National Athletic Trainers’ Association Position Statement: Preventing and Managing Sport-Related Dental and Oral Injuries

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Objective: To provide athletic trainers, health care professionals, and all those responsible for the care of athletes with clinical recommendations for preventing and managing sport-related dental and oral injuries.

Background: Participation in competitive sports continues to grow at both the interscholastic and intercollegiate levels. Therefore, exposure to, and the incidence of athletic-related injury, including orofacial injury, will also likely increase. At the time of this writing, the leading governing agencies for interscholastic (National Federation of State High School Associations) and intercollegiate (National Collegiate Athletic Association) sports require only protective orofacial equipment (eg, mouthguards) for 5 and 4, respectively, of their sanctioned sports. Although orofacial injuries represent a small percentage of all sport-related injuries, the financial burden associated with these injuries (eg, tooth avulsion) can exceed $15 000 over an adult life. Therefore, effective management of sport-related dental injuries is critical to the long-term financial, physical, and emotional health of people who have experienced dental trauma.

Recommendations: Based upon the current evidence regarding sport-related orofacial injury, we provide recommendations related to planning considerations, education, and mouthguard efficacy, material, fabrication, and care considerations. Additionally, suggested best practices for managing sport-related dental injury are also given for athletic trainers and other health care professionals.

Key Words: mouthguard, tooth avulsion, tooth fracture, sports dentistry

Although participation in sports and recreational activities is an important component of an overall healthy lifestyle, many of these activities are associated with a risk of injury. Specifically, several groups1–3 investigating injury rates across non–mouthguard-mandated sports (eg, baseball, basketball, soccer) estimated that orofacial injury rates ranged from approximately 3% to 38% of all sport-specific injuries. As participation numbers in competitive sports continue to grow at the interscholastic (approximately 7.2 million)4 and intercollegiate (approximately 500 000)5 levels, injury exposures will certainly increase, as will the likely occurrence of injury.

To address traumatic dental injuries, a variety of dental injury-management protocols are available. One tool familiar to athletic trainers (ATs) is the Emergency Treatment Card (Figure 1)6 from the Academy for Sports Dentistry. Whereas the card serves as an excellent resource, it does not cover the broader range of dental injuries likely to be encountered by practicing ATs. Another example, likely less familiar to the AT, is the “Guidelines for the Evaluation and Management of Traumatic Dental Injuries”7 document, which was published by the International Association of Dental Traumatology (IADT) and based on a series of 2012 papers8–10 published in the Journal of Dental Traumatology. To further assist clinicians, the IADT...
Dr. Bessette-Thomas has created a Web site (www.dentaltraumaguide.org) based on these guidelines that serves as an online source for visual diagnosis of and treatment recommendations for a broad range of traumatic dental injuries. The guidelines are comprehensive and directed at dental professionals working in clinical settings. As such, a considerable number of the IADT guidelines are out of the scope of the athletic training profession. Therefore, a primary purpose of this position statement is to use the IADT guidelines as a foundation for clinical recommendations regarding patients with dental trauma that ATs can use for acute management and return-to-play decision making.

Although acute dental trauma still occurs, intraoral protective appliances such as mouthguards can be effective in reducing the incidence of dental injury in sport. The National Federation of State High School Associations (NFHS) requires the use of properly fitted mouthguards in only 5 sports (field hockey, football, ice hockey, lacrosse, and wrestling [the last if the athlete wears braces or an orthodontic device]) and the National Collegiate Athletic Association (NCAA) mandates them in only 4 sports (field hockey, football, ice hockey, and lacrosse). Ostensibly, the number of NFHS-sanctioned and NCAA-sanctioned sports that require mouthguards is small compared with the number of sports without mouthguard requirements. Although not all sports require mouthguard use, a meta-analysis indicated that participants not wearing mouthguards (as is typical in non–mouthguard-mandated sports) were 1.6 to 1.9 times more likely to sustain an orofacial injury than participants who wore mouthguards. Because the financial burden of certain dental injuries (eg, tooth avulsions) can exceed $15,000 over an individual’s lifetime, effective management of these acute dental injuries is critical to the long-term oral health outcomes of patients. Therefore, a secondary goal of this position statement is to equip ATs with a set of mouthguard material, fabrication, and care recommendations to help lessen the physical, emotional, and financial costs associated with dental trauma.

The recommendations are presented using an evidence-based review that is based on the Strength of Recommendation Taxonomy (SORT) criterion scale proposed by the American Academy of Family Physicians (Table 1). Each recommendation is awarded a grade of A, B, or C based upon patient-oriented or disease-oriented outcomes. The SORT emphasizes outcomes-based treatments (ie, randomized controlled clinical trials). With respect to mouthguard recommendations, good-quality outcomes-based research is...
limited by the ethical constraints of implementing an experimental design that would preclude an at-risk group from using a mouthguard, especially when mandated in a particular sport. The reader should recognize and consider these limitations when assessing specific recommendations related to planning considerations, education, clinical management of acute dental trauma, mouthguard efficacy, and mouthguard material and fabrication considerations.

**RECOMMENDATIONS**

**Planning Considerations**

1. All ATs and other health care professionals responsible for the care of athletes should be familiar with the National Athletic Trainers’ Association (NATA) position statement “Emergency planning in athletics.” When appropriate, the following recommendations and suggested best practices for clinical management should be integrated into established written emergency action plans. *Strength of recommendation: C*

2. Clinicians responsible for the dental care of athletes should identify an appropriate oral health care specialist (preferably with additional training in sports dentistry) for direct referral. The specialist can assist the AT in establishing an appropriate referral team (eg, endodontist, orthodontist, and oral and maxillofacial surgeon), as well as an appropriate emergency dental facility. *Strength of recommendation: C*

3. Athletic trainers and other health care professionals providing onsite care to athletes should carry a dental trauma pack with their sideline sports medicine kit. A recommended list of items for this kit is given in Table 2. These contents may be modified to meet the needs of the specific sport or team. *Strength of recommendation: C*

**Education**

4. Clinicians responsible for emergency dental care of athletes should have adequate knowledge of the structure and function of the tooth-jaw complex. *Strength of recommendation: C*

5. Athletic trainers and other health care professionals responsible for the emergency dental care of athletes should be able to recognize the signs, symptoms, and classifications of acute dental injury. *Strength of recommendation: C*

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**Table 2. Suggested Generic List of Recommended Dental-Specific First-Aid Items**

<table>
<thead>
<tr>
<th>General Items&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Dentist-Specific Items&lt;sup&gt;c&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academy for Sports Dentistry trauma card (quick reference)</td>
<td>Arch wire</td>
</tr>
<tr>
<td>Adhesive tape</td>
<td>Ball burnisher</td>
</tr>
<tr>
<td>Biohazard bags</td>
<td>Butane cartridges</td>
</tr>
<tr>
<td>Cotton rolls</td>
<td>Butane torch</td>
</tr>
<tr>
<td>Cotton-tip applicators</td>
<td>Dental rope or orthodontic relief wax</td>
</tr>
<tr>
<td>Dental floss</td>
<td>Eugenol</td>
</tr>
<tr>
<td>Elastic bandage (2 in × 48 in [5.08 cm × 121.92 cm])</td>
<td>Explorer instrument (dental pick)</td>
</tr>
<tr>
<td>Extra mouthguards</td>
<td>Hemostat</td>
</tr>
<tr>
<td>Gauze (2 in × 2 in [5.08 cm × 5.08 cm])</td>
<td>Mixing pad</td>
</tr>
<tr>
<td>Gloves (examination grade, disposable)</td>
<td>Needle holder</td>
</tr>
<tr>
<td>Hand cleanser</td>
<td>Needles (long, short)</td>
</tr>
<tr>
<td>Masks</td>
<td>Plugger instrument</td>
</tr>
<tr>
<td>Mouth mirror</td>
<td>Pulp dressing (calcium hydroxide paste)</td>
</tr>
<tr>
<td>Pocket flashlight</td>
<td>Spatula instrument</td>
</tr>
<tr>
<td>Scissors</td>
<td>Spoon excavator instrument</td>
</tr>
<tr>
<td>Tongue depressors</td>
<td>Sutures</td>
</tr>
<tr>
<td>Tooth culture medium</td>
<td>Syringe (aspirating)</td>
</tr>
<tr>
<td></td>
<td>Topical and local anesthetic</td>
</tr>
<tr>
<td></td>
<td>Wire cutters</td>
</tr>
</tbody>
</table>

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<sup>a</sup> Adapted with permission from Ranalli DN, Demas PN. Orofacial injuries from sport: preventive measures for sports medicine. *Sports Med.* 2002;32(7):409–418. Copyright 2002 by Adis International Limited. All Rights Reserved.<sup>19</sup>

<sup>b</sup> General list of dental emergency kit items that are universal and recommended for athletic trainers working within their respective state practice acts.<sup>19</sup>

<sup>c</sup> List of specific items for team dentists to use within their scope of dental practice.
Table 3. Several Mouthguard Classification Systems

<table>
<thead>
<tr>
<th>American Society for Testing and Materials</th>
<th>American National Standards Institute/American Dental Association</th>
<th>Standards Australia International/Australian Dental Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type I: Thermoplastic</td>
<td>Type III: Custom</td>
<td>Custom made</td>
</tr>
<tr>
<td>Class 1: Vacuum formed</td>
<td>Class 1: Vacuum formed</td>
<td>Single-layer vacuum formed</td>
</tr>
<tr>
<td>Class 2: Mouth formed</td>
<td>Class 2: Model formed</td>
<td>Single-layer pressure formed</td>
</tr>
<tr>
<td>Type II: Thermosetting</td>
<td>Type II: Mouth formed</td>
<td>Laminated, air pressure</td>
</tr>
<tr>
<td>Class 1: Mouth formed</td>
<td>Class 1: Thermoplastic</td>
<td>Bimaxillary</td>
</tr>
<tr>
<td>Type III: Stock</td>
<td>Class 2: Chemical setting</td>
<td>Mouth formed</td>
</tr>
<tr>
<td>Type I: Stock</td>
<td>Type I: Stock</td>
<td>Stock</td>
</tr>
</tbody>
</table>

a Reprinted, with permission, from F697-00 (2006) Standard Practice for Care and Use of Athletic Mouth Protectors, copyright ASTM International, 100 Barr Harbor Drive, West Conshohocken, PA 19428.


6. Given the overlap between sport-related dental and concussion injury mechanisms, ATs and other health care professionals should perform a thorough concussion evaluation (see NATA position statement on the management of sport concussion21) in conjunction with the orofacial examination. Strength of recommendation: C

7. Health care professionals, athletes, parents, and coaches should be educated on the importance of wearing a properly fitted mouthguard.12,19,20,22,23 Strength of recommendation: C

8. Clinicians, athletes, parents, and coaches should be educated on the classification systems used to characterize mouthguards (Table 3).20,22–26 Strength of recommendation: C

9. Athletic trainers and other health care professionals, athletes, parents, and coaches should know the international, national, and state governing body rules, regulations, and requirements related to mouthguard use associated with various sports.14,19,27,28 Strength of recommendation: C

Dental and Oral Injury Classification and Acute Care

Tooth Fractures.

10. **Crown Fractures.** Crown fractures do not represent a dental emergency. Although referral is indicated for treatment, it may be postponed temporarily, thereby allowing the athlete to immediately return to play with a mouthguard in situ to reduce the risk of further injury.29–31 Strength of recommendation: C

11. **Enamel-Only Crown Fractures.** An athlete who complains of roughness along the incisal edge of a tooth crown subsequent to a traumatic force likely has an enamel-only fracture. This injury is not a dental emergency and the athlete may return to play immediately with a mouthguard in situ to reduce the risk of further injury.29,31,32 Strength of recommendation: C

12. **Enamel-Dentin Crown Fractures.** The involved tooth may exhibit discomfort, but the athlete can return to play as pain permits with a mouthguard in situ to reduce the risk of further injury. The athlete should be referred to a dentist and managed definitively within 24 hours.29–31 Strength of recommendation: C

If the tooth fragment can be located at the scene, it should be placed in a liquid such as water, saline, or milk and sent with the athlete to the dentist.31 Strength of recommendation: C

13. **Enamel-Dentin-Pulp Fractures.** The involved tooth may exhibit sensitivity to thermal changes, air exposure, or touch due to mastication resulting in pain. The athlete can return to play as pain allows with a mouthguard in situ to reduce the risk of further injury but should be referred to a dentist and treated within 24 hours.29 Strength of recommendation: C

If the pulp is vital, a focal hemorrhage will be evident within the yellow dentin layer, and the athlete will likely report acute pain. The patient should be referred immediately to a trauma-ready dentist for definitive treatment.31 Strength of recommendation: C

If the tooth fragment can be located at the scene, it should be placed in a liquid such as water, saline, or milk and sent with the athlete to the dentist.31 Strength of recommendation: C

**Root Fractures.** Only radiographic examination can verify the root fracture location and eliminate luxation from the differential diagnosis.

14. **Apical One-Third Root Fractures.** Apical one-third root fractures frequently go undetected, as little or no rotational mobility is observed on palpation and pain is not often reported. These injuries do not represent a dental emergency and, although referral is indicated for treatment, it may be postponed temporarily, thereby allowing the athlete to immediately return to play with a mouthguard in situ to reduce the risk of further injury.29,31 Strength of recommendation: C

15. **Middle One-Third Root Fractures.** Middle one-third root fractures may be displaced, making the injured tooth appear elongated compared with the adjacent teeth. Athletic trainers and other health care providers providing onsite care may reposition a displaced fractured coronal segment with finger pressure while wearing examination gloves. Alternatively, the athlete can be asked to gently bite down on a sterile gauze pad to prevent further displacement.31 Strength of recommendation: C

The involved tooth may exhibit discomfort, but the athlete can return to play as pain permits with a
mouthguard in situ to reduce the risk of further injury. However, if the visible tooth is markedly loose, the athlete should discontinue playing to avoid further injury. The athlete should be referred to a trauma-ready dentist or emergency facility for management within 24 hours. Strength of recommendation: C

16. **Cervical One-Third Root Fractures.** Cervical one-third root fractures often present as a crown segment dangling from lacerated, bloody gingival tissue. The athlete should be asked to gently bite down on a sterile gauze pad to prevent further displacement. Strength of recommendation: C

The involved tooth may exhibit discomfort, but the athlete can return to play as pain is tolerated with a mouthguard in situ to reduce the risk of further injury. However, if the tooth is significantly loose, the athlete should discontinue playing to avoid further injury. He or she should be referred to a trauma-ready dentist or emergency facility for management within 24 hours. Strength of recommendation: C

**Tooth Displacement Injuries.**

17. **Tooth Concussions and Subluxations.** Concussions and subluxations do not represent dental emergencies, thereby allowing the athlete to immediately return to play. Although referral is indicated for treatment, it may be delayed up to 24 hours. The tooth should be observed periodically by the dentist for any clinical or radiographic changes. Strength of recommendation: C

18. **Lateral and Extrusive Luxations.** Lateral and extrusively luxated teeth must first be repositioned within the alveolar socket using finger pressure and proper barrier protection. The athlete should then be asked to bite down on a sterile gauze pad to temporarily splint the tooth in preparation for transport. Immediate removal from participation and referral to a trauma-ready dentist or emergency facility is indicated. Strength of recommendation: C

19. **Intrusive Luxations.** Athletes with intrusively luxated teeth should be immediately removed from participation and transported to a trauma-ready dentist or emergency facility, as treatment options depend on whether the root apex is immature or fully formed (this requires radiographic validation). Strength of recommendation: C

20. **Avulsions (Exarticulations).** The athlete should be immediately removed from participation. Prompt intervention by the AT or other health care provider is essential to enhance the probability of a successful clinical outcome. The avulsed tooth must first be located and, if the athlete is alert and oriented, replacement (replantation) attempted. Speed of replantation is the single most important factor for optimal healing and should occur within 5 minutes. The AT may attempt replantation by inserting the root end into the cavity and ensuring proper orientation of the tooth by comparison with the position of the adjacent teeth. Strength of recommendation: C

To prevent additional trauma to the periodontal ligament (PDL), the clinician should refrain from handling the tooth by its root, brushing or scrubbing debris from the tooth, or sterilizing the tooth with boiling water or chemicals. Strength of recommendation: C

If visible debris is on the tooth surface, the AT or other health care professional can gently rinse (for a maximum of 10 seconds) the surface under a gentle flow of a cold water, milk, or physiologic saline. Strength of recommendation: C

Once the tooth has been replanted, the athlete should bite down on a sterile gauze pad to stabilize it before being immediately transported to a trauma-ready dentist for definitive treatment. Strength of recommendation: C

If the avulsed tooth cannot be replanted immediately and completely, the tooth should be submerged in a storage medium to prevent the PDL cells from drying. Hanks’ Balanced Salt Solution is the optimal storage medium for avulsed teeth. However, cold low-fat milk is an acceptable alternative. An avulsed tooth should not be wrapped in dry gauze or a dry paper towel. Strength of recommendation: B

**Mouthguard Effectiveness**

21. Mouthguards are consistently effective at protecting against orofacial injuries. Athletic trainers, coaches, and parents should encourage athletes to wear properly fitted mouthguards during sports activities with an increased risk of orofacial injury. Strength of recommendation: A

22. Mouthguards are not recommended for preventing mild traumatic brain injury or sport-related concussion, as no quality scientific evidence currently supports using any type of mouthguard or mouthguard material for this purpose. Strength of recommendation: A

23. Properly fitted mouthguards can be used by athletes in both aerobic and anaerobic sports. Use of these devices has no negative effect upon ventilatory or strength measures. Strength of recommendation: B

24. Mouthguards, including mandibular orthopaedic repositioning appliances (MORAs), should not be recommended to athletes to improve performance (eg, strength or balance). No quality evidence is currently available to support the use of any such material or device for ergogenic effects. Strength of recommendation: B

**Mouthguard Material, Fabrication, and Care Considerations**

25. Athletic trainers and other health care professionals should be familiar with current mouthguard designs and materials and understand that many variables can influence the effectiveness of a mouthguard. These variables may include the type and thickness of material used, area of coverage, state of protected anatomy, and direction, force, and nature of impact. Strength of recommendation: C

26. Although mouthguards do not currently have to meet any safety standards, ATs and other health care professionals responsible for fabricating mouthguards should understand the general principles for doing so, including their physical and mechanical properties (Table 4). Strength of recommendation: C

27. While working within the scope of their respective state practice acts, clinicians responsible for fabricating and fitting athletic mouthguards should strive to meet the suggested fabrication (ie, fit) recommendations in Table
In younger athletes with primary or mixed dentition, the mouthguard should be routinely inspected for fit and retention to accommodate tooth eruption, occlusal development, and growth.\(^5\) **Strength of recommendation:** C

28. Athletes should be instructed to cleanse the mouthguard with a mild antimicrobial agent and rinse it thoroughly in tepid water both before and after use.\(^24,26\) **Strength of recommendation:** C

29. Athletes should be instructed to store the mouthguard in a clean, rigid, ventilated plastic container.\(^24,26\) **Strength of recommendation:** C

30. Most custom and commercially available mouthguard materials are thermoplastic resins. Therefore, mouthguards should not be exposed to prolonged direct sunlight or sources of heat, as deformation may occur and reduce the protective capabilities of the mouthguard.\(^24,26\) **Strength of recommendation:** C

31. The athlete should examine the mouthguard daily for fit and any damage (eg, tear in material or loss of resiliency). The mouthguard should be replaced if it is loose or damaged.\(^24,26\) **Strength of recommendation:** C

### BACKGROUND AND LITERATURE REVIEW

#### Planning Considerations

Common injuries to the permanent dentition often occur as the result of falls, motor vehicle accidents, violence, and sports. Similarly, sport-related traumatic dental injuries most often result from falls, collisions, or contact with other players, hard surfaces, or sport equipment. Protective equipment, such as a properly fitted mouthguard, both absorbs and distributes the traumatic forces of impact, thereby reducing (but not eliminating) the incidence of dental injuries.\(^12,22,89,90\) However, when injuries to the tooth-jaw complex do occur, they often require immediate intervention by the AT, as well as referral to the appropriate oral health care specialist. With respect to the adult permanent dentition, as for every situation, the AT’s acute treatment goal is to deliver the best possible health care to the athlete.\(^19\)

A dental injury prognosis depends on several factors which, at minimum, include the general physical and oral health of the athlete. As elapsed time from injury to definitive treatment by the appropriate oral health care specialist increases, the general prognosis worsens.\(^19\) Because time is such an important component in the prognosis, ATs should have clear dental-injury management guidelines incorporated into their written emergency action plans. The development and implementation of a dental response plan should follow the guidelines set forward by the NATA position statement on emergency planning in athletics.\(^18\) At the least, the plan should identify appropriate oral health care specialists for direct referral. For example, ATs working with youth leagues, junior high, or high school sports should refer an athlete with a dental injury to the youth’s pediatric or general dentist. Collegiate ATs are encouraged to identify a team dentist to serve as a part of either the onsite or on-call sports medicine team. Preferably, a team dentist will have additional training in sports dentistry, such as that provided by the Academy for Sports Dentistry, such as that provided by the Academy for Sports Dentistry, such as that provided by the Academy for Sports Dentistry.

### Table 4. General Principles and Guidelines for Mouthguard Materials

<table>
<thead>
<tr>
<th>General Material Principles(^a)</th>
<th>General Material Guidelines(^b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy to manipulate</td>
<td>Shore A durometer, 37°C</td>
</tr>
<tr>
<td>Resistant to damage from hot water</td>
<td>Liner: 40–60</td>
</tr>
<tr>
<td>Sufficient elastic modulus to reduce stress beneath material at point of impact</td>
<td>Shell: 55–95</td>
</tr>
<tr>
<td>Sufficient rigidity to distribute forces over a larger surface area of the dentition</td>
<td>Water absorption, 37°C</td>
</tr>
<tr>
<td>Sufficient toughness to resist cutting by biting</td>
<td>≤0.5 weight (%)</td>
</tr>
<tr>
<td>Resistant to fracture under sudden impact</td>
<td>Impact test, 23°C</td>
</tr>
<tr>
<td>Resistant to water absorption in order to prevent tainting by mouth fluids</td>
<td>≥65% absorbed</td>
</tr>
<tr>
<td>Ability to withstand normal cleaning compounds</td>
<td>Tear strength, 37°C</td>
</tr>
<tr>
<td>Resistant to low pH</td>
<td>≥200 N cm(^{-1})</td>
</tr>
<tr>
<td>Tasteless and odorless</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Adapted from “The fabrication, use and maintenance of sports mouthguards,” by Standards Australia International/Australian Dental Association, p. 4. Copyright 2013 by the Australian Dental Association. http://www.ada.org.au/app_cmslib/media/lib/1304/m574050_v1_mouthguard%20handbook%20.pdf.\(^26\)


### Table 5. Suggested Specifications for Fabricating Mouthguards for Athletes in High-Contact and Low-Contact Sports\(^a\)

<table>
<thead>
<tr>
<th>Clinical Fabrication Considerations(^b)</th>
<th>High-Contact Sports</th>
<th>Low-Contact Sports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full enclosure of maxillary teeth to distal surface of second molar for sports with high occlusal loads</td>
<td>Full enclosure of maxillary teeth to distal surface of first molar for sports with low occlusal loads</td>
<td></td>
</tr>
<tr>
<td>≈ 2- to 3-mm Thick on labial aspect</td>
<td>≈ 3-mm Thick on occlusal aspect</td>
<td></td>
</tr>
<tr>
<td>≈ 2 mm On palatal aspect</td>
<td>Edge of labial flange rounded</td>
<td></td>
</tr>
<tr>
<td>Edge of palatal flange tapered</td>
<td>Adjusted occlusion for even contact</td>
<td></td>
</tr>
<tr>
<td>Palatal flange should extend about 10 mm above gingival margin</td>
<td>Labial flange should extend to within 2 mm of vestibular reflection</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Note: At least 1 study\(^26\) suggested no additional shock-absorption protection is afforded by extending mouthguard onto the palate.

\(^b\) Adapted from “The fabrication, use and maintenance of sports mouthguards,” by Standards Australia International/Australian Dental Association, p. 4. Copyright 2013 by the Australian Dental Association. http://www.ada.org.au/app_cmslib/media/lib/1304/m574050_v1_mouthguard%20handbook%20.pdf.\(^26\)
Sports Dentistry. A team dentist can help the AT establish an appropriate referral team (e.g., endodontist, orthodontist, and oral and maxillofacial surgeon), as well as an appropriate emergency dental care facility. In addition to personnel and facilities, ATs should ensure that all necessary dental emergency equipment is available and in working order. The AT should work collaboratively with the team dentist to assemble a dental emergency kit stocked with dental-specific first-aid items (Table 2). To avoid the team dentist to assemble a dental emergency kit stocked and quick access in the event of injury. The dental-injury utility box that affords protection from weather conditions should be separate, such as in a plastic being confused with other first-aid items, the dental working order. The AT should work collaboratively with personnel and facilities, ATs should ensure that all necessary dental emergency equipment is available and in working order. The AT should work collaboratively with the team dentist to assemble a dental emergency kit stocked with dental-specific first-aid items (Table 2). To avoid being confused with other first-aid items, the dental emergency kit should be separate, such as in a plastic utility box that affords protection from weather conditions and quick access in the event of injury. The dental-injury management guidelines should be rehearsed as part of the annual emergency action plan review, as personnel, equipment, and facilities may change.

Education

Dental Anatomy and Function. The adult permanent dentition is composed of 32 teeth: 16 teeth in the maxillary arch and 16 in the mandibular arch. The normal adult has 2 central incisors, 2 lateral incisors, 2 cuspids (canines), 4 bicuspids (premolars), and 6 molars in each arch (Figure 2). The teeth are held in place by underlying alveolar bone and supported by the surrounding oral gingival tissues (Figure 3A). Each tooth contains a visible crown and 1 or more roots. The crown is made of an external hard layer of enamel and an underlying porous layer of dentin. The protective enamel layer is a white shade and is composed of prisms. Conversely, dentin is a yellow shade and is composed of tubules that communicate with the dental pulp (Figure 3A).

The primary function of the root is to anchor the tooth in place. However, unlike the enamel covering the crown, the outer layer of the root is made of cementum over a layer of dentin. The root is suspended in place within the alveolar socket by the PDL. The PDL attaches on 1 surface to the cementum of the root and on the other to the alveolar bone within the socket (Figure 3A). Beneath the dentin of both the crown and root lies the dental pulp. The dental pulp contains cells, blood vessels, nerves, and lymphatic tissues that are housed within the coronal pulp chamber and the root canal, terminating at the apical foramen. The dental pulp has 4 basic functions: formative, nutritive, sensory, and defensive.

The formative function is mesodermal in origin; young pulp consists of undifferentiated mesenchyme cells that, when stimulated, differentiate to form odontoblasts, which produce dentin to protect the pulp. As the pulp ages, fewer stem cells are available, but by this time, the deposition of reparative dentin has progressed sufficiently to reduce the size of the pulp chamber and complete formation of the root apex.

The nutritive function of the dental pulp is performed by the tissue fluids that nourish the dentin via the odontoblasts. The sensory function of the dental pulp mediates only the sensation of pain, regardless of the stimulus, via myelinated sensory nerve fibers. Unmyelinated motor nerve fibers mediate the reflex arc by acting on the muscles of the blood vessels to regulate lumen size.

The defensive function of the dental pulp produces a non–stimulus-specific reaction to any irritation. For mild to moderate irritations, the pulp stimulates the production of reparative dentin. For moderate to severe irritations, the pulp initiates the inflammatory process. For chronic or severe irritations, the pulp progresses through the phases of hyperemia, excess fluid production, infection, and necrosis.

The onsite AT must understand the anatomy and physiology of the tooth-jaw structure and function as the basis for acute dental-injury management. As with all treatment decisions, for informed consent, the patient must be made aware of the pros and cons of alternative treatment modalities.

Signs, Symptoms, Treatment, and Classifications of Dental Injuries

Tooth Fractures. Tooth fractures may be further categorized as crown infractions, enamel-only fractures, enamel-dentin fractures, and fractures that extend through the enamel and dentin into the pulp. Crown Infractions. These injuries are characterized by disruption of the enamel prisms from a traumatic force. Upon transillumination, these injuries present as craze lines (small cracks that affect only the enamel) within the crown region of the tooth. Enamel-Only Fractures. Enamel-only fractures are mild and often appear as roughness along the incisal edge of the tooth crown (Figure 3B). Some athletes may not even realize that such an injury has occurred because enamel-only fractures are usually not sensitive to touch or temperature stimuli and may only feel rough to the athlete’s tongue. Similar to crown infractions, enamel-only crown fractures do not represent a dental emergency and referral may be delayed. However, referral to a dentist is indicated for further diagnostic evaluation and baseline documentation. Treatment options will likely include smoothing of the rough enamel incisal edge or placement of a restoration with an appropriate dental material.
Enamel-Dentin Crown Fractures. Enamel-dentin crown fractures typically present as thin white tooth enamel surrounding the underlying yellow layer of more porous dentin (Figure 3B). In addition, the athlete often reports sensitivity to air, cold, or touch when the tooth pulp is vital. The athlete may return to participation as discomfort permits, and referral can be delayed up to 24 hours. The primary objective in this circumstance is to cover the exposed dentin with a biologically acceptable agent to reduce sensitivity and protect the pulp from further damage. If a dental emergency kit is available and onsite personnel have sufficient knowledge and experience, a thin layer of calcium hydroxide paste or a mixture of zinc oxide with eugenol may be placed temporarily over the exposed dentin. Treatment options include aesthetic restoration or bonding the fractured crown segment back to the injured tooth. Otherwise, the dentist is likely to perform an aesthetic, tooth-colored restoration using an appropriate dental material.

Enamel-Dentin-Pulp Fractures. Crown fractures that extend through the enamel and dentin into the pulp are more problematic (Figure 3B). If the pulp is vital, a focal spot of hemorrhage will be evident within the yellow dentin layer. In addition, the athlete may report acute pain. In contrast, if the pulp is nonvital, no hemorrhage will be present. Instead, either seepage of putrescent exudate or a dry, hollowed-out area will be evident. A foul odor may emanate from the tooth and the athlete may not report pain. Regardless, this tooth injury is considered subacute, and the athlete can return to play as pain allows. Referral to a trauma-ready dentist should occur within 24 hours for definitive treatment. Diagnosis and treatment depend on the following factors: the time interval between the injury and the initiation of treatment (the longer the interval, the poorer the prognosis), status of the dental pulp (vital versus nonvital), and the degree of root end closure at the apex of the tooth (as determined via a periapical radiograph). Onsite care providers will generally not be able to make a definitive assessment.

For both enamel-dentin and enamel-dentin-pulp fractures, if the tooth fragment can be located, it should be placed in a liquid such as water, saline, or milk and sent with the athlete to the dentist. The liquid is intended to prevent desiccation of the fragment and allow for the most
Tooth Concussions. A tooth that sustains a mild traumatic injury in the absence of a fracture or displacement is categorized as a tooth concussion, which is not to be confused with the brain injury of concussion. The concussed tooth may exhibit postimpact symptoms such as touch sensitivity. However, even mild injuries to a tooth can result in loss of pulp vitality or tooth loss in the future.

Subluxations. The mildest form of tooth displacement is a subluxation, in which the traumatized tooth maintains its position within the alveolar bone and exhibits minimal mobility. The only clinical sign may be minimal seepage of blood from the gingival sulcus surrounding the injured tooth. A subluxed tooth initially may exhibit postimpact tenderness, and warm salt water rinses may be beneficial.

Lateral and Extrusive Luxations. With a lateral luxation, an external force has displaced the tooth (buccally, lingually, distally, or mesially) so that it is out of normal position and deviated from its long axis (Figure 3D). Extruded teeth present with marked displacement and, depending on the severity of the luxation, may be misaligned yet not mobile. Treatment options will likely require repositioning and immobilization via placement of a semirigid, acid-etched composite resin or wire splint.

Intrusive Luxations. Intrusively luxated teeth are forced into their sockets in an axial (apical) direction (Figure 3D). Immediate onsite intervention by the AT or other health care provider is essential to enhance the probability of a successful clinical outcome. The avulsed tooth must first be located and replantation attempted within 5 minutes. To prevent additional trauma to the PDL, practitioners should refrain from handling the tooth by its root, as maintaining the viability of the PDL cells on the root surface is critical to a positive clinical outcome. Debris should never be brushed or scrubbed from the tooth, and the tooth should not be sterilized with boiling water or chemicals. If debris is visible on the tooth surface, the clinician can rinse the surface under the gentle flow of a liquid such as tepid water, milk, or physiologic saline. If the athlete is alert and oriented, replantation of the tooth can be attempted by inserting the root end into the socket and ensuring proper orientation of the tooth with the adjacent teeth. Once the tooth has been replanted, the athlete should bite down on a sterile gauze pad to stabilize the tooth and be immediately transported to a trauma-ready dentist for definitive treatment. If the avulsed tooth cannot be replanted immediately and completely, the tooth should be submerged in a storage medium. Hanks’ Balanced Salt Solution is the optimal storage medium for avulsed teeth. However, when ice is available, it can serve as an alternative. Other less effective solutions are using saline or saliva or placing the avulsed tooth in the vestibule between the lips and teeth. Water should be avoided or used as the last option because it damages the PDL cells. Athletic trainers and other health care providers should always avoid transporting an avulsed tooth wrapped in dry gauze or a dry paper towel.
Role of a Properly Fitted Mouthguard. In a statement approved in 2010, the Academy for Sports Dentistry adopted the position that the single word “mouthguard” must be replaced by the phrase “a properly fitted mouthguard.” Furthermore, the statement identified key considerations for the properly fitted mouthguard, including but not limited to the following: (1) material meets approval of the US Food and Drug Administration, (2) fabricated over a stone model from an impression, (3) adequate thickness in all areas (eg, 3 mm in the occlusal area), and (4) regularly inspected under the supervision of a dentist. Most mouthguards worn by athletes during sports activities are the boil-and-bite types, which do not meet the definition of “properly fitted” as defined by the Academy. Furthermore, many researchers who examined the influence of mouthguards on orofacial injury focused on either stock or boil-and-bite mouthguards. In some instances, the investigators included participants who used any mouthguard type. Notably, when custom (ie, properly fitted) mouthguards were compared with other mouthguard types, injury rates did not differ. This is likely because most commercially available (eg, boil-and-bite) and properly fitted (eg, custom) mouthguards are made of a similar ethylene vinyl acetate copolymer material. Although no superior protective benefit has been demonstrated, the properly fitted mouthguard can play an important role in perceived comfort. A properly fitted device can decrease discomfort and fatigue, which are often associated with mouthguard noncompliance. Therefore, if athletes report discomfort related to mouthguard use (stock or boil and bite), it may be beneficial to guide them toward a properly fitted mouthguard to increase compliance.

Mouthguard Classification Systems. In the United States, the most popular classification system is from the American Society for Testing and Materials (ASTM) International Designation: F 697-00 (2006) titled, “Standard Practice for Care and Use of Athletic Mouth Protectors.” Other classification systems exist in the United States and internationally [Table 3], but a complete comparison is beyond the scope of this position statement. For the purposes of this position statement, we refer only to the ASTM classification system. Despite recommendations by sports dentists and other sports medicine professionals to use custom-fitted appliances, the stock (type III) and mouth-formed (type I, class 2) mouthguards are the most common appliances because of their low cost and wide availability. These appliances are defined as

- **Thermoplastic Vacuum Formed (Type I, Class 1).** Type I (class 1) and custom-made mouthguards (as well as laminated mouthguards) are the appliances recommended most often by clinicians. These custom mouthguards require fitting by a trained sports dentist. Impressions of the mouth are formed into stone casts, and ethylene vinyl acetate (EVA) materials or laminated combinations of EVA are thermoformed (via a vacuum or air pressure machine) over the mold to produce a congruently fitted mouthguard.

- **Thermoplastic Mouth Formed (Type I, Class 2).** These boil-and-bite mouthguards are advances over stock mouthguards in that they require some fitting to the user by heating and immediate wearing, which provides a minimal level of customization to the teeth and gums.

- **Thermosetting Mouth Formed (Type II, Class 1).** Thermosetting mouthguards are relatively new to the sports dental appliance culture. No commercially available thermosetting mouthguard appliances are available at the time of this writing.

- **Stock (Type III).** These appliances require no specialized fitting by the user. Off-the-shelf appliances that are simple semirigid trays that neither conform to nor are retained by the upper dentition, they are often the least expensive option for parents, coaches, and athletes.

**International, National, and State Governing Rules**

For each of its sanctioned high school sports, the NFHS publishes official rules books. These books provide comprehensive explanations of all aspects of the sport, including a common section on game and player equipment. When protective equipment such as a properly fitted mouthguard is required, the information is covered in this section of the rules book. In addition to these rules books, the NFHS also publishes a *Sports Medicine Handbook*, in its fourth edition at the time of this writing. Compiled by members of the NFHS Sports Medicine Advisory Committee, this handbook contains recommendations for administrators and sports medicine staff on best practices for preventing injuries in high school athletes. Procedures for the emergency management of dental injuries, as well as information on the importance of a properly fitted mouthguard, are contained in this handbook. Similarly, the NCAA has developed a manual of health guidelines for intercollegiate athletics programs, published annually as the *NCAA Sports Medicine Handbook*, most recently in its 24th edition. In the equipment section of this handbook, ATs can find a list of sports that mandate properly fitted mouthguards, as well as any position, color, or tooth coverage-based rule restrictions. For organized youth sports, ATs should refer to the protective equipment rules of each national governing body to determine best safety practices.

**Mouthguard Effectiveness**

**Effectiveness of Mouthguards for Orofacial Injury.** In the United States, Woodmansey reported that 39% of all dental injuries are sport related. A more recent study of Taiwanese 15- to 18-year olds showed that sports and leisure activities accounted for 30.8% of traumatic dental injuries. In addition to the physical injury, the indirect costs of traumatic orofacial injury may have financial, psychological, and social consequences for participants and their families. Unfortunately, the true incidence of orofacial injury worldwide is difficult to establish due to varying access to and quality of health care, inconsistent definitions and reporting mechanisms, and limited quantitative data regarding mouthguard use and orofacial injury. In a systematic review of mouthguard use and injury (orofacial and concussion), Knipik et al found that only 14 of 69 original research studies met the review criteria. Of the 14 investigations, only 1 was a prospective randomized control study; the remaining investigations involved nonrandomized or 1-group ecological interventions, prospective cohorts, or cross-sectional surveys. Based on post-1980 nonquestionnaire studies,
mouthguard nonusers were nearly 2 times more likely to suffer an orofacial injury than mouthguard users.12

**Brain Concussion Risk-Reduction Effectiveness.** The dentist for the Notre Dame University football team was one of the first individuals to illustrate through radiographic evidence that an intraoral appliance could change the temporomandibular joint relationship.128,129 More specifically, a 3-mm-thick intraoral appliance could separate the mandibular condyle from its fossa. This separation was posited to create a “recoil” space and is the basis for the hypothesis that 3-mm-thick intraoral appliances can attenuate transmitted forces to the cranial vault from a blow to the chin. Another historical and highly referenced study used to support the attenuation claim was conducted by Hickey et al,130 who monitored intracranial pressure in cadavers after an impact to the chin. These historical studies have been criticized for their poor methodologic quality and a lack of the experimental chin. These historical studies have been criticized for their poor methodologic quality and a lack of the experimental evidence that an intraoral appliance could create a concentric circle to reposition the mandible into a more kinesiologically effective and efficient.132,133 Investigations into both airway dynamics and the physiologic effects of an array of mouthguards for preventing concussion. Therefore, these devices should not be recommended for this purpose.66,70,131

**Aerobic and Anaerobic Effectiveness.** A logical concern associated with wearing a mouthguard is the effect the device has upon an athlete’s ability to breathe effectively and efficiently.132,133 Investigations into both airway dynamics and the physiologic effects of an array of mouthguards have been conducted.72–77 However, evidence for the effects of individual types is limited. Although airflow dynamics can be altered by mouthguards, compared with the no-mouthguard condition, the main physiologic variables were not negatively affected.72–77 Furthermore, several authors’4,134,135 have suggested a positive influence of mouthguards upon physiologic factors during high-intensity bouts of exercise. Specifically, blood lactate levels decreased by up to 22% compared with no-mouthguard conditions and variables such as V˙O₂, V˙O₂/kg, and V˙CO₂ improved. Mouthguard use in sport will continue to increase over time, so investigations into the effects of intraoral devices upon normal physiologic function need to continue and be expanded.

**Effectiveness of Mandibular Orthopaedic Repositioning Appliances.** Fabricating the oral appliance to reposition the mandible into a more kinesiologically appropriate posture has been suggested. To accomplish this, the appliance is fabricated so that the 3-dimensional maxillomandibular dimensions create a concentric circle on occlusion, a phenomenon known as centric occlusion. The premise is that perfect centric occlusion would cause the local jaw musculature to adapt physiologically and increase sensory input to the cerebral cortex, which would then facilitate increased performance on various tasks, including those that rely on vision, posture, balance, and motor skill.

In the mid-1980s, investigations of the potential effects of MORAs on appendicular musculoskeletal strength were conducted.41–45,79,80 The past several decades have seen many attempts by basic scientists and clinicians to prove or disprove this hypothesis.41–45,136–138 These studies have been criticized as lacking true experimental designs, adequate sophistication of statistical analyses, and sufficient knowledge by the dental clinician researchers of how to test muscle strength. Thus, research in this area waned for several years until the mid-1990s and early 2000s, when Gelb et al43,44 and others134–137,139 investigated the effects of MORAs on additional human performance factors, including strength, posture, visual focusing, gas exchange, and lactate and cortisol levels. These studies produced largely equivocal results and were criticized for poor experimental methods; the only outcome that can be inferred is that MORA-type devices do not negatively affect human performance. As such, the devices are not recommended for improving ergogenic capabilities. In addition, although it is acceptable for athletes with a prognathic mandible or mandibular protrusion (or both) to use these devices, their efficacy in lowering the injury risk is unknown.

**Mouthguard Material, Fabrication, and Care Considerations**

**Protective Mechanisms.** A properly fitted mouthguard has been posited to protect against injury through at least 2 mechanisms: splinting and energy dissipation. Splinting (Figure 4) involves taking an initial focal impact force and redistributing it across a larger surface area of material. To accomplish this, a material needs to be stiff; however, if the material is too stiff, it is likely to be uncomfortable and contribute to noncompliance. Similarly, energy dissipation (Figure 5) is the ability of the material to deform with the impact and return to its normal shape while dissipating some of the energy. In a broader sense, we refer to these combined properties as a viscoelastic response. The term viscous indicates that a material deforms slowly when exposed to an external force.83 The term elastic indicates that once a deforming force has been removed, the material will return to its original configuration.83 The mechanical properties of viscoelastic materials are typically examined by means of stress-strain (or load-deformation) tests. During these tests, a viscoelastic material exhibits hysteresis loop behavior when the stress versus strain curves are superimposed. The area within the loop represents the energy lost due to heat dissipation, which in part explains why viscoelastic materials are good shock absorbers.83

From a clinical standpoint, one of the most important properties of viscoelastic mouthguard materials is their ability to potentially reduce the magnitude of impact forces to the teeth by either absorbing the energy or lengthening the time of the impact event.83 However, as the mouthguard material decelerates the impact event over the longer time period, the material has to travel (ie, compress) further and a bottoming-out phenomenon may occur. At the point where the material fully compresses (termed densification), there is an abrupt increase in force transmission to the tooth substrate, which may ultimately lead to injury.83

**Mouthguard Materials, Properties, and Processing.** Mouthguards are formed from plastic materials. Most chemists and chemical engineers use the terms plastics and

Figure 5. Illustration of mouthguard force-dissipation mechanism. Left: A, The external force is introduced to the unprotected anterior aspect of the tooth, resulting in complete transfer of momentum of motion. Right: A, The external force is directed at the protected anterior aspect of the tooth. B, The protective thickness of the mouthguard material compresses, dissipates a certain amount of energy as heat, and transfers the remaining energy to the substrate tooth. The same mechanism occurs when there is a violent contact to the tip of the teeth from a violent collision between the upper and lower dentitions. Reprinted from *Materials in Sports Equipment*, Vol. 2 (p. 134), A. Subic, 2007, Cambridge, England: CRC Press. Copyright 2007 by Woodhead Publishing Limited. Reprinted with permission.
Polymers can be broadly categorized into 2 subcategories: (1) thermoplastics are 2-dimensional (ie, not cross-linked) molecules that can be softened by applying heat, reshaped, and returned to their original state by cooling; and (2) thermosetting plastics are 3-dimensional (ie, cross-linked) networked polymers that cannot be reshaped by heating. In an athletic training clinical setting, Orthoplast (Patterson Medical Holdings, Inc, Warrenville, IL) is an example of a thermoplastic material, whereas the rubber outer sole of an athletic shoe represents a thermosetting polymer. Currently, the majority of materials used for mouthguards, regardless of their class categorization (eg, boil-and-bite versus custom), are thermoplastic copolymers of EVA.

Several properties of polymers should be considered when choosing a material for a particular application. One of the most fundamental properties is glass transition temperature, T_g. Every plastic material has a temperature below which the polymer chains cease movement and the material exhibits “glassy” behavior. Conversely, above this temperature, the material has increased chain movement and exhibits “rubbery” behavior. A polymer material being used at its T_g exhibits “leathery,” or viscoelastic, behavior. At intraoral temperature, EVA copolymers are rubbery (ie, elastic) materials that are not optimal for mechanical damping. Regardless, EVA has many advantages (eg, low cost and easy fabrication) and will likely remain in abundant use until better materials are discovered.

To process EVA copolymers into mouthguards, the material is heated (usually in boiling water or near the heating element of a custom forming machine) above its crystalline melting temperature (T_mn), which is typically 65°C to 70°C. The exact melting temperature is determined by the vinyl acetate ratio in the copolymer (ie, the greater the vinyl acetate content, the lower the crystalline melting point). Once the EVA copolymer sample is heated above its melting point, crystalline regions (ie, physical cross-links) are no longer present, thereby removing the barrier to viscous melt flow. At a critical temperature above the crystalline melting temperature, the EVA material reaches a softening point at which the melt strength is severely reduced. At this point, the EVA material begins to flow on a time scale that allows it to conform to the teeth (as in a boil-and-bite device) or over a positive mold of the teeth (as in a custom device). After the heat source is removed, the temperature of the EVA material decreases below the crystalline freezing (T_c) point (typically 40°C to 50°C) and crystalline regions reform. This process “locks in” the newly formed structure of the mouthguard, thereby restoring the EVA material to the rubbery state and making it ready for end use.

**Mouthguard-Fabrication Techniques.** Mouth-formed mouthguards, as their name implies, rely upon the end user to place a moldable material into the mouth to create a final impression and fit. This technique improves on the fit and retention offered by basic nonmoldable mouthguard trays by accepting a basic impression of the dentition into the material. This type of device requires that the material be malleable while taking the impression but solidified during end use. The most common material for this application today is EVA, which is available in a broad range of compositions (ie, soft to hard). Placing the EVA in boiling water increases the material’s temperature and softens it for molding. It is noteworthy to mention that, although EVA copolymers are historically the most widely used materials, other polyethylene blends, polycaprolactones, and propylene-based elastomers are gaining in popularity because of similar results: a softened, malleable material that can be fabricated. The softened mouthguard is placed on the dentition, and the user’s mouth is closed. Air is evacuated by sucking and biting down on the mouthguard, which allows the material to flow around the teeth and gums. Although mouth-formed mouthguards are the most common type in use today, user error during the formation process can lead to inconsistent thickness, fit, and retention.

The custom-fitted approach incorporates a dental model of the athlete’s teeth as the template for the molding process. The dental model is made from an impression of the teeth and dental arch. The impression is usually taken of the maxillary arch with an appropriate dental-impression material (eg, elastic algae-based product, such as alginate). If the athlete has a prognathic mandible or mandibular protrusion such that the mandibular teeth extend forward beyond the maxillary anterior teeth with both arches in occlusion, a mandibular impression may be used. The quality of the impression is the key to a satisfactory dental model and an appropriate custom mouthguard. An appropriate mouthguard cannot be fabricated if the impression does not have good internal definition, does not extend adequately beyond the teeth, does not register the soft tissues well, or becomes distorted, damaged, or torn. Therefore, the impression should be taken by a qualified dental professional. Once the negative impression is taken, a positive model of the teeth is made by pouring a hard-setting dental stone into the impression. The following custom fabrication techniques allow for a greater level of heating and pressure of the basic mouthguard material, which permits greater flow around the structures and ultimately provides a more accurate representation of the teeth, gums, and maxillary arch. Additionally, these techniques enable the dental professional to control the occlusal, labial, and palatal thicknesses of the mouthguard, as well as the smoothness of the edges and coverage of the intraoral structures.

For the vacuum-forming technique, a sheet of EVA is placed in a holding device in the forming machine, where it is softened using a heating element. Once melt-flow temperature is achieved, the material visually sags. The heat source is then removed and the softened material is lowered over the dental model. The sheet is drawn tightly over the teeth by a vacuum, resulting in an excellent internal adaptation. However, it is difficult to control material thickness, as this depends on operator-dependent factors such as material temperature and time in the vacuum. This technique can be used for laminating layers of material, but it is generally more difficult to perform and has less successful outcomes.

The pressure-laminate technique also involves placing a sheet of EVA in a holding device in the forming machine, where it is softened using a heating element. The material is heated as in the vacuum technique, but the softened mouthguard material is applied to a dental cast within a high-pressure chamber. Use of the pressure chamber results in much clearer and complete internal definition. Again, consistency of the end product is operator dependent, but...
this technique allows multiple layers to be integrated into the mouthguard by laminating 1 sheet to another, thereby controlling appliance thickness.

**Fit and Compliance.** The athlete’s perceived comfort with the mouthguard is critical and of paramount importance for compliance. Noncompliance has been related to bulkiness, stability, hardness, dyspnea, speaking difficulty, oral dryness, and nausea. Custom-fabricated mouthguards that are individually crafted and adjusted by licensed dentists address the salient tooth surfaces (Figure 6) and coverage areas (Figure 7) and can eliminate some of these problems. Adjustment may require the athlete to insert the mouthguard while the clinician checks the occlusion of the opposing arch for balance or premature contact. McClelland et al noted that perceived comfort ratings of a mouthguard increased when the palatal peripheries were tapered and the labial and buccal peripheries were rounded. Tapering the palatal periphery controls the lingual bulk. Similarly, by shaping the margins, it is possible to improve comfort without sacrificing the device’s protective quality.

![Figure 6](image1.png)

**Figure 6.** Illustration of basic tooth surfaces (left) and gingival anatomy (right) related to mouthguard fabrication. Adapted from “Mouthguards for use in sport and recreation—requirements and test methods,” by Technical Committee PH/3/11, 2001, *DD 253:2001*, p. 4-5. Copyright 2001 by the British Standards Institute. Permission to reproduce extracts from British Standards is granted by BSI Standards Limited (BSI). No other use of this material is permitted. British Standards can be obtained in PDF or hard copy formats from the BSI online shop: www.bsigroup.com/shop or by contacting BSI Customer Services for hard copies only: Tel: +44 (0)845 086 9001, e-mail: cservices@bsigroup.com.

![Figure 7](image2.png)

**Figure 7.** Recommended mouthguard-coverage areas. A, Coverage to the distal surface of the first molar for low-contact sports. B, Coverage to the distal surface of the second molars for high-contact sports. Note that the third molars are shown for completeness. However, in most individuals, these fail to erupt or have been removed, and therefore, the entire upper dentition will be covered for high-contact sports. The asterisk denotes that the third molars are shown for completeness. Adapted from “Mouthguards for use in sport and recreation—requirements and test methods,” by Technical Committee PH/3/11, 2001, *DD 253:2001*, p. 5. Copyright 2001 by the British Standards Institute. Permission to reproduce extracts from British Standards is granted by BSI Standards Limited (BSI). No other use of this material is permitted. British Standards can be obtained in PDF or hard copy formats from the BSI online shop: www.bsigroup.com/shop or by contacting BSI Customer Services for hard copies only: Tel: +44 (0)845 086 9001, e-mail: cservices@bsigroup.com.
A more detailed list of clinical mouthguard-fabrication specifications is located in Table 5. Visually, these mouthguard-fabrication specifications are represented in the mouthguard surface map illustrated in Figure 8. Unfortunately, use of these types of appliances is restricted by availability and expense. Most of the expense of custom-fabricated mouthguards is in the clinician’s fabrication time and not in material costs. Although some research has established that mouthguards protect the teeth and mandible from injury, best practices regarding the fabrication process and materials have not been determined.

Performance Testing, Use, and Care. Only the American National Standards Institute/American Dental Association and Standards Australia International/Australian Dental Association provide guidelines that specifically describe the performance testing (ie, physical and mechanical properties) requirements that must be met by mouthguard material manufacturers. However, performance factors were based upon a single study of basic physical and mechanical properties of commercial EVA sheets and fabricated mouthguard specimens. These properties and their performance thresholds are provided in Table 4. All measures except shock absorption were obtained at an approximate intraoral temperature of 37°C.

Cleaning, Maintenance, and Storage. With respect to cleaning, storage, and shipping, ASTM designation F697-06 provides general recommendations, including washing the mouthguard daily in cold or lukewarm water and using antimicrobial cleaning agents such as Listerine (Johnson & Johnson Consumer Inc, New Brunswick, NJ), Scope (Procter & Gamble, Cincinnati, OH), or Defense Sport Mouthguard Rinse (Sani Brands, Inc, Allentown, PA). When storing a thermoformable mouthguard, excessive heat should be avoided. The best recommendation for shipping a custom-made mouthguard is to fully seat the mouthguard on its dental stone model.

Suggested Best Practices

In most instances, an athlete will know that a dental injury has occurred. Once the injury is reported, the health care provider should evaluate the intraoral location, as well as the type and severity of injury. The segment of permanent teeth most often affected by sport-related dental trauma contains the 6 maxillary anterior teeth (central incisors, lateral incisors, and canines); the central incisors are involved most frequently. Dental injuries may be classified as crown fractures, root fractures, or tooth-displacement injuries. Determining the extent and severity of the dental injury will better enable the onsite AT to recognize and manage the condition. Subjective symptoms reported by the injured athlete are beneficial in establishing the diagnosis. For example, an athlete who reports that a tooth is sensitive to air, cold, or touch likely has a crown fracture that extends beyond the outer enamel into the underlying dentin of a vital tooth. In contrast, constant, piercing, or throbbing pain suggests more severe and often irreversible damage to the dental pulp.

Additional diagnostic adjuncts can be used by the AT to facilitate triage of patients with dental injuries. A pocket flashlight can be used for visual examination to identify fractures, displacements, bite (occlusal) disturbances, soft tissue edema, or hemorrhage. Transillumination of the traumatized tooth will aid in identifying enamel prism damage (infractions) in the absence of an overt fracture. This technique is typically performed in a darkened room with a bright light directed at the tooth to locate infractions and fractures, which present as dark areas or lines. Transillumination can also identify tooth crown discoloration caused by hemorrhage from the pulp exuding into the dentin tubules. Palpation of the traumatized tooth using proper barrier protection can provide valuable information regarding displacement and mobility. When considered together, these individual diagnostic procedures supply the care provider with a more comprehensive assessment to properly triage the injured athlete. Hence, triage for a sport-related dental injury may range from no immediate response indicated to onsite temporary intervention with subsequent referral for dental follow up to immediate transport to a trauma-ready dentist or emergency facility for definitive management.
The importance of the orofacial region as an integral component of the overall cranial complex cannot be overemphasized. As such, to assess the likelihood of a concussion, clinicians are advised to perform a rapid neurologic screening on athletes who have sustained any sport-related traumatic dental injury. The injured athlete can then be triaged accordingly. 142,147 In most instances, the health care professional will know or have access to the patient’s medical history and general health status, such as tetanus immunization status. For clean minor wounds, a tetanus booster is recommended when the time since the last booster exceeds 10 years. When the wound has been contaminated, a booster is recommended if the time since the last booster exceeds 5 years. If the athlete had not previously received the complete regimen, tetanus immune globulin may be required.19 Antibiotics, oral disinfectant rinses (eg, oral chlorhexidine), or both may be prescribed by the attending dentist for an athlete who has sustained an avulsed tooth, an alveolar bone fracture, a maxillary or mandibular jaw fracture, or a soft tissue through-and-through laceration.

Athletic trainers and others providing onsite care to athletes should take the lead in recommending the appointment of sports dentists to their sports medicine teams.144 Team dentists can be tasked with fabricating custom mouthguards, assembling the contents for a dental emergency kit, and expeditiously managing sport-related traumatic dental injuries. At the very least, the AT should develop a list of available dentists for consultations and referrals. Return-to-play decisions after sport-related traumatic dental injuries should be conducted in consultation with the attending dentist.145–148

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