Abstract Submission FORM

A SUCCESSFUL CASE OF SECONDARY PREVENTION OF MRONJ, STANDARZID BY DIALOGUE BETWEEN ONCOLOGISTS, DENTISTS AND DENTAL HYGIENISTS

SECTION: *2C*

Francesco Sforza [1], Giovanna Mosaico [2]*, Martina Salvatorina Murgia [3], Antonia Sinesi [4], Raffaella Romano [1], Germano Orrù [3] and Cinzia Casu [3].

AFFILIATION:
1. DDS, Carovigno (BR), Italy
2. RDH, Carovigno (BR), Italy
3. Department of Surgical Science, Oral Biotechology Laboratory, University of Cagliari, Italy
4. CPS, DH ASL Taranto, Italy

Background.
Drug-related osteonecrosis of the jaw (MRONJ) is a potentially serious condition which may occur in patients receiving long-term antiresorptive medications (bisphosphonates and denosumab), often in combination with antiangiogenics, for treatment of oncological diseases and for osteoporosis, in the absence of head and neck radiotherapy. Removable dentures have been classified as a risk factor in the development of osteonecrosis of the jaws (ONJ), in fact they can cause microtraumas to the oral mucosa, furthermore, they can become a bacteriological niche for mostly fungal infections. Primary prevention, the main goal of which is the elimination of risk factors, is aimed at recovery and/or maintain good oral health and reduce the risk of developing pathologies conditions or any other adverse event. Secondary prevention is implemented in patients already undergoing treatment with drugs at risk of ONJ, in which it is necessary to intercept all clinical and radiological signs, primary and secondary, associated with the initial stages of the disease. The aim of this work is to document a primary and secondary prevention experience of a cancer patient with removable total dental prosthesis at risk of MRONJ.

Patients and methods.

A 79-year-old female patient suffering from IgAK multiple myeloma was brought to our attention for a specialist dental examination preparatory to therapy with intravenous bisphosphonates (zolendronic acid). The patient with complete bimaxillary edentulism, wearing upper and lower removable prostheses, had no root residues on objective examination; the gingival tissues were moderately erythematous, the genial mucous membranes, the oral floor and the lingual belly were normal.
In addition to the clinical examination, the patient underwent a radiographic examination (Orthopantomography) which certified the absence of ongoing infectious-inflammatory processes and a readjustment and stabilization of the removable prostheses through resin relining which completed the preventive oral preparation for suitability of the start of antiresorptive therapy. The patient was asked for dental clearance at each administration of the drug (monthly) which led to intercepting the prodromes of the osteonecrotic complication at the fourth administration of the drug with evidence of jaw pain, appearance of ulcerations of the attached gingiva in various locations and evident signs of osteosclerosis to the CBCT exam.
All this led to an immediate suspension of zolendronic acid and consequent modification of the oncological therapy associated with careful monitoring (periodic dental specialist visits). We also suspended the use of the dentures for 2 weeks and prescribed rinsing with bicarbonate solution 3 times a day after careful oral hygiene of the mucous membranes and tongue.

Results.
The secondary prevention protocol prepared made it possible to successfully prevent the appearance of necrosis phenomena of the jaw bones.

Conclusions.
Dentists and dental hygienists, within a multiprofessional team, play a key role in the primary and secondary prevention of MRONJ. A standardized multidisciplinary approach is needed, which promotes a lasting dialogue between specialists involved in the management of patients at risk of MRONJ.

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