The Oncologist®

Letters to the Editor

In Reply

CHERRY L. ESTILO,[a] CATHERINE VAN POZNAK,[b] JOSEPH M. HURYN[a]

[a]Memorial Sloan-Kettering Cancer Center, New York, New York, USA; [b]University of Michigan Comprehensive Cancer Center, Ann Arbor, Michigan, USA

Disclosure: The content of this article has been reviewed by independent peer reviewers to ensure that it is balanced, objective, and free from commercial bias. No financial relationships relevant to the content of this article have been disclosed by the authors, planners, independent peer reviewers, or staff managers.

The pathogenesis of osteonecrosis of the jaw (ONJ) remains unknown. We share the interest in understanding the role of antiangiogenic therapy in the etiology of ONJ. Hence, the query of our clinical experience for potential risk factors for ONJ. However, our assessment of 74 patients treated with a range of antiangiogenic therapies and i.v. bisphosphonates failed to show an association between ONJ and the use of antiangiogenic agents [1], yet we identified two patients who developed ONJ following bevacizumab therapy without prior use of a bisphosphonate [2]. The data are further confounded by the fact that most patients who receive antiangiogenic agents also receive other chemotherapy drugs. Therefore, while the Aragon-Ching data [3], as well as our own report [2], suggest a potential role for antiangiogenic therapy in the development of ONJ, one cannot fully conclude a definite association between antiangiogenic agents and ONJ. Clearly, prospective studies with a large sample size are needed to address risk. The upcoming ONJ registry trial, Southwest Oncology Group (SWOG) 0702, will prospectively study 7,000 patients with metastatic bone disease treated with zoledronic acid. SWOG 0702 takes a multidisciplinary approach to integrate both dental and oncology data to address risk factors and incidence, as well as investigate correlatives to explore the mechanisms underlying ONJ. Data generated from SWOG 0702 and other investigations will ultimately lead to a better understanding of the risks and etiology of ONJ.

REFERENCES

1 Estilo CL, Van Poznak CH, Wiliams T et al. Osteonecrosis of the maxilla and mandible in patients with advanced cancer treated with bisphosphonate therapy. ***The Oncologist*** 2008;13:911–920.

2 Estilo CL, Fornier M, Farooki A et al. Osteonecrosis of the jaw related to bevacizumab. J Clin Oncol 2008;26:4037–4038.

3 Aragon-Ching JB, Ning Y-M, Chen CC et al. Higher incidence of osteonecrosis of the jaw (ONJ) in patients with metastatic castration resistant prostate cancer treated with anti-angiogenic agents. Cancer Invest 2008 (in press).

Correspondence: Cherry L. Estilo, D.M.D., Memorial Sloan-Kettering Cancer Center, New York, New York, USA. Telephone: 212-639-7644; Fax: 212-717-3601; e-mail: estiloc@mskcc.org Received October 21, 2008; accepted for publication October 31, 2008; first published online in ***THE ONCOLOGIST Express*** on December 16, 2008. 1083-7159/2008/$30.00/0 doi: 10.1634/theoncologist.2008-0228