Case report

Is resective surgery still the best practice for ONJ stage III? A case report of a conservative therapy

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Aim. Osteonecrosis of the jaw (ONJ) is a severe adverse reaction of bisphoshonate (BPs) treatment, that can significantly affect the quality of life of cancer patients (1).
Main aims of the ONJ treatments is to reduce pain, to control infection and to slow the progression of the disease or, when it is achievable, to have a complete healing, eradicating the necrotic bone and, so, the infection. According to AAOMS guidelines, symptomatic patients with stage III disease may require resection and immediate reconstruction with plates or obturator. However, recently, the tendency is to treat by conservative surgery all ONJ stages, expecially when the patients is not suitable for major surgery; because it has been found to provide resolution of acute infection and to offer long-term well-being for patients (2, 3).
We report the management of a case of a mandibular stage III ONJ, treated with conservative surgery.
Materials and methods. A 60-year-old partially edentulous man was referred to our Sector of Oral Medicine (UNIPA), for the presence of bone exposure.
Anamnestically, the patient was affected by a prostatic cancer with bone metastases and reported 2 cycles of zoledronic acid ev. Extraoral examination showed the presence of a painful swelling in the left mandibular body, with a beginning of a fistula. Intraoral examination showed a bone exposure in the third quadrant associated with abscess. By mean of TC beams, the ONJ process involved entirely the mandibular body. The ONJ was classified as stage III of AAOMS staging system.
Applying the PROMaF protocol (http://www.policlinico.pa.it/portal/index.php?option=displaypage&Itemid=264&op=page&SubMenu), the medical therapy provided a pre- and post-operative antibiotic systemic treatment (ampicillin/sulbactam im and metronidazole per os) and the use of chlorexidine mouthwashes and sodium-hyaluronate gel topically.
The surgical protocol expected: 1) anesthesia without adrenaline; 2) full-thickness mucoperiosteal flap; 3) curettage of the necrotic bone, by mean of a piezo-surgery device; 4) irrigation with rifamycin sodium; 5) tension-free suture. Post-operative instructions were given. Follow-ups visit were scheduled at ten days to remove the suture, then at 1,3 and 6 month.
Results. Ten days after, the wound showed a central depression covered by granulation tissues; nevertheless, the complete mucosal healing was achieved before the next control. Recently, tt the last follow-up visit, there were no clinical signs related to ONJ.
Conclusion. Successful treatment is defined as clinical and radiological improvement or as no clinical and radiological signs of ONJ relapse. Preserving the quality of life of cancer patients should be a key point in choosing the surgical approach; for these reason, when conceivable, ONJ stage III may be treated initially with conservative treatment, avoiding more complex procedures for the clinicians and demanding surgery for the patients.

References

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