

## SUMMERTIME DENTAL TRAUMA

Collaborative Management for Predictable Outcomes



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THE ORAL REGION  
COMPRISES 1% OF THE  
TOTAL BODY AREA, YET  
IT ACCOUNTS FOR 5%  
OF ALL BODY INJURIES.

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The summer months in Charleston predictably provide higher levels of oral/facial trauma for the dental team to manage than any other time of year. With children out of school, more of us spending time outdoors, and an overall increase in sporting activities, the risk of injury to the face and teeth increases.

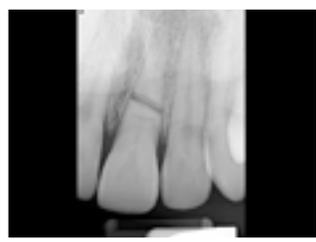
Within the past few years much has been learned about best practices for early management of the many types of traumatic dental injuries we encounter.

We do know that urgent collaboration of care between the restorative doctor, specialists, and lab technician provides the most effective management of these unique cases.

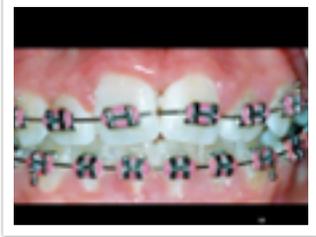
Although the history of trauma guidelines is quite limited, the American Association of Endodontists has been involved since the 1980s. In recent years, a little known group called the International Association of Dental Traumatology has developed guidelines for management of traumatic dental

injuries. Their guidelines contain input from specialists in all relevant disciplines of dentistry and can be found at [www.dentaltraumaguide.com](http://www.dentaltraumaguide.com).

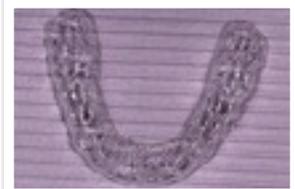
Make sure to depend on your specialists for the most modern approaches to manage these often complex types of cases. They will understand the guidelines and should apply them appropriately to the specific case. Predictability will increase as we adhere to the proven principles.



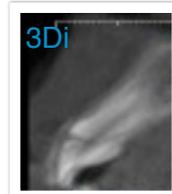
This teenage boy sustained a blow to his mouth during sports. Although current literature might justify an attempt to preserve fractured #9, the predictability in this highly aesthetic and unforgiving area is greater with an implant supported restoration. Non-restorable #9 was removed and immediately replaced and temporized with an implant supported restoration. Final photo with permanent restoration in place reveals an excellent outcome.



This teenage girl has severe subluxation of #8 while in ortho treatment. The tooth was immediately manually repositioned and stabilized with the current ortho wire. Endodontic treatment was provided within 7 days given the closed apex and severity of subluxation.



This young female fell, subluxating #8 and #9 and fracturing #9. 3Di scan showed no root fracture or bone fracture. The teeth were immediately manually repositioned, #9 was prepped and temped for a crown, and an Essex retainer was made to function as her splint for 4 weeks. Although false negative pulp tests can persist for 3 months following trauma, RCT was performed on #7,8,9 given the severity of trauma.



This young female was struck in the mouth. 3Di scan shows fracture of #9 extends below bone with very little crown left intact. Fortunately the bone support is intact. Compromise to the site and poor long term prognosis with traditional restoration justified removal of #9 and placement of an immediate implant with an immediate provisional. Because external resorption is a common, delayed, unpredictable, and non-restorable problem in traumatized teeth, it is important to discuss this with patients when/if the tooth is to be preserved.



This patient was struck in the mouth causing subluxation and fracture of #9 & #10. Restoration of #9/10, RCT of #9 (#10 had previous RCT), and palatal splint is conservative treatment.