HPV: CAUSE FOR CONCERN

Speaker: Jacquelyn Fried, RDH, MS

Course Objectives:

• National and global trends related to the incidence and prevalence of HPV associated head and neck cancers.

• How characteristics of oral (typically HPV negative) and oropharyngeal (typically HPV positive) cancers differ.

• Theories associating bacteria, inflammation, plaque biofilm and saliva with HPV positive head and neck cancers.

• Ways to enhance their current practices to address HPV associated head and neck cancers.

• Approaches to patient education regarding the prevention of HPV-associated head and neck cancers.

CODA Standards:

• 2-16: Graduates must demonstrate competence in:
  a. assessing the oral health needs of community-based programs
  b. planning an oral health program to include health promotion and disease prevention activities
  c. implementing the planned program, and,
  d. evaluating the effectiveness of the implemented program.

• 2-17: Graduates must be competent in providing appropriate life support measures for medical emergencies that may be encountered in dental hygiene practice.

• 2-18: Graduates must be competent in the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care and practice management.
2-19: Graduates must be competent in applying legal and regulatory concepts to the provision and/or support of oral health care services.

Canadian Competency:

- A7. Evaluate clients' health and oral health status using determinants of health and risk assessment to make appropriate referral(s) to other health care professionals.
- A15. Prepare to assist in the prevention and management of outbreaks and emergencies.
- B12. Apply knowledge of common health risks to inform public policy, and educate practitioners and the public.
- C9. Apply the behavioral, biological and oral health sciences to dental hygiene practice decisions.
- C14. Convert findings in a manner relevant to clients using the principles of health literacy.
- D3. Identify populations with high risk for disease including oral disease.
- F2. Collect accurate and complete data on the general, oral, and psychosocial health status of clients.
- F3. Use professional judgment and methods consistent with medico-legal-ethical principles to complete client profiles.
- F7. Discuss findings with other health professionals when the appropriateness of dental hygiene services is in question.
- F14. Provide recommendations in regard to clients' ongoing care including referrals when indicated.
- H5. Collaborate with community, interprofessional and intersectoral partners to achieve health promotion goals for individuals and communities.
- H6. Select and implement appropriate health promotion strategies and interventions for individuals and communities.

Additional Faculty Resources:

CDC Patient Fact Sheet on HPV and Oralpharyngeal Cancer (downloadable): [http://www.cdc.gov/std/hpv/stdfact-hpvandoropharyngealcancer.htm](http://www.cdc.gov/std/hpv/stdfact-hpvandoropharyngealcancer.htm)
Medscape video for health professionals on how to address HPV prevention with young patients: HPV in Our Midst: Understanding the Problem and Having the Conversation: http://www.medscape.org/viewarticle/826415


(includes < 4 minute video which can be used for patient education on prevention and vaccination)
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Viewing Questions
May assign questions to be answered/considered while watching the webinar:

1. How do oral cavity cancers and oropharyngeal cancers differ from each other in terms of
   a. Incidence/population affected? Age, sex, race, sexual orientation, education level, etc.
   b. Associated risk factors?
   c. Histological features?
2. What is the general incidence of HPV infection in the U.S? Globally? Gender? Ethnicity?
3. What is the incidence and what are current trends of HPV in general and of oral HPV infection specifically? Why is it considered an epidemic?
4. Which behaviors are associated with oral HPV infection?
5. Why is HPV considered a public health issue?
6. What areas of research are still needed? What do we NOT know?
7. How is HPV infection diagnosed in the absence of lesions or symptoms?
8. What is the association between HPV and periodontal disease incidence according the studies cited in the webinar?
9. Identify some of the challenges to early detection of oral HPV infections?
10. Why are dental professionals in the forefront of patient education about HPV? How do we address this condition with patients?
11. How has the vaccination been promoted and how effective has it been so far?
12. How does the information from the webinar impact you personally and professionally?

Classroom Activities for Additional Learning:
1. Students will role play communication strategies with a patient concerning HPV.
2. in-class Quiz: after students have watched the webinar.
3. Script/skits: Professor and/or students develop and demonstrate how to address conversations about HPV infection and prevention with patients (small group activity, then present to class). May also be a video project.
4. Class review of current medical history/treatment and care plans used in clinics: How well do they address STDs in general and HPV in particular? Have students brainstorm possible changes/additions and follow-up questions to positive responses. Review referral protocols.
5. Review of lesions to look for during oral cancer screening which are associated with HPV infection. COHN webinar has great examples - have student locate similar lesions in their own texts and resources used in clinic.

6. Debate issue: "HPV is a serious public health issue which should be addressed by dental hygienists on a daily basis in practice."
Exam Questions

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Additional Exam Questions:

1. Which two HPV strains are most often associated with oropharyngeal cancer?
   A. HPV 15 and 17
   B. HPV 16 and 17
   C. HPV 16 and 18
   D. HPV 17 and 18

   Answer: C
   Rationale: HPV 16 is the most closely associated with OPC, followed by HPV 18. HPV 16 and 18 are considered “high risk strains” associated lesions with a greater chance of malignant progression. HPV 16 is also associated with cervical and ano-rectal epithelial cancer. A association was suspected for many years, but now has been called a “causal” factor for oropharyngeal cancers.

2. Incidence of HPV positive infections is on the rise in which demographic group?
   A. Caucasian females
   B. Caucasian males
   C. Black females
   D. Black males

   Answer: B.
   Rationale: Although many demographic groups are affected, the upward trend in diagnosis of HPV positive associated OPC is in Caucasian males.

3. HPV infection may be detected through a blood test (serological marker). The infection may remain latent with no symptoms or lesions for up to a year.
   A. The first statement is TRUE, the second is FALSE.
   B. The first statement is FALSE, the second is TRUE.
   C. Both statements are TRUE.
   D. Both statements are FALSE.

   Answer: C.
Exam Questions

Rationale: Although a person may have a positive blood test, the blood levels may either clear completely or remain inactive, and recur at a later time.

4. Which of the following are risk behaviors for oral HPV and increased risk for HPV-OSCC (oral squamous cell carcinoma)?

   A. oral-genital contact
   B. oral-anal contact
   C. oral-oral contact
   D. frequent oral sex
   E. All of the above

Answer: E
Rationale: All of these behaviors are associated with an increased risk of HPV. Oral-oral contact is least likely according to the most eminent researchers, but research so far has not separated these behaviors.

5. The higher the level of education, the greater the risk of contracting HPV.

   A. this statement is true
   B. this statement is false.

Answer: True
Rationale: College affords more opportunities for more sex and more partners.

6. Why is there a resurgence of HPV oral-pharyngeal cancers in the middle years of life?

   A. Decreased immunity
   B. Age
   C. Reactivation of latent virus
   D. All of the above

Answer: D
Rationale: The trend is called “bi-modal,” meaning there are two peaks of age groups (when graphed) when the highest diagnosis occurs, one during 30 to 34 years and the other between 60 and 61 years.