# Dental Trauma in Children

Canonical:
https://directory.collinsstreetspecialistcentre.com.au/procedures/paediatric-dentistry/dental-trauma-in-children/

## Description:

--- title: "Dental Trauma in Children" slug: /paediatric-dentistry/dental-trauma-children/ type: procedure specialty: paediatric-dentistry specialists: ["Dr Susan Hinckfuss", "Dr Sarah Scott", "Dr Ang...

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# Dental Trauma in Children: What to Do When Your Child Knocks a Tooth

Children fall. They run, they tumble off bikes, they collide with furniture and other children at remarkable velocity. Dental trauma — knocked-out, broken, or displaced teeth — is one of the most common dental emergencies in childhood, particularly in the one-to-three-year age group (when children are learning to walk) and again in the seven-to-ten-year window (when permanent front teeth are freshly erupted and sport injuries are more common).

A dental emergency involving your child is frightening. Knowing what to do in those first critical minutes — and understanding which situations are genuinely urgent — can make a significant difference to the outcome.

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## What Is Dental Trauma?

Dental trauma refers to any injury to the teeth, gums, supporting bone, or surrounding soft tissues caused by an impact or force. In children, the most common scenarios include:

- **Avulsion** — the tooth is completely knocked out of its socket - **Luxation injuries** — the tooth remains in the mouth but is displaced from its normal position (pushed in, pushed out, tilted, or loosened) - **Crown fractures** — chipping or breaking of the visible portion of the tooth (the crown) - **Root fractures** — a fracture occurs at or below the gum line - **Concussion** — the tooth is struck but not displaced; tender but in position - **Soft tissue injuries** — cuts to the lips, gums, tongue, or cheeks (often dramatic in appearance but usually less serious than they look)

The correct management differs significantly depending on: - Whether it is a **primary (baby) tooth** or a **permanent tooth** - **How much time has passed** since the injury - The **type and severity** of the injury - The **age and developmental stage** of the child

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## The Most Critical Distinction: Baby Tooth or Permanent Tooth?

This single question determines what to do next.

### Permanent Teeth: Act Immediately

A permanently knocked-out tooth (avulsion) is a true dental emergency. The tooth has the highest chance of successful re-implantation if it is returned to the socket **within 30–60 minutes** of being knocked out. After an hour out of the mouth, the specialised cells on the root surface (periodontal ligament fibres) begin to die, and long-term success becomes significantly less likely.

**If your child's permanent tooth is knocked out completely:**

1. **Find the tooth** — Pick it up by the crown (the white part you can see). Do not touch the root. 2. **Do not scrub or wipe the root** — If it has grit on it, rinse gently with milk or the child's own saliva. Do not use water, do not scrub, do not dry it. 3. **Try to replace it in the socket immediately** — If the child is calm enough, gently seat the tooth back into the socket in the correct orientation and have the child bite on a clean cloth to hold it there. This is the ideal outcome. 4. **If you cannot replace it:** Store the tooth in milk (the best widely available option), in the child's own saliva (the child can hold it inside their cheek if old enough and not at risk of swallowing it), or in a commercial tooth preservation kit (Hank's Balanced Salt Solution) if you have one. Do NOT store in tap water — this damages the root cells rapidly. 5. **Get to a dentist or hospital emergency department immediately.** Call ahead so they can prepare.

Time is the critical factor. Every minute matters.

### Baby Teeth: Do Not Re-Implant

If a baby tooth is completely knocked out, **do not attempt to put it back.** Re-implanting a baby tooth carries a significant risk of damaging the permanent tooth bud developing underneath. Instead:

- Comfort your child - Rinse the mouth gently with water to clean the area - Apply gentle pressure with a clean cloth if there is bleeding from the gum - See a paediatric dentist within 24 hours for assessment

The dentist will examine the socket, check that no portion of the tooth remains, and discuss space management if the tooth was lost early and the permanent replacement is many years away.

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## Emergency First Response: By Injury Type

### Knocked-Out Permanent Tooth (Avulsion) See above. **Time is critical — act within 30 minutes if possible.**

### Displaced Tooth (Luxation) If the tooth is still in the mouth but looks out of position — pushed forward, backward, sideways, or intruded (pushed into the gum) — **do not attempt to move it yourself.** Seek urgent dental care, same day. For intruded teeth (pushed in), the management differs depending on the extent and whether it is a baby or permanent tooth — specialist assessment is essential.

### Chipped or Broken Tooth - Collect any fragments if you can find them — in some cases, fragments can be bonded back to the tooth - Rinse your child's mouth gently with warm water - If there is pain, exposed darker material (the pink or yellow inner tooth structure), or sensitivity to air and cold, this is more urgent — aim to be seen within hours - If the chip is minor and the tooth is not sensitive, an appointment within 24–48 hours is usually appropriate

### Tooth Pushed Loose (Concussion or Subluxation) A tooth that feels wobbly after a knock but is in its normal position should be assessed by a dentist the same day. Avoid hard foods; stick to soft diet until reviewed.

### Bleeding from the Mouth Soft tissue injuries to the lips, tongue, and gums often bleed dramatically — which is frightening, but rarely indicates a serious injury. Apply firm pressure with a clean cloth for 5–10 minutes. If bleeding does not stop, or the wound is large and gaping, emergency department assessment is appropriate.

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## What to Expect at Collins Street Specialist Centre

When you bring your child in following dental trauma, our paediatric dental team will:

**1. Immediate assessment** A calm, systematic examination of the affected teeth and surrounding structures. For very distressed children, we use age-appropriate communication and our behavioural management skills to make the assessment as gentle as possible.

**2. Imaging** Digital periapical X-rays (low-dose, targeted) and/or CBCT imaging where needed to assess root fractures, bone involvement, and the position of permanent tooth buds in relation to displaced primary teeth.

**3. Treatment planning** Treatment depends on the findings. Options range from: - Monitoring with no immediate intervention - Repositioning and splinting a displaced permanent tooth - Pulp therapy if the nerve is affected - Extraction if a tooth cannot be saved - Space management after premature tooth loss

**4. Follow-up schedule** Dental trauma requires follow-up, even when the initial treatment is complete. Changes can occur weeks or months after an injury — including darkening of the tooth (common and sometimes reversible), resorption of the root, or infection. Regular review appointments allow problems to be detected and managed early.

Our endodontic specialists are also on-site at CSSC if specialist root canal management is needed following trauma — an important advantage of our multidisciplinary model.

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## After the Appointment: What to Watch For

Following any dental trauma in a child, monitor carefully for:

- **Tooth darkening** — a tooth that turns grey or dark yellow following injury may have a damaged nerve. This should be assessed by a dentist; sometimes it resolves spontaneously, sometimes root canal treatment or extraction is needed. - **Gum swelling near a traumatised tooth** — this may indicate infection and needs prompt attention - **Persistent sensitivity** or pain that doesn't improve after the first few days - **The permanent tooth being slow to erupt** — sometimes an injury to a primary tooth can affect the permanent tooth developing underneath

**For splinted teeth:** If a tooth has been repositioned and splinted following luxation or avulsion, your child should eat only soft foods for the duration of the splint. Keep the area as clean as possible — bacteria around the splint can slow healing.

**Ongoing care:** Your child should be reviewed at the intervals recommended by your specialist. These appointments are not optional — some of the most significant complications of dental trauma (root resorption, delayed infection) are symptom-free and only detectable on X-ray.

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## Why See a Specialist Paediatric Dentist?

Dental trauma in children is a genuinely complex area of dentistry. The correct management depends on the type of injury, the age of the child, the developmental stage of the dentition, and whether the

tooth involved is primary or permanent. Getting this wrong can mean losing a tooth unnecessarily, damaging the permanent tooth bud, or missing a treatable complication.

Specialist paediatric dentists receive formal training in dental traumatology as part of their postgraduate programme — including the management of avulsed teeth, luxation injuries, and the long-term follow-up protocols that determine outcomes. This is not an area where guesswork is appropriate.

Additionally, a child who has experienced dental trauma is often frightened and in pain. The skills needed to provide good emergency dental care to a distressed child — technical precision combined with genuine behavioural management ability — are the hallmark of specialist paediatric dentistry.

Prof Chankhrit Sathorn, one of our specialist endodontists at CSSC, also serves on the editorial board of *Dental Traumatology*, the leading international journal in this field — reflecting the depth of expertise available at our centre.

All CSSC paediatric specialists hold specialist registration with the Dental Board of Australia, verifiable at AHPRA.gov.au.

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## Our Paediatric Specialists

**Dr Susan Hinckfuss** — BDSc (Melb), DCD (Melb) — has extensive experience managing dental trauma in children, including complex luxation injuries, avulsions, and enamel fractures. Her time as Assistant Clinical Professor at the University of Minnesota included significant exposure to dental traumatology in a high-volume paediatric setting.

**Dr Sarah Scott** — BBiomedSci (Hons), BDent, DClinDent (Paeds) — provides experienced, calm management of dental emergencies in children of all ages, including the follow-up monitoring that is critical for good long-term outcomes after trauma.

**Dr Angel Babu** — DClinDent PAED (Otago) — lists dental trauma as a specific area of clinical expertise. As a senior dental registrar at the Royal Children's Hospital Melbourne, Dr Babu regularly manages acute dental trauma presentations and complex follow-up cases. Registered in Australia and New Zealand.

**Dr Aish Kesava** — DCD (Paeds) — specialist paediatric dentist providing comprehensive care including emergency trauma management. *(Extended clinical biography forthcoming.)*

Our specialists consult from Level 8, Manchester Unity Building, 220 Collins Street, Melbourne CBD. For dental emergencies, call **(03) 9650 2726**. No referral is required.

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## When to Go to Hospital Instead

Go directly to your nearest hospital emergency department if your child has: - Lost consciousness, even briefly, after the injury - Signs of concussion (confusion, vomiting, unequal pupils) - Significant facial swelling or bruising - A jaw that appears misaligned or cannot close properly - Bleeding that will not stop after 10–15 minutes of firm pressure - Any concern about the safety of the airway

Dental trauma frequently accompanies head injuries — always treat the child as a whole, not just the tooth.

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## Related Treatments

- [**Dental Anxiety in Children**](/paediatric-dentistry/dental-anxiety-children/) — Managing the fear that often follows traumatic dental experiences - [**Dental Trauma (Endodontic

perspective)**](/endodontics/dental-trauma/) — Root canal management following traumatic tooth injuries - [**Facial Trauma**](/oral-maxillofacial-surgery/facial-trauma/) — For injuries involving the jaw, facial bones, or complex soft tissue repair - [**Your Child's First Dental Visit**](/paediatric-dentistry/first-dental-visit/) — Establishing a dental relationship before emergencies happen