

# Międzynarodowy konsensus w sprawie diagnostyki i leczenia jałowej martwicy żuchwy

Zachęcamy do zapoznania się z opublikowanym w Journal of Bone and Mineral Research, opracowaniem na temat jałowej martwicy żuchwy. Praca przedstawia dane odnośnie epidemiologii, patofizjologii, diagnostyki i leczenia tego schorzenia. Jednocześnie prezentuje wytyczne co do postępowania, opracowane w postaci wielodyscyplinarnego, międzynarodowego konsensusu.

Streszczenie dostępne poniżej.

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**Diagnosis and management of osteonecrosis of the jaw: a systematic review and international consensus.**

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## Abstract

This work provides a systematic review of the literature from January 2003 to April 2014 pertaining to the incidence, pathophysiology, diagnosis, and treatment of osteonecrosis of the jaw (ONJ), and offers recommendations for its management based on multidisciplinary international consensus. ONJ is associated with oncology-dose parenteral antiresorptive therapy of bisphosphonates (BP) and denosumab (Dmab). The incidence of ONJ is greatest in the oncology patient population (1% to 15%), where high doses of these medications are used at frequent intervals. In the osteoporosis patient population, the incidence of ONJ is estimated at 0.001% to 0.01%, marginally higher than the incidence in the general population (<0.001%). New insights into the pathophysiology of ONJ include antiresorptive effects of BPs and Dmab, effects of BPs on gamma delta T-cells and on monocyte and macrophage function, as well as the role of local bacterial infection, inflammation, and necrosis. Advances in imaging include the use of cone beam computerized tomography assessing cortical and cancellous architecture with

lower radiation exposure, magnetic resonance imaging, bone scanning, and positron emission tomography, although plain films often suffice. Other risk factors for ONJ include glucocorticoid use, maxillary or mandibular bone surgery, poor oral hygiene, chronic inflammation, diabetes mellitus, ill-fitting dentures, as well as other drugs, including antiangiogenic agents. Prevention strategies for ONJ include elimination or stabilization of oral disease prior to initiation of antiresorptive agents, as well as maintenance of good oral hygiene. In those patients at high risk for the development of ONJ, including cancer patients receiving high-dose BP or Dmab therapy, consideration should be given to withholding antiresorptive therapy following extensive oral surgery until the surgical site heals with mature mucosal coverage. Management of ONJ is based on the stage of the disease, size of the lesions, and the presence of contributing drug therapy and comorbidity. Conservative therapy includes topical antibiotic oral rinses and systemic antibiotic therapy. Localized surgical debridement is indicated in advanced nonresponsive disease and has been successful. Early data have suggested enhanced osseous wound healing with teriparatide in those without contraindications for its use. Experimental therapy includes bone marrow stem cell intralesional transplantation, low-level laser therapy, local platelet-derived growth factor application, hyperbaric oxygen, and tissue grafting.

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**KEYWORDS:**

BISPHOSPHONATES; DENOSUMAB; DIAGNOSIS; IMAGING; MANAGEMENT; OSTEONECROSIS OF THE JAW; RISK FACTORS; TREATMENT