

A Systematic Evaluation of the Effect of Antiresorptive Medicines and Medication-Related Osteonecrosis of the Jaw in Nononcologic Immunosuppressed Patients

Gloria Simmons*

Editorial office, Journal of Medical Diagnostic Methods, Barcelona, Spain

COMMENTARY

Medication-Related Osteonecrosis of the Jaw (MRONJ) is a serious condition that affects the jaws of people who have been exposed to certain medicines. It is most commonly seen in patients who have been prescribed Bisphosphonate (BP) therapy. Patients on various treatments, such as the RANK ligand inhibitor (denosumab) and antiangiogenic therapies, have lately been found to have it. Other concomitant medical disorders may enhance the risk of MRONJ, according to some researchers. The major goal of this study was to review the available information and assess the reported outcomes of Osteonecrosis of the Jaws (ONJ) in immunocompromised individuals caused by antiresorptive medications. The search yielded twenty-seven studies that were suitable for analysis. Two hundred and six patients were enrolled in the study. All of the patients were found to be immunosuppressed in some way, with some of them having more than one condition contributing to their immunosuppression. The most common cause of MRONJ in this cohort (n=197) was a tooth extraction. MRONJ problems and recurrence following therapy have been described infrequently in the literature, however fourteen cases have been observed. The data evaluated revealed that an invasive operation is the most common cause of MRONJ, with a high rate of post-operative complications or recurrence after treatment. However, because to the lack of high-quality studies in the literature, it is difficult to draw firm conclusions about the outcomes examined in this systematic review.

Medication-Related Osteonecrosis of the Jaws (MRONJ) is a

potentially serious disorder caused by the use of certain medications, such as antiresorptive or antiangiogenic pharmaceuticals. These drugs are used to treat the skeletal manifestations of cancers and/or bone metastases, as well as to treat osteoporosis, Paget's disease, and hypercalcemia.

Furthermore, studies have revealed that the risk of ONJ may be influenced by the antiresorptive agent's potency and treatment length. MRONJ, for example, is more common in patients receiving intravenous Bisphosphonates (BPs) than in individuals getting oral BPs. Clinicians and surgeons must be aware of the risk factors that can contribute to the development and severity of MRONJ in addition to the signs, symptoms, and occurrence of the disorder. The primary risk factor for MRONJ is exposure to antiresorptive and antiangiogenic treatment MRONJ, on the other hand, has been shown to be altered by a variety of local and systemic variables. ONJ has been linked to and accelerated by specific medical disorders in recent research. For example; Anemia, diabetes mellitus, immune-suppression disorders, and renal failure, have all been linked to an increased risk of MRONJ. However, it's uncertain whether these coexisting diseases or ailments are contributory causes in their own right.

Following a diagnosis of MRONJ, the AAOMS classification and staging system can then be used to guide the management strategy. Furthermore, it is currently accepted that some patients may present with nonspecific symptoms and may not have evidence of exposed bone. In the most recent AAOMS positional paper, this category of patients has been classified as Stage 0.

Correspondence to: Gloria Simmons, Editorial office, Journal of Medical Diagnostic Methods, Barcelona, Spain, E-mail: editor.jmdm@journalres.com

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