively large lesion measuring over 5 cm in diameter.

**Dentists have a critical role in early identification of and effective care during OSCC progression.**

A complete list of references is available from the publisher.

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