

Challenges and Controversies in the Diagnosis of MRONJ[†]

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Medication-related osteonecrosis of the jaw (MRONJ) is a relatively rare but potentially serious and debilitating complication. It consists of progressive bone destruction in the maxillofacial area of patients exposed to the treatment with drugs associated with the risk of ONJ (antiresorptive and antiangiogenic agents), in the absence of a previous radiation treatment [1].

In order to adjudicate MRONJ case, many considerations are essential for the clinician.

Firstly, in absence of bone exposure and or fistula, other signs or symptoms (e.g., abscess, periodontal instability, presence of swelling and/or pus, severe pain, lockjaw, sequestrum) are not diagnosed. This is due to restricted criteria of AAOMS definition in which these clinical findings are not included but already recognized and reported in literature [2–4].

Furthermore, many times the clinical history of the patient is not complete and all identified and reported drugs related to ONJ are not identified from the dentist, the practitioner, or the oncologist. Many clinicians take in account only bisphosphonates as drugs related to ONJ risk. Nowadays, many other drugs have been related to this adverse event, from antiresorptive to antiangiogenic agents (e.g., Bisphosphonates, Denosumab, Bevacizumab, Sunitinib). The lack of knowledge and the necessity of a continuous update is an essential element for all clinicians.

After, other critical point for MRONJ diagnosis is the disclaimer of imaging whereas this is essential for unexposed clinical form of osteonecrosis. The adding of radiological findings in case of suspicious of MRONJ determine not also an underestimation of frequency data but also a delay for staging and management [5,6].

It is important to note that in few years, many data are added to the definition of MRONJ and, probably, much more should be discovered. This is the main controversy in terms of diagnosis. The uniformity in terms of clinical and radiological findings must be achieved in short time since the underestimation and delay diagnosis have to avoid in order to support the affected patient, already overloaded from primary disease (i.e., cancer).

The main challenge is to create a multidisciplinary network for a standardized approach, with a sustained dialogue among specialists involved, should be always adopted in order to improve the efficacy of diagnosis process and to ameliorate the patient's quality of life

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