

Case study

Management of Medication-Related Osteonecrosis of Posterior Maxilla with Buccal Fat Pad Flap: Case Report

Kagan Deniz DDS PhD* , Firdevs Senel DDS PhD**

***Assistant Professor at Baskent University, School of Dentistry, Department of Oral and Maxillofacial Surgery**

**** Professor at Beykent University, School of Dentistry, Department of Oral and Maxillofacial Surgery**

Abstract:

Bisphosphonates are one of the most commonly prescribed drugs in bone-associated diseases. Medication-related osteonecrosis of the jaws (MRONJ) is a new term and the common side effect of long term bisphosphonate therapy; characterized with the presence of exposed necrotic bone and non-healing mucosa. Although there have been an increasing number of MRONJ cases; its management is still a challenge for clinicians. In this case report, management of MRONJ with buccal fat pad flap in an osteoporotic patient is described.

Introduction:

Anti-resorptive and anti-angiogenic drugs, such as bisphosphonates, denosumab, bevacizumab, infliximab play an important role in the treatment of metastatic bone diseases, paget disease, fibrous dysplasia, multiple myeloma, Crohn's disease, rheumatoid arthritis and osteoporosis, although they may also be responsible for the occurrence of medication-related osteonecrosis of the jaw (MRONJ).¹⁻³ MRONJ has been defined by the American Association of Oral and Maxillofacial Surgeons (AAOMS) as *the presence of exposed necrotic bone or bone that can be probed through an intra-oral or extra-oral fistula in the maxillofacial region, which has persisted for longer than 8 weeks, occurring in patients undergoing treatment with anti-resorptive or anti-angiogenic agents with no history of radiation therapy or obvious metastatic disease to the jaws.*¹

Although there have been an increasing number of MRONJ cases since its first description in 2003 by Marx, acknowledgement regarding the management of this condition is still a challenge and dilemma.³ Previous reports were noted that surgical management of this condition would lead to further osteonecrosis and so the treatment was limited to drug holiday, chlorhexidine mouth rinses, systemic antibiotics and protection the area from local trauma and there is no consensus regarding a non surgical versus a surgical approach.⁴⁻⁷

As, one of the opinions about MRONJ generation is based on impaired soft tissue healing reconstructing the site with well vascularized tissues should be considered to obtain predictable healing when surgical treatment is inevitable⁸.

Buccal fat pad flap is a well described technique and it has proved of value for the treatment of oro-antral communications.⁹⁻¹⁰ Although, there have been various indications for buccal fat pad flap implementation in oral and maxillofacial surgery, we presented its use in MRONJ management in stage II case with reference to AAOMS position paper.¹¹

In this case report, management of MRONJ occurred secondary to tooth extraction in an osteoporotic patient is described.

Case:

64 year-old maxillary edentulous woman was referred to the clinic for removal of maxillary impacted third molar. The past medical history was positive for diabetes mellitus, rheumatoid arthritis and hyperthyroidism. Extraction was performed under local anesthesia and mucosa was subsequently sutured primarily. 10 days after extraction, patient call us for persistent pain and mucosal swelling of the operated area. In oral examination the mucosa was erythematous and tender to palpation. Curettage was done and oral antibiotics (amoxicillin 500 mg, 3 times daily) and mouth rinse (0.12% chlorhexidine) were prescribed.

However, 2 months later patient reported same symptoms as initial. Panoramic radiography showed non-healed bone in the third molar socket. Local debridement of the area and primary closure of the mucosa was performed. In following controls, due to recurrent mucosal opening, it was decided to let the wound, take care of itself and irrigated with rifamycin (Rifocin 125 mg/1,5 ml flacon) regularly. At the end of the 1 month, lesion restricted itself and typical stage II MRONJ appearance characterized with exposed necrotic bone surrounded by inflamed-erythematous oral mucosa was arised (Figure 1).

Due to typical MRONJ appearance, whether patient had ever receive bisphosphonate therapy was questioned it was revealed that, she had been diagnosed with osteoporosis and has received oral risedronate sodium for 10 years. Therefore, bisphosphonate therapy was ceased and the patient was scheduled to perform sequestrectomy. Under local anesthesia sequester 20 x 10 x 10 mm in size was removed (Figure 2). However oral mucosa was not enough for primary closure without tension. Buccal fat pad flap which is commonly used for closure of oro-antral communications, is considered for soft tissue reconstruction. After horizontal incision from the zygomatic buttress to the posterior maxilla, blunt dissection through the m. buccinator and its fascia was performed. Buccal fat pad was herniated into the mouth, and buccal extension of this tissue was pulled over the defect and sutured to deepithelialized mucosal margins (Figure 3). Combined antibiotics; composed of amoxicillin+clavulanic acid (Augmentine 625 mg) and metronidazole (Flagyl 500 mg), paracetamol (Parol 500 mg) and chlorhexidine mouth rinse were prescribed, and patient was instructed for regular controls. Removed sequester was examined histopathologically and leukocyte-rich mixed inflammatory cells, among the necrotic bone trabecules with empty lacunes were detected (Figure 4,5). Fat tissue surface was epithelialized and defect was completely covered with normal mucosa. There was no recurrence in the follow-up period of 7 months (Figure 6).

Discussion:

MRONJ begins mostly in patients under IV bisphosphonate therapy for malignancies. However, reports of MRONJ occurred in long-term oral bisphosphonate users have also been published. Many authors have reported that extraction of the teeth was a trigger factor in the occurrence of MRONJ.¹²

Management of MRONJ is still complicated. Nowadays, management strategy is non-surgical treatment; in which treatment consist of; maintenance of good oral hygiene, antibiotics, analgesics, chlorhexidine mouth rinse use or surgical treatment.¹¹ However, even after this protocol, so many patients still present with, or progress to, severe bone necrosis.¹² In our patient, medical therapy and superficial debridement was failed to alleviate the symptoms.

Primary closure of surrounding soft tissue is very important for healing of necrotic bone. Bisphosphonates cause, oral soft tissue toxicity and healing damage with long term usage. For management of exposed necrotic bone, additional free soft tissue flaps should be considered.⁸

Reconstruction of the palate, buccal mucosa, closure of oro-nasal fistulas and coverage of the surface of the bone grafts, and reconstruction after post-traumatic defects in the maxillary area with a well vascularized buccal fat pad has been documented.⁹⁻¹⁰ Anatomically, its blood supply is provided by the maxillary artery, superficial temporal artery and facial artery.¹³

The buccal fat pad flap may be considered as a safe method for soft tissue closure.^{9,10} Pedicled buccal fat pad flap quick epithelialization of the uncovered fat is a characteristic feature and its histologically proven. The stratum above the originally uncovered buccal fat pad consists of stratified squamous epithelium migrating from the adjacent mucosal regions.^{14,15}

Main drawback of our treatment is that it can only be used posterior maxillary bone necrosis area and limitations exist concerning the size of the necrotic bone area to be closed. Although the size of the defects have been up to 60 x 50 x 30 mm in literature,^{15,16} successful closure was obtained mostly in small defects and oro-antral communications.

Conclusion:

Based on outcome of the presented case, pedicled buccal fat pad flap may be considered as an alternative and safe procedure in MRONJ management in posterior maxilla when additional soft tissue is required with keeping in mind its recommendations and limitations.

Figure Legends

Figure 1: Clinical view of the exposed necrotic bone and surrounding soft tissue

Figure 2: View of removed sequestre

Figure 3: Intraoperative photograph illustrating the defect closure with pedicled buccal fat pad flap

Figure 4: Leukocyte-rich inflammatory infiltration with acellular lacunae (H&E, ×400)

Figure 5: Acellular lacunae of necrotic trabecule (H&E, ×400)

Figure 6: Intraoral view of the area 7 months after the surgery.

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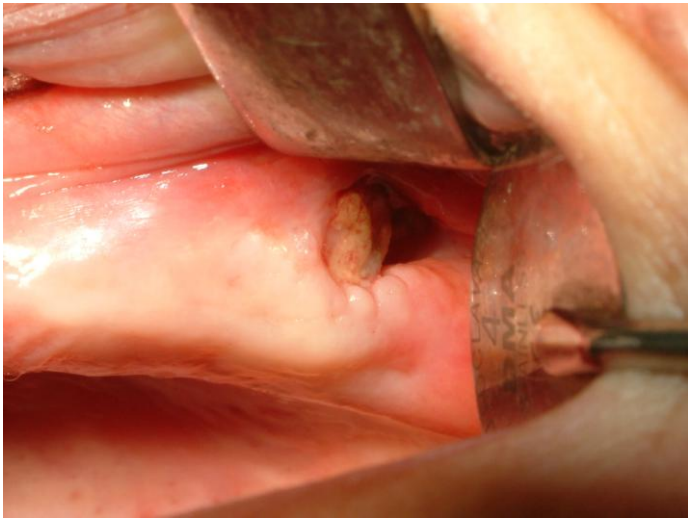


Figure 1

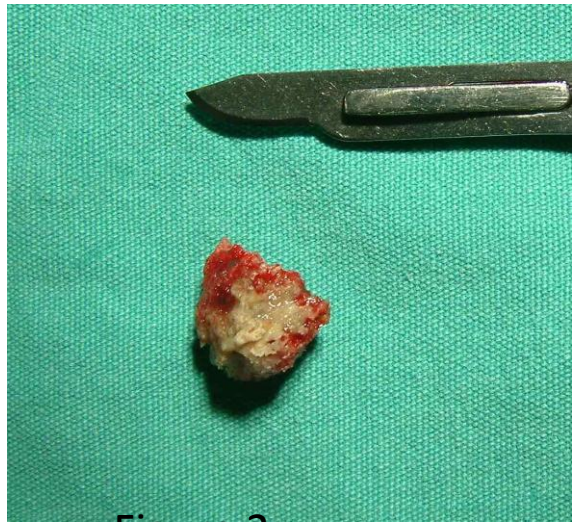


Figure 2

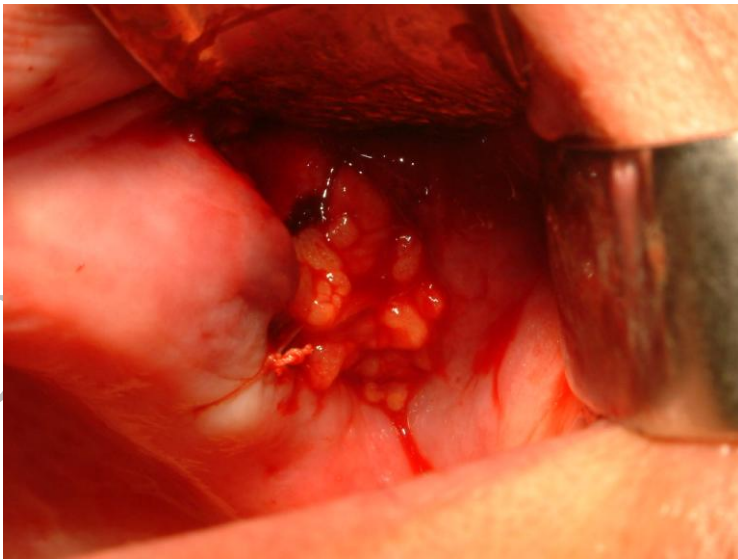


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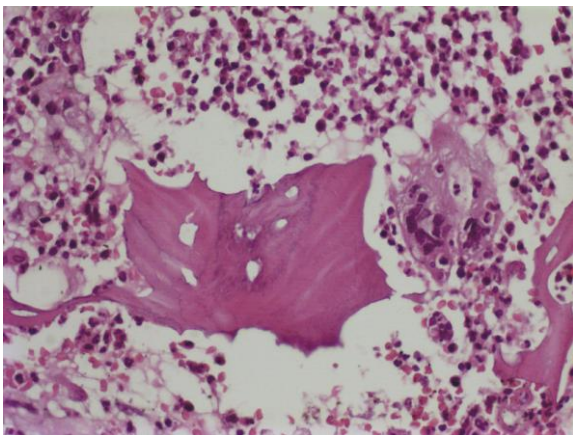


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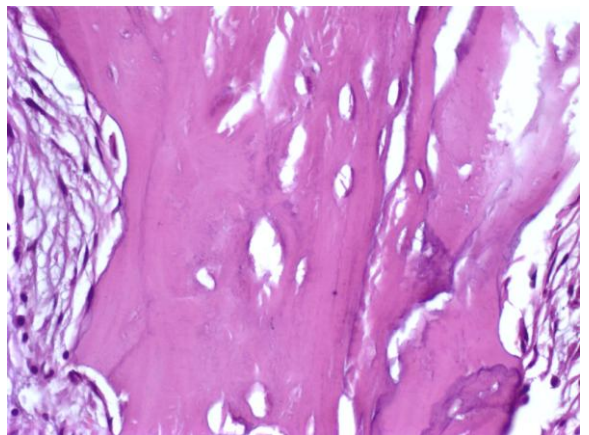


Figure 5



Figure 6

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