

Fragment Reattachment and its Complications in Children with Dental Trauma

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Description

The most prevalent cause of trauma in the head and neck region is dental trauma. Over 34% of juvenile facial fractures include dental and dentoalveolar trauma. Dentoalveolar injuries can be caused by the same etiologies that produce face trauma, such as motor vehicle accidents, sports, and falls. Because both blood and avulsed teeth can induce aspiration, it's crucial to have an examination before undergoing any surgical procedure. Alveolar fractures account for 5% to 9% of all dentoalveolar injuries. The most usually damaged teeth are the maxillary central incisors, and the crown is the most commonly harmed area of the tooth.

An oral surgeon or a paediatric dentist should be consulted if there is any concern about dental or dentoalveolar injuries among children. Although panoramic films may still be recommended at times, imaging for face fractures, like as CT scans, may often assist establish the degree of the oral injury. Repair methods vary depending on the severity of the injury of the child. Dental extraction, tooth reimplantation, debridement, and alveolar splinting are some of the procedures available for the treatment child dental trauma. These treatments should ideally be performed in combination with the correction of any face fractures.

Dental trauma, on the other contrary, is widespread in children and is one of the most common causes for seeking rapid dental care, for both physical and psychological reasons. The doctor faces a significant task when it comes to restoring damaged teeth for the children comparatively in adults. Several variables impact its care, with cosmetic considerations being one of the most essential, particularly when maxillary incisors are implicated.

Previously, the most frequent methods of treating or surgical procedure of such teeth were composite and jacket caps. However,

nowadays, whenever a shattered fragment is available, reattachment of the same tooth fragment is the therapeutic option available in children dental injury treatments as the child tooth are a little bit fragile when compared to teenagers and adults. It is a more direct, and conservative technique with consent of the child's parents or guardians. To improve bond strength, a variety of procedures and bonding materials were offered. Some of the most experienced paediatricians proposed the fragment reattachment to the children with further preparation, while others have found that no amount of preparation improves the reattached fragment's retention or fracture strength in terms of children but in adults it might improve to some extent. Dentin-bonding agents alone or in combination with composite materials, as well as dual, self-cured or light-cured luting cements, are the most often utilised bonding materials. Hydration is also vital, bond strength and aesthetics are both dependent on it.

Paediatric Dentists encounters a range of legal and risk management challenges while dealing with child dental trauma situations. The easiest way to minimise charges of inadequate care is to pay close attention to precise and accurate records. It is critical to collect and maintain high-quality data, which should include both radiographic and photographic imaging of the child patients in order to avoid any mis-communications. Maintaining records and pictorial evidence necessitates personnel whose training is assessed and frequently updated for quality, accuracy, and adherence to hospital policies and norms.

I conclude that Fragment reattachment of a broken tooth for children is an excellent choice whenever possible. If reattachment fails, alternative therapeutic options are still available. The most essential thing is to generate awareness about the need of preventing trauma and, in the event of a tooth fracture, preserving the shattered piece and seeking early dental care.