Mouth Cancer (Oral Cancer) – Head and Neck Cancers

Aims: To discuss cancers that come under the heading Head and Neck Cancers.

Objectives: On completion of this verifiable CPD article the participant will be able to demonstrate, through completion of a questionnaire, the ability to:

- Recognise the role of the dental team in detecting the early signs of cancer or pre-cancer.
- Identify some of the statistics relating to head and neck cancer.
- Identify patients that may be considered to be at an increased risk of head and neck cancer.
- Identify the signs and symptoms of head and neck cancers.
- Know the criteria for referral following the 2015 National Institute of Clinical Excellence (NICE) guidelines (updated October 2023).

Introduction

Head and neck cancer is a term used to describe a group of cancers that affect the tissues and organs in the head and neck region. This includes:

- Laryngeal cancer
- Nasopharyngeal cancer
- Cancer of the ear
- Mouth and oropharyngeal cancer (covered in a separate article on the website)
- Oesophageal Cancer
- Tongue cancer (covered in a separate article on the website)
- Thyroid Cancer
- Nasal and paranasal sinus cancer
- Salivary gland cancer
- Tonsil Cancer

This article will discuss other types of head and neck cancer which the dental team should be aware of to look for signs during patient examinations. Screening for head and neck cancer is important because it can help detect the disease in its early stages when it is most treatable. Early detection of head and neck cancer is crucial because it can allow for more effective treatment options and in some cases, early detection may even lead to a cure. Additionally, regular screening may also help identify people who have an increased risk for developing head and neck cancer and

the dental team can provide the most appropriate advice and refer patients appropriately. [1,2]

Statistics

Cancer Research UK reports there were 12,759 new cases of head and neck cancer each year in 2017-2019 in the UK. From 2017-2019 there were 4,143 deaths from head and neck cancer. Head and neck cancer is the 8th most common cancer in the UK. The incidence rates of head and neck cancer are highest in people aged 65-69. Around 2,300 cases of head and neck cancer each year in England are linked to deprivation.[3]

Cases

New cases of head and neck cancer each year, 2016-2018 average, UK.

Deaths

Deaths from head and neck cancer, 2017-2019, UK.

Survival

Survive head and neck cancers for 10 or more years, 2009-13, England

Prevention

Preventable cases of head and neck cancer, UK[3]

Examining the Patient

The British Dental Association State that “Early detection of oral cancer needs more than just understanding of the signs and symptoms of disease. The process must be managed effectively and handled sensitively. Every member of the dental team has a part to play, and protocols should be developed for effective delivery of:

1. Regular examination of the oral cavity of patients attending the practice.
2. Management of patients with lifestyles that contribute to an increased risk of oral cancer.
3. Management of detected mucosal lesions with appropriate referral.”

At every examination, the patient should be thoroughly examined for potential malignancy.

The following table briefly shows the components of an oral cancer examination:

1. Extra oral examination: Examine the head and neck and palpate the lymph nodes.
2. Examine the lips: Note colour, texture, and any surface abnormalities.
3. Labial and Buccal Mucosa: Note colour, texture, swellings, or other abnormalities.
4. Alveolar ridge and gingiva.
5. Tongue: Inspect the ventral and dorsal surfaces of the tongue and the lateral borders. Palpate the tongue.
6. Floor of the mouth: With the tongue elevated, examine the floor of the mouth for changes in texture, swelling, colour or other abnormalities.
7. Hard palate.
8. Soft palate and oropharynx.
9. Salivary glands- parotid/sublingual/submandibular.

The Mouth Cancer Foundation has developed a simple Mouth Cancer Screening protocol to ensure that dentists are able to standardise the process for all patients over the age of 16 years. The video linked is below. Please click on it to watch it.[3]

https://youtu.be/O9GHDkl9MwI

This examination can be carried out in the dental chair using gloved hands, a mirror and good lighting. Before the examination, the dental team should communicate to the patient what they are doing and looking for. The time after the examination is ideal for giving appropriate advice to those at risk.

The examination appointment also gives the dental team the opportunity to question the patient about their lifestyle to ascertain whether they are at a higher risk of developing oral cancer and to give advice accordingly. Details of the examination, lifestyle and advice should be recorded clearly in the dental records.

Cancer Research UK advise that a high level of suspicion is required when assessing patients for oral cancer, but that many other conditions may present with similar changes. Early oral cancers and precancerous lesions are often subtle and asymptomatic. The level of suspicion should be higher if a patient has been identified as being at higher risk.[3]

Risk Factors for Head and Neck Cancer

Anything that can increase your risk of getting a disease is called a risk factor. Different cancers have different risk factors. Having one or more of these risk factors does not mean you will definitely get cancer. The following are risk factors for head and neck cancers:

Smoking

Smoking tobacco (cigarettes, pipes, cigars) increases your risk of developing head and neck cancer. Research suggests that 17 - 64% of head and neck cancers are linked to exposure to tobacco smoke in the UK. Smokeless tobacco, including chewing tobacco, such as betel quid (gutkha) or Paan is known to cause mouth cancer. It is not a safe alternative to cigarettes.[6]

Alcohol

Drinking alcohol increases your risk of head and neck cancer. Research suggests that 22 - 38% of head and neck cancer are linked to alcohol consumption in the UK.

Smoking and drinking together further increase the risk of mouth and oropharyngeal cancer. [6]

Human papilloma virus (HPV)

The human papilloma virus (HPV) is a type of virus that infects the skin and the cells lining body cavities. It is estimated that around 80 out of 100 people (around 80%) will be infected with HPV at some time during their lifetime.

For most people, HPV causes no harm and gets better on its own. You do not catch cancers like an infection, but the virus can cause changes in the mouth and throat. These changes are more likely to become cancerous in the future.

HPV spreads through close skin to skin contact, usually during sexual activity. The virus is very common, however, only a very small number of people with HPV develop mouth or oropharyngeal cancer.

Research suggests that 1 - 80% of head and neck cancer cases are linked to HPV. [6]

Age

Head and neck cancer incidence is strongly related to age, with the highest incidence rates being in older people. On average each year in the UK in 2017-2019, more than a fifth of new cases (22%) were in people aged 75 and over.

Age-specific incidence rates rise from around age 30-34, steadily for females and remain stable in older age groups. Rates for males rise from around age 35-40 and drop from age 65-69. The highest rates are in in the 85 to 89 age group for females and the 65 to 69 age group for males.

Incidence rates are significantly lower in females than males in a number of (mainly older) age groups. The gap is widest at age 65 to 69, when the age-specific incidence rate is 2.8 times lower in females than males. [6]

Oral Conditions

An estimated 12% of people with oral dysplasia (including oral leukoplakia and erythroplakia) develop oral cancer, a meta-analysis showed.

Research shows head and neck cancer risk is 2.6 times higher in people with periodontal disease. Head and neck cancer risk is at least 60% higher in people who lose 6+ teeth; risk increases with number of teeth lost.

Oral cancer risk is 42% higher in people who wear dentures versus those who do not and is 4 times higher in people with ill-fitting dentures versus non-denture-wearers, a meta-analysis showed. [6]

Family History

Head and neck cancer risk is 70% higher in people with a family history of head and neck cancer, particularly siblings. Studies show that head and neck cancer risk is

higher in people with a family history of other tobacco related cancer versus those without. Head and neck cancer risk among alcohol and tobacco users is more than 7 times higher in people with a family history of the disease versus those without. [6]

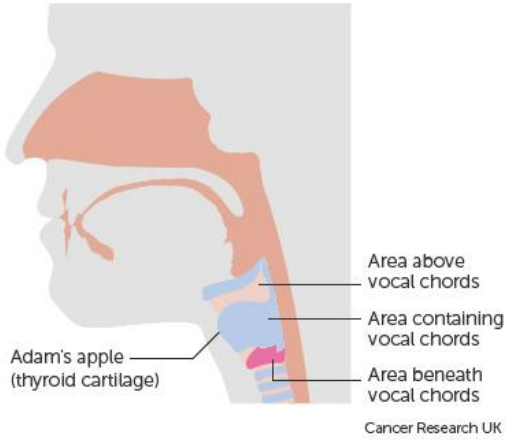
Sunlight and sunbeds

Too much ultraviolet (UV) radiation from the sun or sunbeds is the main cause of skin cancer. Skin cancers are relatively common on the head and neck as these areas are more often exposed to UV radiation. Skin cancer can develop on the lip or ears.

There are other risks factors for specific head and neck cancers these include:

- 80% of nasopharyngeal cancer cases are caused by Epstein-Barr virus.
- Oral, oropharyngeal and pharyngeal cancer risk is around twice higher in people with HIV/AIDS, compared with the general population.
- Laryngeal cancer risk is twice as high in people with Helicobacter pylori (H. pylori) infection versus those without.
- Oral cavity and pharynx cancer risk is 2-5 times higher in organ transplant recipients compared with the general population.
- Laryngeal cancer risk is 1.6-2 times higher in organ transplant recipients compared with the general population.
- Laryngeal cancer risk is more than four times as high in people with systemic lupus erythematosus, compared with the general population.
- Laryngeal cancer risk is 2.2 times higher in people with gastro-oesophageal reflux disease (GORD/GERD), versus people without GORD.
- Laryngeal cancer develops in 14% of people with laryngeal dysplasia, on average around 6 years after dysplasia diagnosis.
- Nasopharyngeal cancer risk in adulthood is 2.5 times higher in people with the highest intakes of Chinese-style salted fish during childhood, versus those with the lowest, a case-control study showed.
- Laryngeal cancer risk is 36% higher among people with the highest processed meat intake versus those with the lowest. Laryngeal cancer risk is not associated with red or white meat intake.[6]

Laryngeal cancer



The larynx is also known as the voice box; it is located at the top of the trachea (windpipe) and below the pharynx. It is between the base of the tongue and the top of the trachea.

The larynx:

- Protects your windpipe during swallowing.
- Allows the air you breathe to pass in and out of the lungs.
- Produces sound for speaking.

The larynx is made of several pieces of a smooth, shiny tissue called cartilage. The cartilage and is surrounded by fibrous tissue. The largest cartilage of the larynx is the Adam's apple (thyroid cartilage).

There are 3 main parts to the larynx. These parts are:

- The supraglottis - the area above the vocal cords that contains the epiglottis cartilage
- The glottis - the area of the vocal cords
- The subglottis - the part below the vocal cords, containing the cricoid cartilage that continues down into the windpipe.[6,7]

In the UK, Laryngeal cancer is considered rare. Around 2,400 people are diagnosed in the UK each year. Laryngeal cancer is more than four times more common in men than in women. There are few cases in people under 40 years of age, nearly three quarters of cases present in people aged 60 or over.[1]

The cancer develops in the flat, skin like, squamous cells that cover the surface of the epiglottis, vocal cords and other parts of the larynx. Adenocarcinoma is uncommon compared to squamous cell laryngeal cancer. Sarcomas of the larynx and lymphoma or plasmacytoma of the larynx are extremely rare.

The main symptoms of laryngeal cancer include:

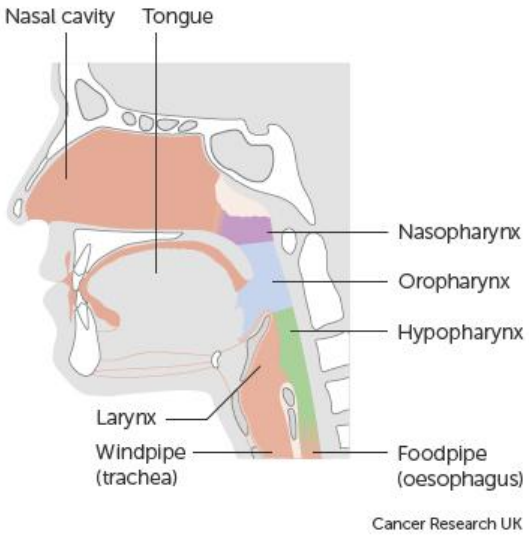
- A change in the voice, such as sounding hoarse.
- Pain when swallowing or difficulty swallowing.

- A lump or swelling in the neck.
- A persistent cough.
- A persistent sore throat or earache.
- In severe cases, difficulty breathing.

There are also several types of rare benign tumours of the larynx that can cause similar symptoms to laryngeal cancer, including:

- Giant cell tumours.
- Granular cell tumours.
- Benign tumours of muscle (rhabdomyomas and leiomyomas).
- Benign tumours of nerves (schwannomas).[6]

Nasopharyngeal cancer



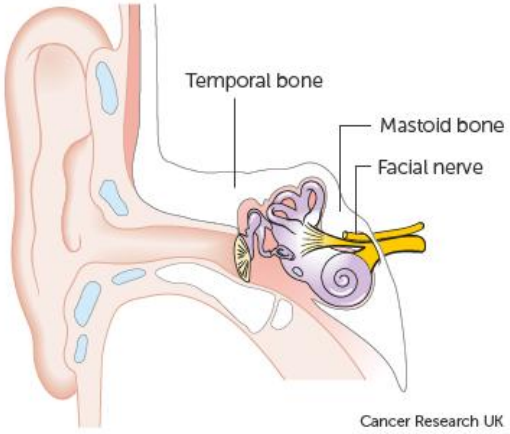
Nasopharyngeal cancer is a rare type of cancer that affects the part of the throat connecting the back of the nose to the back of the mouth (the pharynx). In the UK, only about 260 people are diagnosed with nasopharyngeal cancer each year.[1] It is more common in some ethnic groups living in the UK; for example, it is more common in people of Chinese origin. It is also more common in men than women.[1]

It is often difficult to recognise nasopharyngeal cancer because the symptoms are similar to other, less serious conditions. Also, many people with nasopharyngeal cancer don't have any symptoms until the cancer reaches an advanced stage.

Symptoms of nasopharyngeal cancer can include:

- A lump in the neck.
- Hearing loss – usually only in one ear.
- Tinnitus a blocked or stuffy nose.
- Nosebleeds.[8]

Cancer of the Ear



Ear cancer is when abnormal cells in the ear start to grow and divide in an uncontrolled way. Most of these cancers start in the skin of the outer ear. Between 6 and 10 out of 100 skin cancers (between 6 and 10%) develop on the outer ear. Cancers that develop inside the ear (the middle and inner ear) are rare.[6]

The cause of ear cancer is largely unknown.

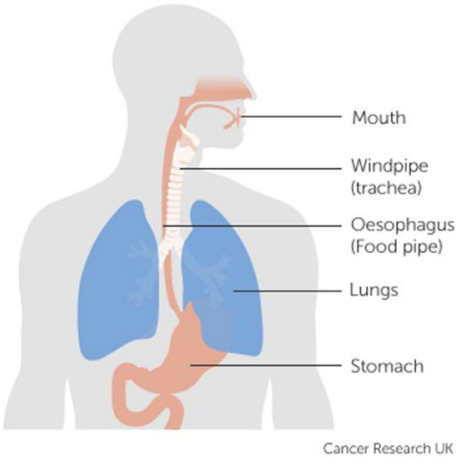
Risk factors for cancer of the ear flap include:

- Having fair skin.
- Exposure to ultraviolet sunlight.

The middle ear - People with a history of repeated ear infections over a long time have a higher risk of developing cancer in the middle ear. Doctors are not yet clear why this happens.

Cancer of the temporal bone and inner ear is rare. The possible causes are cancers extending from the ear flap. In some cases, cancers from the parotid gland or lymph nodes around the ear can spread to the temporal bone.[9]

Oesophageal Cancer



Cancer of the oesophagus, also known as oesophageal cancer, is a serious type of cancer that affects the oesophagus. Around 9,400 people are diagnosed with

oesophageal cancer each year in the UK. It is the 14th most common cancer in adults. It is more common in older people. In the UK, on average each year around 40 out of 100 (around 40%) of new cases are in people aged 75 and over. It's very rare in people younger than 40.[3]

The oesophagus is the part of the digestive system that carries food from the throat to the stomach and is about 26cm (10.5 inches) long in adults. The top part of the oesophagus lies behind the windpipe (trachea). The bottom part runs down through the chest between the spine and the heart.

The oesophagus has 3 main sections - the upper, middle and lower. Cancer can develop anywhere along the length of the oesophagus. Squamous cell cancers occur more commonly in the upper and middle regions. Adenocarcinomas tend to be more common at the lower end, including the junction where the oesophagus joins the stomach.[10]

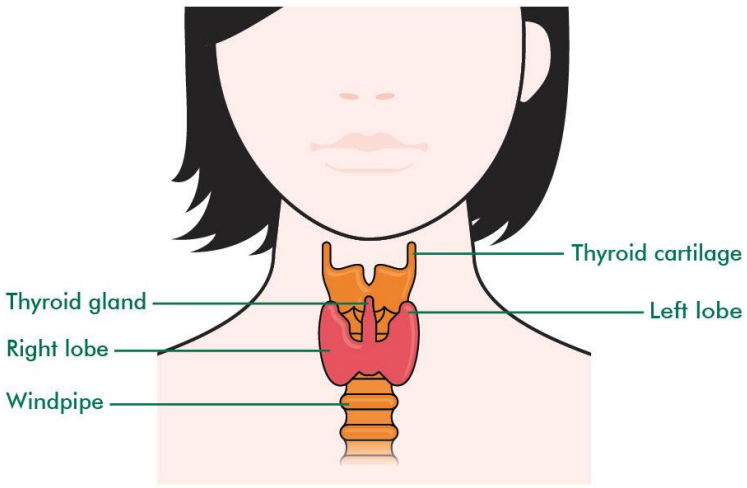
Over 95% of oesophageal cancers are squamous cell carcinomas or adenocarcinomas. There are other rarer types of cancer of the oesophagus. These include soft tissue sarcomas such as gastrointestinal stromal tumours.[3]

Oesophageal cancer does not usually cause any symptoms in the early stages when the tumour is small. It is only when the tumour gets bigger that symptoms tend to develop.[10]

Symptoms include:

- Difficulty swallowing.
- Weight loss.
- Pain or discomfort in the throat. or behind the breastbone.
- Acid indigestion.
- A hoarse voice.
- A persistent cough.
- Vomiting.
- Coughing up blood.
- Darker stools.[10]

Thyroid cancer



The thyroid is a gland that makes and releases hormones. It is found at the base of the neck, at the front, just behind the small hollow where the collar bones meet. The thyroid gland is in 2 halves, connected by a thinner bridge of thyroid tissue. Thyroid cancer is quite a rare cancer. Around 4,000 people are diagnosed in the UK each year. It is more common in women than in men.[11]

There are four main types of thyroid cancer. They are:

Papillary Carcinoma – This is the most common type of thyroid cancer. It is more common in women and is most common in people in their 30s and 40s. It is usually slow growing, but it can sometimes spread to lymph nodes in the neck or close to the thyroid.

Follicular Carcinoma – Follicular thyroid cancer is most common in people aged between 40 and 60 and it is more common in women. Follicular thyroid cancer sometimes spreads to other parts of the body, such as the lungs or bones.

Medullary Thyroid Carcinoma – This is a rare type of thyroid cancer. It starts in the C cells in the thyroid. About 25% of medullary cancers are caused by an inherited faulty gene which runs in the family. Medullary thyroid cancer can spread to other parts of the body, such as the liver or lungs.

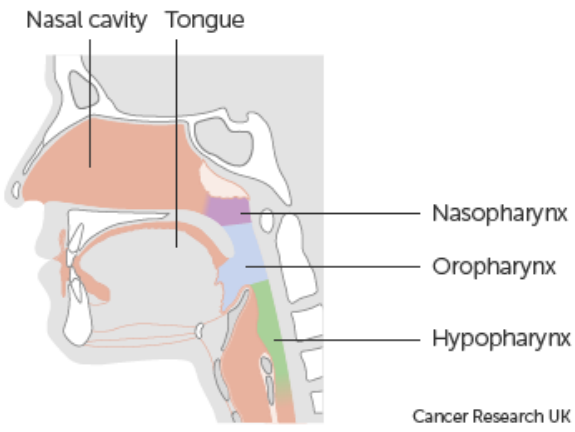
Anaplastic Thyroid Carcinoma – This is the rarest and most aggressive type of thyroid cancer, accounting for less than 1 and 3 out of every 100 thyroid cancers; it usually affects older people over the age of 60 and is more common in women.[11]

The symptoms of thyroid cancer can include:

- A lump at the base of the neck.
- A hoarse voice that lasts for more than a few weeks.
- A persistent sore throat or difficulty swallowing.
- A lump elsewhere in your neck.

Thyroid lumps are very common. It is not unusual for older people to have small lumps in their thyroid glands called nodules. As many as 9 out of 10 women over the age of 70 will have these. Only about 1 in 20 thyroid lumps are cancer. An enlarged thyroid gland that is not cancer is sometimes called a goitre.[11]

Nasal and Paranasal Cancer



Cancer can start in the lining of the space behind the nose (nasal cavity) or the nearby air cavities (paranasal sinuses) and sometimes spread to lymph nodes and other parts of the body.[12]

Nasal cavity

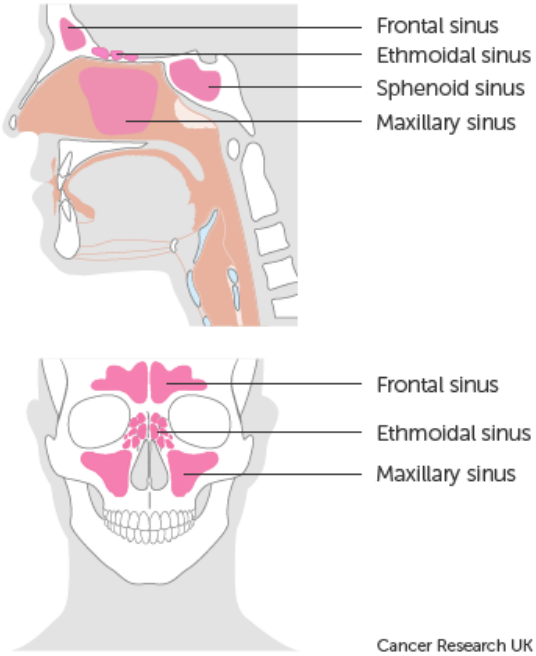
Your nostrils open into the space behind the nose (nasal cavity). The nasal cavity is a space above the roof of your mouth. It curves down to connect with your mouth at the back of your throat.

The nasal cavity warms and moistens the air we breathe and helps to filter out small particles and harmful bacteria. It also has small receptors that catch the molecules responsible for smell in the air.

The area where the nose and throat meet is called the nasopharynx. If you have cancer here, it is called nasopharyngeal cancer. It is different from nasal and paranasal sinus cancer.

The nasal cavity is close to your eyes, the nerves that leave at the bottom part of the brain (cranial nerves) and your mouth. Cancer in this area can sometimes spread causing pressure and pain in these structures. This could affect your vision and ability to open your mouth. Cancer in the nasal cavity can also affect your sense of smell.[12]

Paranasal sinuses



Paranasal means around or near your nose. Sinuses are spaces or small tunnels. Paranasal sinuses are small, air-filled spaces within the bones of your face. They are above and behind your nose and behind your cheekbones. They give your voice its clarity and tone and lighten the weight of your skull. There are several pairs of sinuses and cancer can develop in any of them.[12]

Salivary Gland Cancer

Salivary gland cancer is a rare type of head and neck cancer. It starts in one of the salivary glands. There are several different salivary glands inside and near your mouth. Most tumours that start in the salivary glands are non-cancerous (benign), but some are cancerous.[13]

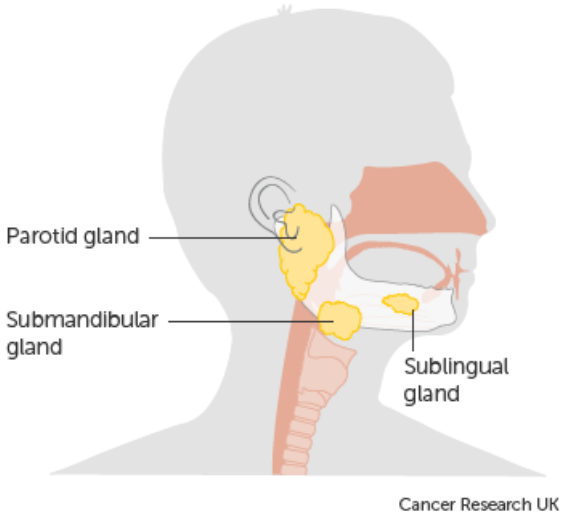
There are two main types of salivary glands called the:

- Major salivary glands.
- Minor salivary glands.

Major salivary glands

We have 3 main pairs of major salivary glands, the:

- Parotid glands – just under the lobes of your ears.
- Sublingual glands – under your tongue.
- Submandibular glands – under each side of your jawbone.[13]



Minor salivary glands

As well as the 3 major pairs of salivary glands we have over 600 smaller, minor salivary glands throughout the lining of the mouth and throat.

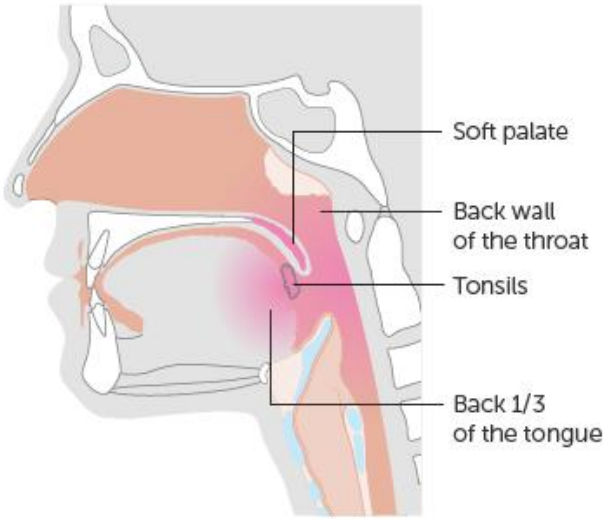
There are a number of different types of cells in the salivary glands. Cancer can start in any of these cells. The exact type of salivary gland cancer will depend on which cell type the cancer started in.

Salivary gland cancer is a very rare cancer. Around 720 people are diagnosed with salivary gland cancer in the UK every year. It is slightly more common in men than women.

It is not known what causes salivary gland cancer, but several factors can increase your risk.[13]

Tonsil Cancer

Cancer of the tonsil is a type of head and neck cancer. Symptoms often include a painless neck lump and a sore throat. The main risk factors for tonsil cancer are smoking, drinking alcohol and infection with the human papilloma virus (HPV).[14]



Most tonsil cancers are a type called squamous cell carcinoma. A small number of tonsil cancers are lymphomas.

Symptoms can include:

- A sore throat.
- Ear pain.
- A painless lump in your neck.
- Difficulty swallowing.[14]

Recommended Referral Pathway as Detailed in the NICE Guidelines and Cancer Research Referral Guidelines

Referral Details

It is important that certain details are recorded on a patient referral so that a waiting list can be prioritised. The following details are direct recommendations from Cancer Research UK.[3]

- Patient's details. This includes the patient's name, address and telephone number.
- Medical history: Including doctor's name and contact details.
- Relevant social history: Including smoking and drinking status.
- Detailed description of the lesion including duration, site, size, colour, texture and findings upon palpitation.

- Clinical diagnosis in order to categorise the urgency of the referral.

Urgency of Referral (England, Northern Ireland and Wales)

Non-Urgent

Requires routine referral or tests

Urgent

Faster Diagnosis Framework

The NICE Guidelines for suspected cancer referrals were updated in October 2023 in line with NHS England's standard on faster diagnosis of cancer. **People should have a diagnosis or ruling out of cancer within 28 days of referral.** The NHS Cancer Programme has developed a Faster Diagnosis Framework, which sets out NHS England and Improvement's strategic approach to speed up cancer diagnosis and improve the patient experience. https://www.england.nhs.uk/cancer/faster-diagnosis/

The full guidelines can be accessed from https://www.nice.org.uk/guidance/ng12
The details below are taken directly from these referral guidelines:

1.8 Head and neck cancers

Laryngeal cancer

1.8.1 Consider a suspected cancer pathway referral for laryngeal cancer in people aged 45 and over with:

- Persistent unexplained hoarseness or
- An unexplained lump in the neck (new 2015)

Oral cancer

1.8.2 Consider a suspected cancer pathway referral for oral cancer in people with either:

- Unexplained ulceration in the oral cavity lasting for more than 3 weeks, or;
- A persistent and unexplained lump in the neck. 2015)

1.8.3 Consider an urgent referral (for an appointment within 2 weeks) for assessment for possible oral cancer by a dentist in people who have either:

- A lump on the lip or in the oral cavity, or;
- A red or red and white patch in the oral cavity consistent with erythroplakia or erythroleukoplakia. (2015)

1.8.4 Consider a suspected cancer pathway referral by the dentist for oral cancer in people when assessed by a dentist as having either:

- A lump on the lip or in the oral cavity consistent with oral cancer, or;
- A red or red and white patch in the oral cavity consistent with erythroplakia or erythroleukoplakia. (2015)[15]

Thyroid cancer

1.8.5 Consider a suspected cancer pathway referral for thyroid cancer in people with an unexplained thyroid lump. (2015)[15]

Further guidance for referrals in Wales and Scotland can be found with the following links:

https://www.dental-referrals.nhs.wales/dentists/cancer/

https://www.nhscfsd.co.uk/media/wdnfgyxz/nhs-scotland-optimal-head-and-neck-cancer-diagnsotic-pathway-v1-december-2023.pdf

Dental teams should familiarise themselves with the relevant referral guidelines for the area in which they practice.

Conclusion

Research suggests that early detection of oral cancer can increase survival rates. The dental team are in a position whereby they can identify potential risk factors and discuss these with patients during the course of preventative care.

Each patient should be examined for oral cancer at each dental examination and a high level of suspicion used to identify early signs of oral cancer. NICE guidelines should be followed when referring patients for further investigation.

A diagnosis of cancer will have an enormous impact on a patient and the dental team are in the position that they can help patients on a practical level to stay as comfortable as possible during and after treatment and offer signposting to other supporting services.

Personal Development Plan and Reflective Learning

This CPD is linked to the following GDC Enhanced CPD Development Outcome:

C. Maintenance and development of knowledge and skill within your field of practice.

Reflective learning is now a requirement of the GDC Enhanced Professional Development Scheme. As such, you will now have the opportunity to answer some reflective learning questions, if you complete these now you will fulfil the requirements of the GDC. These will be:

1) What did you learn (or confirm) from the activity that was helpful or relevant to your daily work and patients?
2) Comment on any changes/updates needed in your daily work
3) How has completion of this CPD article benefitted your work as a DCP?

Further Reading

Suspected cancer: recognition and referral

Know Your Throat Video

https://www.dentalhealth.org/thestateofmouthcancer

References

1. Mouth Cancer Foundation (2023) Available from: https://www.mouthcancerfoundation.org/what-is-mouth-cancer/ (accessed 13/05/2025).
2. Oral Health Foundation (2022) Available from: https://www.dentalhealth.org/Handlers/Download.ashx?IDMF=3d5ff14b-e667-4905-88a4-a3d0cebf05ad (accessed 13/05/2025).
3. Cancer Research UK (2023) Available from: https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/head-and-neck-cancers#heading-Five (accessed 13/05/2025).
4. Mouth Cancer Foundation (2023) Available from: https://www.mouthcancerfoundation.org/awareness/professionals-screening-guide/screening-by-a-dentist/ (accessed 13/05/2025).
5. Cancer Research UK (2023) Available from: https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/head-and-neck-cancers/risk-factors#heading-Thirty-Six (accessed 13/05/2025).
6. Cancer Research UK (2023) Available from: https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/head-and-neck-cancers/incidence#heading-One (accessed 13/05/2025).
7. NHS (2023) Available from: https://www.nhs.uk/conditions/laryngeal-cancer/ (accessed 13/05/2025).
8. Cancer Research (2023) Available from: https://www.cancerresearchuk.org/about-cancer/nasopharyngeal-cancer (accessed 13/05/2025).
9. Cancer Research (2023) Available from: https://www.cancerresearchuk.org/about-cancer/head-neck-cancer/cancer-of-the-ear/what-is-cancer-of-the-ear(accessed 13/05/2025).
10. NHS (2023) Available from: https://www.nhs.uk/conditions/oesophageal-cancer/ (accessed 13/05/2025).
11. Cancer Research (2023) Available from: https://www.cancerresearchuk.org/about-cancer/thyroid-cancer/about-thyroid-cancer (accessed 13/05/2025).
12. Cancer Research (2023) Available from: https://www.cancerresearchuk.org/about-cancer/nasal-sinus-cancer/about (accessed 13/05/2025).
13. Cancer Research (2023) Available from: https://www.cancerresearchuk.org/about-cancer/salivary-gland-cancer(accessed 13/05/2025).

14. Cancer Research (2023) Available from: https://www.cancerresearchuk.org/about-cancer/head-neck-cancer/tonsil/about (accessed 13/05/2025).
15. NICE (NG12) (2023) Suspected cancer: recognition and referral. Available at: https://www.nice.org.uk/guidance/ng12/chapter/1-Recommendations-organised-by-site-of-cancer#head-and-neck-cancers (accessed 13/05/2025).