ROOT CANAL OR EXTRACTION IF BEING TREATED WITH A BISPHOSPHONATE OR AFTER HAVING STOPPED TREATMENT WITH A BISPHOSPHONATE?

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Disclaimer: Please recognize that I am not a Medical Doctor. I have been an avid student researching and studying prostate cancer as a survivor and continuing patient since 1992. I have dedicated my retirement years to continued research and study in order to serve as an advocate for prostate cancer awareness, and, from a activist patient's viewpoint, to help patients, caregivers, and others interested develop an understanding of prostate cancer, its treatment options, and the treatment of the side effects that often accompany treatment. Readers of this paper must understand that the comments or recommendations I make are not intended to be the procedure to blindly follow; rather, they are to be reviewed as my opinion, then used for further personal research, study, and subsequent discussion with the medical professional/physician providing prostate cancer care.

The answer to the topic question remains a big question. According to this explanation, if stopping the bisphosphonate it can be several months to a year, but even then no certainty before it "may" be safe for either root canal or tooth extraction:

http://www.yourdentistryguide.com/osteonecrosis/

The concern is whether osteonecrosis of the jaw (ONJ) is in development, and it appears that the only way to make that determination is to go to an oral and maxillofacial surgeon and arrange for a new screening tool that helps determine this risk, particularly if having been on Zometa or any bisphosphonate for over three years, called CTX (C-Telopeptide) that measures the rate of bone turnover. Results of 150 to 600 pg/mL (pictogram milliliter) indicate minimal risk to no risk of developing ONJ; results of less than 100 pg/mL indicate a high risk. This test is performed in a laboratory. Alternatively, X-rays or tests for infection by taking microbial cultures "might" identify if ONJ is occurring. And if so, then definitely extractions would be dangerous, and possibly less so with root canals. Importantly, you need to meet with a good oral and maxillofacial surgeon to discuss the fact you have been on Zometa or any bisphosphonate and for how long and determine a manner in which to determine if ONJ has occurred.

I also have this information provided by Medical Oncologist Stephen Strum several years ago that I suggest be copied and taken to an oral and maxillofacial surgeon to discuss:

WHILE RECEIVING BISPHOSPHONATE THERAPY Oncologists should consider referring all patients already receiving IV bisphosphonates to a dentist or oral and maxillofacial surgeon for an examination and a surveillance schedule. The dental team should carefully evaluate the **oral cavity for exposed bone in the areas most commonly affected, such as the posterior lingual area of the mandible, and for radiographic evidence of osteolysis, osteosclerosis, widened periodontal membrane spaces, and furcation involvements.** A dental cleaning and fluoride carriers should be considered, and **tooth removal should be avoided if at all possible. If the tooth is nonrestorable because of caries, root canal treatment and amputation of the crown is a better option than removing the tooth. Similarly, teeth that demonstrate 1 or 2 mobility should be splinted rather than removed.** If the mobility is 3 or more or is associated with a periodontal abscess, there is a strong possibility that osteonecrosis is already present and the abscess and/or granulation tissue is merely covering exposed bone. In these situations, removing the tooth and providing antibiotic treatment, as described in the previous section, is the only recourse. Elective surgery within the jaws, such as removal of third molar teeth or tori, periodontal surgery, or placement of dental implants, is strongly discouraged at this time. Denture wearing is acceptable, but the prosthesis should be examined for areas of excessive pressure or friction and given a soft reline if needed.