

Bisphosphonate-Associated Osteonecrosis of the Jaw Posing as a Diagnostic Tight Spot

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Clinical acumen is an acquired trait, something one gain by experience. Many a time one may not be able to explain how the correct diagnosis was given in some critical situations, and this is not accidental. It is the subconscious that analyses the previous knowledge and correlates with the current situation. Here is a case report, which underlies the need for theoretical knowledge to be support practical success and highlighting the need for updating. Even in the era of apps and androids one's mind can work faster than all of these.

A 60-year-old male patient was referred for dental consultation by a physician following bone necrosis of jaw bones. He had difficulty in having food as the exposed bone was chipping off, but pain was minimal. He had a history of multiple myeloma 10 years back which was treated by both radio and chemotherapy. Three years back another course of radiotherapy was given. The patient was currently on many medications. On examination, the patient was of average built and no specific findings were present on general and extraoral examinations. Intraoral examination revealed denuded necrotic bone bilaterally on the posterior aspect of both the jaws (Figures 1-3). There was practically no tenderness on palpation. The absence of signs of inflammation put us in a dilemma. Osteomyelitis was ruled out due to the absence of signs of inflammation, and osteoradionecrosis was excluded as last radiation therapy was 3 years back. So the reason for bone necrosis could not be immediately pinpointed. On examining the patient's prescription, zoledronate was one of the drugs given and that too parenteral for 3 months and then switched to

oral. Hence, this piece of information suddenly aided in the diagnosis of bisphosphonate-related osteonecrosis of the jaw (BRONJ).^{1,2} Bisphosphonate is not a commonly



Figure 1: Maxillary right posterior edentulous area with necrotic and denuded bone. No signs of inflammation evident



Figure 2: Mandibular left posterior region (36, 37) showing denuded and necrotic bone with no signs of inflammation

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Figure 3: Mandibular left posterior region with necrotic and denuded bone

prescribed drug, and it was the first time the authors came across such a phenomenon. We were planning to browse the literature for other causes of bone necrosis, but then this sixth sense revelation was of great help. This drug has a long span of action and complications may extend even up to 10 years. The drug usage is in its adolescent stage so that many oral physicians may not even be aware of such an entity i.e. BRONJ as it is known as. So one may fail to

include it in the case history, and diagnosis and treatment may suffer.

Points to Ponder

- BRONJ is not a common presentation in dental clinics. Since bisphosphonates are increasingly being used for many bony lesions, this should also be considered in the differential diagnosis of bone necrosis.
- Keeping abreast with the current is mandatory as a clinician. With newer treatments and medications, the complications and oral manifestations also increase which may cause a dilemma for the clinician.

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