Policy Statement 2.2.5 – Prevention and Management of Oral Injuries

AUSTRALIAN DENTAL ASSOCIATION

Position Summary

Recreational and work environments should be designed to minimise oral and facial injury. There should be public education programs, social marketing, and community action to promote awareness of potential oral injuries and protocols such as the use of mouthguards to reduce these risks. Dentists should refer to the International Association of Dental Traumatology[1] guidelines for the management of traumatic dental injuries.

1. Background

1.1. Oral damage is often irreversible, frequently complex, difficult, and costly to repair.

1.2. Oral injury can occur anywhere. Young children and teenagers have been identified as high-risk groups, particularly when learning to walk and when new and/or high-risk activities are involved.

1.3. Certain occupations expose workers to oral injuries. Such hazards can arise from:

- Physical impact from work equipment where fracturing of teeth is likely, including labourers, tradespeople, and riggers.
- Tooth abrasion where abrasive dust or particles may enter the mouth, including miners, bricklayers, and tilers.

1.4. Different risk levels are associated with participation in particular sports. These can be categorised into four risk levels with oral protective measures appropriate to the risk:

- Sports during which the use of mouthguards is strongly recommended, including off-road bike riding, skateboarding, rock climbing, white-water rafting, trampolining, combat sports, football, basketball, squash, and field hockey.
- Sports during which protective equipment for the head is worn, which may thus obviate the need for mouthguards, including full-face helmets in ice hockey and goalkeepers in field hockey cricket, rollerblading, and cycling.
- Sports during which oral protective equipment is not normally worn but where mouthguard use could be justified under certain circumstances, including high diving, surfboarding, and skiing.
- Sports where mouthguard use would be impractical or not warranted due to low risk of injury, including swimming, athletics, aerobics, and rowing.

1.5. Oral piercing jewellery may also increase the risk and degree of oral injury.

1.6. Preventive dentistry includes the prevention of physical injury, particularly to the teeth and associated structures.

1.7. Children with prominent front teeth may be a higher risk of injury and may benefit from orthodontic assessment and early treatment to reduce this risk.

1.8. The most effective protection against oral damage is a custom fitted mouthguard, where precision fit and quality materials offer maximum comfort & injury prevention. Over-the-counter mouthguards provide better protection than no mouthguard, however their protection varies depending on the design, comfort, adaptation and thickness of the final product. Quality control of at-home custom adaptation is not achievable.

1.9. Further information is contained in Australian Standard HB209-2003 “Handbook: Guidelines for the Fabrication, Use and Maintenance of Sports Mouthguards”.

[1] https://www.iadt-dentaltrauma.org/for-professionals.html

1.10. Significant oral injury may still occur despite preventive activities and promotion.

1.11. The management of damaged teeth and oral tissues depends on many factors including whether the damaged teeth are baby or adult teeth, the time elapsed since the injury and the type and extent of injury suffered.

1.12. Prompt assessment by a dentist including proper diagnosis, treatment planning, treatment, and follow up are important to assure a favourable outcome.

2. Position

Prevention

2.1. Prevention of oral injury should be a high priority; all relevant bodies should be encouraged to develop and promote protocols for risk minimisation of oral injury.

2.2. All dental care funding schemes should allow for the provision of custom-made mouthguards.

2.3. Recreational equipment and environments should be designed to minimise oral injury. No sports should have the aim of inflicting physical injury.

2.4. Appropriate health and safety requirements should be observed at the workplace, such as dust extraction or filtration when generating abrasive particles.

2.5. Public education programs should promote awareness of potential oral injuries and the importance of parental supervision and protective equipment. Appropriate protection should be normalised and expected in the community.

2.6. There should be appropriate legislation/regulation on the use of protection, assessment of risks, and training of supervisors of activities at risk.

2.7. There should be targeted training in assessment and provision of oral protection in schools, sporting clubs, and workplaces.

2.8. Protective equipment such as helmets and mouthguards should be used during training as well as competition.

2.9. There should be community action in sports clubs, schools, and workplaces to reduce risk and encourage mouthguard use. Where a risk of oral injury exists, sporting bodies should adopt a mandatory mouthguard policy such as that outlined in Appendix 1.

2.10. The need to wear a mouthguard should be assessed by a dentist based on risk factors, including an individual's sporting or occupational activities and dental anatomy.

Management

2.11. Persons who have suffered oral injury should be promptly assessed by a dentist and be treated and reviewed as recommended by the dentist.

2.12. Relevant bodies and dentists should refer to the International Association of Dental Traumatology (IADT) guidelines for the management of traumatic dental injuries, ensuring that any therapeutic treatment is compliant with local regulation.

Policy Statement 2.2.5

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Appendix 1 to Policy Statement 2.2.5 – Mandatory Mouthguard Policy for All Registered Players Applicable During All 'On Field" Activities Including Training and Games

Introduction:

Every year thousands of people are treated for dental injuries that could have been avoided by wearing a protective, custom-fitted mouthguard. Wearing a custom-fitted mouthguard helps to absorb and spread the impact of a blow to the face, which may otherwise result in an injury to the teeth, mouth or jaw.

Dental injuries can result in time off school or work to recover, can be painful and disfiguring, may involve lengthy and complex dental treatment. The cost of an injury to the teeth or jaw far exceeds the cost of a mouthguard.

Types of mouthguards:

- **Over-the-counter (boil and bite) mouthguards**
  These mouthguards include stock mouthguards that do not require fitting, and mouthguards that can be placed in hot water and then self-fitted by biting into them. These offer little or no protection and can dislodge during play but may be appropriate during orthodontic treatment.

- **Custom-fitted mouthguards**
  Custom fitted mouthguards are superior to over-the-counter mouthguards and are made by a dental practitioner from a dental impression (mould) and a plaster model of the teeth. They provide the best protection fit and comfort for all levels of sport.

The mouthguard policy

Considering the safety and protection benefits presented by mouthguards, the **<insert club name>** committee have voted unanimously to instigate a mouthguard policy with immediate effect.

Mouthguards are mandatory and are required to be worn by all players during training and games.
The club will operate a strict **'No Mouthguard, No Play'** policy without exception.

Coaches and Managers will be directed to actively check all players for compliance and remove non-complying players from training or game environments until such time as they comply.

The club's priority is to deliver the highest standards of safety on and off the field at all times. This policy is implemented as part of this objective.

By registering your child with the Club you agree to abide by this policy.

<Insert name of Club President>