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Treatment of BRONJ

Felice S. O'Ryan, DDS, Oakland, CA

Bisphosphonate-related osteonecrosis of the jaws (BRONJ) has received wide-spread attention since the first reports in 2003. Although BRONJ has been reported in association with oral formulations, intravenous nitrogencontaining bisphosphonates confer the greatest risk and prevalence appears to be related to cumulative exposure and bisphosphonate potency. The majority of cases developed following invasive dental procedures (including extractions, dental implants and root canal therapy), in areas of periodontal disease and in response to local trauma, although spontaneous occurrence is not uncommon. Numerous treatment approaches have been described but no consensus regarding management exists.

Osteonecrosis related to oral bisphosphonates is generally focal, less severe, and more likely to resolve in response to local measures compared to the intravenous-exposed patients in whom BRONJ is often refractory to treatment. Treatment recommendations in this group include discontinuing oral bisphosphonates (in conjunction with the patient's physician), chlorhexidine rinses, oral antibiotics if infection is present and pain medications as needed. Spontaneous exfoliation of necrotic bony spicules with subsequent healing has been found. Resolution of the ONJ in response to local debridement in symptomatic cases has also been reported although some patients have required multiple procedures and intravenous antibiotics. Monitoring of bone turnover with serum CTX has been described but the predictive relationship of s-CTX and bone healing has yet to be established.

BRONJ associated with IVBP presents with a wide spectrum of severity and an unpredictable clinical course. It is generally more extensive, painful and difficult to treat; lesions may demonstrate initial healing only to be followed by chronic and often debilitating recurrence. A wide varietv of interventions, ranging from palliative care to resection with microvascular reconstruction, have been proposed; however, no agreed-upon treatment protocol exists. Cessation of the bisphosphonate, when possible, may improve treatment response. Advocates of a conservative approach recommend limited resection of necrotic bone, removal of mobile bony sequestra or sharp areas of bone with local soft tissue closure. Successful treatment of symptomatic stage 2 or stage 3 disease with resection of necrotic bone has shown favorable outcomes. Microvascular reconstruction has also been reported in limited numbers of patients although this may not be appropriate for patients with metastatic disease.

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SYMPOSIUM: DIAGNOSIS AND TREATMENT OF CHRONIC FACIAL PAIN

Thursday, October 15, 2009, 10:00 am-12:00 pm

Diagnosis and Evaluation of Chronic Facial Pain Patients

Steven Graff-Radford, DDS, Los Angeles, CA

Facial pain is a debilitating disorder if left untreated. Too often patients are labeled as having psychopathol-

ogy when face pain etiology is unclear. These patients are categorized as "atypical," "idiopathic" or "psychogenic." Idiopathic, when referring to a medical problem suggest there is something unknown, and does not define the problem. It is postulated that the most commonly undiagnosed facial pain conditions include neuropathic and tem-