had died from lung cancer. Incisional biopsy confirmed a poorly differentiated invasive squamous cell carcinoma arising from the base of the tongue. Treatment was with combined surgery and radiotherapy. He is currently making good progress.

Discussion

These patients illustrate the importance of digital palpation when there is a high index of suspicion of oral cancer, as such tumours—including advanced invasive squamous cell carcinomas—may not be associated with visible mucosal change such as ulceration, red patches, or white patches. Around 60% of oral cancers are estimated to present with ulceration and 30% to present as "growths,"[1] but it is important to remember that this is not always the case as is illustrated by our three cases. In these cases the mucosa appeared normal. These patients were known to be at risk, and a thorough examination was therefore mandatory, but it was only by palpation that the true nature and extent of the tumours were appreciated.

Oral cancer is potentially curable if diagnosed early.[2] It is also largely preventable owing to its strong association with tobacco and alcohol consumption, although other risk factors are less strongly implicated.[2 3] Patients often present late because in many cases symptoms may not be apparent until the disease is advanced, they may be anxious about the symptoms and delay seeking help, or they believe that the symptoms will eventually disappear. Once the cancer has spread to the cervical lymph nodes (which may not be clinically enlarged) the chance of cure is reduced by about half.[4] The T stage of TNM staging, and in particular the depth of invasion of the tumour, are significant predictors of regional spread and overall survival.[5] Other factors such as speed of tumour growth are also important prognostic variables.[6 7] Therefore failure to routinely perform a digital examination in patients with oral symptoms may result in tumours, particularly small and potentially curable ones, remaining undetected.

The overall incidence of, and death from, oral cancer is similar to that of cervical cancer and malignant melanoma.[7 8] The overall incidence is estimated at around 3.4 per 100 000 population per annum—that is, about 2000 new cases each year in the United Kingdom—and its incidence may be increasing in young people.[3 9] If oral cancer is detected and treated early, however, both mortality and morbidity are significantly reduced.[2] A high index of suspicion is therefore required in all patients presenting with oral symptoms regardless of known risk factors.

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Correction

Morphine induced allodynia in a child with brain tumour

The μ was missing in several dosages in this lesson of the week by Heger et al (4 September, 627-9). In the case report, dosages of 10, 6950, and 280 g/kg per hour were reported; these should have been 10, 6950, and 280 μg/kg per hour.

A patient who changed my practice

The baby and the bathwater

An obstetric post in rural Ireland in the mid 1980s convinced me that all births should take place in hospital. Indeed, I was the utterly convincing, friendly, woman doctor wheeled out to change the mind of the occasional weirdo, errant mother who wanted anything else. I was pretty good at cranking up from "softly, softly," to the full blown "how can you put your baby at risk, you irresponsible excuse for a woman?" approach. I listened only to let them get it out of their system.

Ten years later a patient changed me. She was a 36 year old doctor expecting her first baby. Her general practitioner in London suggested a range of birth options coordinated locally under the NHS. Having met the community midwife (a Ghanaian grandmother with over 2000 births to her hand), read the literature, and canvassed opinions from all and sundry, she announced that she would consider a home birth. I was appalled.

Eventually, she had a home water birth with two midwives and no interventions. She described the experience as "tough, hard work, but the best day of my life—I feel like the empress of the world." I briefly considered a psychiatric consult—could birth be this good?

She turned up, pregnant again, during my new job in Australia. Now she had to navigate the murky waters of public hospital versus private obstetrician versus private midwife. She was meticulous about all stages of antenatal care and deeply appreciated ultrasounds, high tech screening, and anything that would help her know what was going on with the pregnancy. But she questioned everything the doctors and midwives recommended, and her opinions on normal birthing practice in the local hospital were unprintable.

She provided us with a steady flow of the latest information and then expected us to read and understand it. At one stage a portable birthing pool was inflated for a dry run in the delivery ward while electricians and midwives doubtfully observed her modestly attired in a swimsuit and discussed the potential consequences of a burst pool wall. In short she was a bit of a pest. Finally, two private midwives assisted her short and uneventful home water birth.

This irrepressible patient made me uncomfortable. She highlighted the shortfalls in a disparate collection of service providers (Australia) compared with an integrated and well planned one (United Kingdom). She challenged my training, my professional standing with peers and colleagues, and ultimately changed my practice. There are days when I long to be an all knowing, all powerful medical god again. But then I look at my two children, sigh happily, and accept that those good old days are gone.

Yes, you've finally guessed.

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