Author's response to reviews

Title: Sinusitis and Oroantral Fistula in Patients with Bisphosphonate-associated Necrosis of the Maxilla

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Author's response to reviews: see over
Revision of manuscript „Sinusitis and Oroantral Fistula in Patients with Bisphosphonate-associated Necrosis of the Maxilla”

Dear Dr. Stamm,

We thank you and your Reviewers the revision of our manuscript “Sinusitis and Oroantral Fistula in Patients with Bisphosphonate-associated Necrosis of the Maxilla”. We revised the manuscript according to the comments of the reviewers. The edited parts of the manuscript are highlighted using blue font.

We thank Reviewer 1 for his valuable comments and may use the opportunity to address them.

1. We have revised the sentence to add more clarity. The AAOMS 2014 update on Medication-related osteonecrosis of the jaws recommends a surgical debridement or resection for patients in stage 2 or 3. In early stages antibiotics and oral mouth rinses are recommended which lead in only 53% of the patient to freedom of symptoms. We see promising results early surgical debridement with plastic wound closure and intravenous antibiotic treatment.

“In the 2014 update on Medication related osteonecrosis of the jaws the American Association of Oral and Maxillofacial Surgeons (AAOMS) recommends surgical debridement or resection only in stage 2 and 3.”
2. All patients underwent 2 days of preoperative intravenous antibiotic treatment. So far there is no evidence that oral versus intravenous antibiotic treatment improves the outcome of patients undergoing treatment for MRONJ, however the bioavailability of antibiotics is higher in patients treated with intravenous antibiotics. In our standard procedure we admit patients with MRONJ two days prior to surgery and start antibiotic treatment with penicillin and metronidazole we continue the treatment until discharge usually two to three days after surgery. We refrain from prescribing oral antibiotics directly prior to surgery.

“Microbiological samples are taken at the time of initial contact with the patient and at the time of surgery when purulent drainage is visible.”

“The antibiotic testing of the microbiological samples revealed no resistances against the antibiotic regimen used.”

3. Since this was the first attempt to surgically treat the MRONJ-lesion in these 12 patients we chose a moderate operative method. We saved the buccal fat pad for any possible future operations in this area. It would provide a vascularized protective padding for the necrosis site. However the periosteum helps to develop a thick bone sealing scar that seals the bone from the oral cavity.

“Regarding the size of the defect three extensive defects with complete opening of the basal alveolar crest, seven large defects ranging from 15 to 30mm and two small defects ranging von 5 to 15mm were seen.”

We also would like to thank Reviewer 2.

Yours sincerely
Dr. Dr. Pit Voss