Re: Bisphosphonates

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- *From*: The Webby <tmjiatroepidemic@xxxxxxx>
- *Date*: Thu, 07 Dec 2006 09:16:32 –0800

I admit to a person interest in this topic. In fact, I posted about this very topic back in March of this year.

I lost both of my jaw joints (TMJ) to osteonecrosis which was one of many unfortunate complications resulting from orthognathic surgery (mandibular advancement to protect me from developing jaw joint pain) in 1983. People with a long history in smd are likely familiar with "my story".

Back in 2000, I underwent dental care under general anesthesia in the OR of UCLA. (This was necessary because of my very limited jaw opening.) The pre–admission workup revealed that I had significant osteoporosis and the internal medicine doctor was more than eager to immediately place me on both hormone therapy *and* Fosamax. I was concerned about what impact the osteoporosis might have had upon the jaw bone because one of the difficulties of the dental surgery and dental restorative work was the fact that overextending the opening of my jaw under general anesthesia could result in the two artificial jaw joints (TMJ) literally popping off the bone; fracturing the jaw and destroying my prosthetic–situation.

Anyway, long story short, I said "no" to the Fosamax simply because at that time, there was only seven years experience with the drug. It was going to be prescribed as a drug I would take for the rest of my life. I was not willing to take the risk about such a new drug. On the other hand, I was willing to accept that I had a "high risk of fracture" according to my bone density studies (and I still do). On the balance scale, there was "the risk of the unknown" on both sides of the scale. I decided to stick with not rocking the boat. And! Am I ever glad that I made the decision not to take that drug.

I can't imagine today, a good six years after that event, why there hasn't been more concern about this among people who have serious conditions related to "the surgical TMJ".

Should I one day find myself needing this family of drugs for the treatment of a cancer, I am very willing to admit that I would not be able to make a decision to be aggressive towards the cancer. The thought of more osteonecrosis of the jaw is absolutely terrifying to me.

The one thing I see at this point, is another unfortunate chapter in the book titled, "The TMJ Iatroepidemic".

Webby

In article <1165217442.158371.232620@xxxxxxxxxxxxxxxxxxxxxxxxxxxx>, "Alexander Vasserman DDS" <purple543210@xxxxxxxx> wrote:

> I understand what you are saying. But for me it does not make sense to give something to patients thats treats one problem while creating another. It's different if we had no proof or knows cases of adverse effects, but in the case of bisphosphonates we do. I suppose patients undergoing cancer treatment an are fighting for their life, what's a risk of jaw necrosis to them?? I'm sure it is further from their mind. Heck the chemo alone is toxifying to their system. However there are many patients right now that are taking these meds for prophylactic reasons not knowing the risks. I certainly think we need to find alternative treatment for cancer patients and those taking the meds for prevention with the emphasis and urgency on the former. Apparently this is how we treat people in this part of the world we exchange one problem for another and get them hooked on pills and surgery as the answer to everything. (will that be paper or plastic...brand name or generic)
>
> Steven Bornfeld wrote:
>
>> Alexander Vasserman DDS wrote:
>>
>>> well that's fine for patients with current dental problems but
>>> what
>>> about if there is future dental trauma due to injury? What
>>> then???
>>
>> Alex––
>>
>> Whatever I say today may be worthless tomorrow. Cox–2 inhibitors were the biggest thing since sliced bread; now they ain't. We always have to make the best decisions we can based on the available evidence. Most important is that we don't operate in a professional vacuum––we know why the patients are being medicated; other professionals know our concerns, and we try to work out the best overall assessment of risk and benefit to the patient––and hopefully bring the patient into the decision–making process––since whatever clinical decisions we make develop the risks

they must accept.

Steve

> Mark & Steven Bornfeld wrote:
>
> > Alexander Vasserman DDS wrote:
> >
> > > I would think it would be
> > > prudent for patients who are
> > > being put on
> > > these medications to at the
> > > very least take cake of all
> > > their dental
> > > problem and be clear of any
> > > dental complicaions as a
> > > result of dental
> > > treatment for a period of at
> > > the very least 2 years before
> > > initiating
> > > these meds. Because once
> > > they start these meds and
> > > another dental
> > > problem arises they
> > > automatically become part
> > > of the statistics.
> >
> > Maybe. But at the very least, oncologists and
> > urologists who wish to
> > put their patients on IV bisphosphonates
> > should inform their patients of
> > the very real risk and find out if they are
> > current with their dental
> > care.
> > Full disclosure: my dad has stage IV prostate
> > ca with bony metastasis.
> > His urologist decided to put him on Zometa,
> > and not a word about risk
> > of dental treatment. I told him I was a
> > dentist, and whether it might
> > be possible to delay starting the Zometa
> > while I dragged my dad into the
> > office for the first time in a couple of years.
> > My dad needed two
> > extractions and one root canal. Naturally I
> > was not happy, and resisted
> > the urge to tapdance on the urologist's head.

I asked if he was aware
of the problem, and he said he'd "never seen
a case" of ONJ.
Well, hopefully I edjakated him.

Steve

> Hummy wrote:
>
> > But ONJ in
> > these cases
> > is not rare,
> > and it is a
> >
> > > condition
> > > with
> > > a
> > > significant
> > > morbidity
> > > itself,
> > > an
> > > no−−that's
> > > ZERO−−effective
> > > treatment
> > > at
> > > this
> > > time.
> > >
> > > Steve
> >
> > Hi Steve,
> > I appreciate
> > your
> > response.
> > Yes, I agree
> > that ONJ
> > has a
> > significant
> > morbidity
> > with no cure
> > at this time.
> > We surely
> > don't have
> > the full
> > picture yet.
> > Still, I try to
> > stay current

with
women's
health
issues.
Just so you
know from
where I get
my
information,
here is what
I am
being told
in the
current
issue of my
Harvard
Women's
Health
Newsletter:

Since we
last wrote
about this
problem,
more cases
of
osteonecrosis
have been
reported.
Most have
occurred
among
cancer
patients
taking
intravenous
bisphosphonates,
but a
handful
have
involved
otherwise
healthy
women
taking oral
forms of
these drugs
for
osteoporosis
prevention
or

treatment...
...Compared to the millions of women taking bisphosphonates, the number of osteonecrosis cases is still negligible. The American Dental Association estimates the prevalence to be only about 0.7 cases per 100,000 person years. That translates to 7 cases per year for every one million people taking oral bisphosphonates. The risk is mostly among cancer patients taking zoledronate or pamidronate. To further investigate the extent of the problem among otherwise healthy

women
taking
bisphosphonates,
researchers
at the
Harvard
School of
Dental
Medicine
are
examining
medical
insurance
claims for
jaw surgery.
Also,
the National
Institute of
Dental
Research
plans to
study the
development
of the
condition in
bisphosphonate–takers...

Hummy

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