service of Baylor College of Dentistry. We analyzed the data as to histologic type, location, presence of clinical pigmentation, and configuration, as well as patient age, gender, and race. Intramucosal nevus was the most common type (57.1%), followed by common blue nevus (23.8%), compound nevus (8.3%), and junctional nevus (3.6%). Combined nevus and cellular blue nevus were extremely rare (2.4% each). The hard palate was the most commonly affected site (38.1%), followed by the buccal mucosa (17.86%), vermilion border (17.86%), and gingiva (11.9%). We also report a case of intramucosal nevus with lipomatous-like changes and neurotization on the gingiva. In addition, we report 2 cases of junctional dysplastic nevus, one on the vermilion border of the lip and the other on the hard palate. OMN and early developing melanoma can be clinically indistinguishable; therefore, all unexplained pigmented lesions of the oral cavity should be biopsied. Melanocytic lesions presenting dysplastic or atypical changes should be completely excised.


Introduction. Sjögren syndrome (SS) is a rare autoimmune dyscrasia. Primary SS (pSS), or Sicca syndrome, affects salivary and lacrimal glands predominantly, whereas secondary SS (sSS) occurs in conjunction with other autoimmune connective tissue disorders. In addition to reduced salivary and lacrimal function, serious systemic aspects of the disease are recognized. Care for SS patients is palliative, because no established therapies target the immune dysfunction directly. Initially, T cells were considered to be key mediators of disease; currently an important role for B cells is emerging, because B-cell abnormalities are seen systemically and within salivary glands. However, the contribution of B cells to SS is poorly understood. For B cells to function most effectively, they must be recruited to specific sites where they interact with other cells and secrete mediators to orchestrate immune responses. CXCL13 is a B-cell chemokine that is elevated in many autoimmune diseases. Accordingly, we hypothesized that CXCL13 is up-regulated during SS progression and may serve as a valuable biomarker of disease.

Study design. We quantified CXCL13 by real-time polymerase chain reaction and enzyme-linked immunosorbent assay at various disease time points using pSS and sSS models.

Results. CXCL13 transcript and protein levels increased with disease severity in salivary tissue and serum, respectively. Moreover, CXCL13 colocalizes with lymphocytes in salivary tissue, and serum CXCL13 correlates with saliva levels during late-stage disease.

Conclusion. These data indicate that CXCL13 in salivary tissue and/or sera may be pathogenetically involved in SS disease and may serve as a marker of SS progression and severity. Therapeutic targets of CXCL13 may provide an innovative approach in the management of this debilitating disease.


Bisphosphonates are commonly used pharmaceutical agents in the management of diseases involving high bone turnover. Intravenous bisphosphonates are associated with a high incidence of bone necrosis in the jaws, also called bisphosphonate-related osteonecrosis (BRON). Only ~2%-3% of the patients with BRON take the oral preparations. As a major referral center, we have accumulated detailed information on 34 patients with this complication and with funding from Merck and Co. have initiated a study to create a detailed database of these patients. We use the American Academy of Oral and Maxillofacial Surgeons guidelines for defining the disease (exposed necrotic bone in the oral cavity for 6-8 weeks and unresponsive to therapy in a patient on any of the high-potency bisphosphonates). We document the radiographic changes associated with BRON and any changes that may precede bone exposure (preosteonecrosis). Triggers such as extractions, presence of lobulated tori, prominent mylohyoid ridge, and so on are examined. Importantly, the time of initiation of oral bisphosphonate therapy, duration of therapy, the presence of periodontal disease, and the onset of osteonecrosis have been documented.


Of the 4 commonly speculated mechanisms for bisphosphonate-related osteonecrosis of the jaw (BRONJ), namely, repetitive microtrauma, primary osteoclastic dysfunction, antiangiogenic effects, and a primary bacterial infection from oral commensal microflora, the osteoclastic dysfunction and anti-