Integrative Wellness and Rehabilitation Practices in Sports Medicine: A Holistic Perspective on Athlete Recovery, Insights, and Innovation

RICHA WADHAWAN¹, MAYANK LAU²,SHUBHAM KUMAR³, PURU TRIVEDI⁴, AKASH GOEL ⁵ DEVRAJ DUARA⁶, EUGEANE MARY KHARMALKI⁷

1. PROFESSOR, ORAL MEDICINE, DIAGNOSIS & RADIOLOGY, PDM DENTAL COLLEGE & RESEARCH INSTITUTE, BAHADURGARH, HARYANA

2. PROFESSOR, PROSTHODONTICS AND CROWN & BRIDGE, PACIFIC DENTAL COLLEGE, UDAIPUR, RAJASTHAN

 POST GRADUATE, ORTHODONTICS & DENTOFACIAL ORTHOPEDICS, MAHARANA PRATAP COLLEGE OF DENTISTRY & RESEARCH CENTRE, GWALIOR, MADHYA PRADESH
POST GRADUATE, DEPARTMENT OF PROSTHODONTICS AND CROWN & BRIDGE, MAHARANA PRATAP COLLEGE OF DENTISTRY & RESEARCH CENTRE, GWALIOR, MADHYA PRADESH

 POST GRADUATE, ORTHODONTICS & DENTOFACIAL ORTHOPEDICS, SHREE BANKEY BIHARI DENTAL COLLEGE & RESEARCH CENTRE, GHAZIABAD, UTTAR PRADESH
POST GRADUATE, ORAL MEDICINE, DIAGNOSIS & RADIOLOGY, K.D. DENTAL COLLEGE & HOSPITAL, MATHURA, UTTAR PRADESH

 DENTAL SURGEON, SUPERCARE HOSPITAL, SHILLONG, MEGHALAYA Corresponding author: wadhawanricha1@gmail.com

Abstract:Sports dentistry is a burgeoning field that plays a pivotal role in athlete health and performance by focusing on preventing and treating orofacial injuries sustained during sports activities. Athletes often underestimate the impact of orofacial trauma, which can damage both soft and hard oral tissues, including teeth. Dentists can significantly raise awareness among athletes, coaches, and sports administrators about these injuries and advocate for the use of protective mouth and face gear across various sports disciplines. This article discusses the incidence, risk factors, and prevention of orofacial sports injuries, highlighting the critical role of protective equipment in minimizing harm and reducing treatment costs. Treatment options for structural damage focus on restoring both aesthetics and function. Dentists are pivotal in sports medicine, aiding athlete recovery and performance through wellness and rehabilitation strategies. The collaboration of dentists, orthodontists, prosthodontists, oral surgeons, pedodontists and endodontists is essential in managing injuries and promoting oral health in athletes. Integrating traditional sports medicine with complementary therapies enhances athlete well-being. Innovative technologies in sports rehabilitation are discussed, emphasizing personalized care plans tailored to each athlete's needs. This holistic approach addresses physical, mental, and emotional aspects of recovery, aiming to optimize athletic performance and reduce injury risks while promoting long-term health and well-being in sports medicine.

Keywords: Sports Dentistry, Orofacial trauma, Orofacial protective devices, Abrasion, Treatment planning, Integrative medicine, Sports rehabilitation, Personalized care, Faceguard, Osseointegrated implants

Date of Submission: 02-07-2024

Date of Acceptance: 13-07-2024

I. Introduction:

Participating in vigorous recreational activities and sports offers physical fitness, skill enhancement, and stress reduction benefits. However, the popularity of sports among young people has increased sports-related dental and craniofacial injuries. Sports Dentistry plays a crucial role in preventing, managing, and researching dental trauma, while also educating athletes.¹ Optimal oral health significantly boosts athletes' performance during competitions. Sports Dentistry not only treats orofacial injuries but also addresses broader athlete health issues like respiratory problems and medication compliance. With increasing global sports participation for recreation and fitness; dental and facial injuries are inevitable. These range from soft tissue issues like concussions, lacerations, and bruising, to hard tissue injuries such as tooth intrusion, extrusion, and avulsion.²Severe cases can involve fractures of teeth, alveolar bone, facial bones, and temporomandibular joint

injuries from direct impacts. Sports dentistry, established by the International Academy for Sports Dentistry in 1958, plays a critical role in preventing and treating dental injuries and related oral diseases caused by sports and exercise.³ It emphasizes both prevention and treatment of orofacial injuries, supporting athlete health amid increasing sports participation across ages. Sports dentists are adapt at protecting orofacial structures, managing emergencies, and understanding patient behaviour. Dental trauma, a significant concern highlighted by epidemiological studies, surpasses dental caries and periodontitis among young individuals. This necessitates that all dental specialties possess comprehensive expertise in dentofacial care, including prompt interventions for sports-related injuries.⁴Orthodontists focus on correcting dental and skeletal irregularities, which can enhance an athlete's oral health and performance. Dental injuries, such as soft tissue lacerations, fractures, tooth avulsion, and damage to gums and facial bones during sports, can be reduced with properly fitted protective gear like customized mouth guards, ensuring both fit and comfort.⁵

Oral Surgeons contribute in sports dentistry by managing severe facial and dental trauma resulting from accidents or collisions. This includes treating fractures of the jaw and facial bones, replanting avulsed teeth, and addressing complex injuries requiring surgical intervention.⁶Prosthodontists are experts in restoring and replacing teeth and oral structures. In sports medicine, prosthodontists may fabricate custom dental prostheses, such as crowns, bridges, or dental implants, to restore function and aesthetics following dental injuries or trauma sustained during sports activities.⁷Pedodontists focus on the dental care of children and adolescents. In sports dentistry, they educate young athletes and their parents on preventive measures to reduce the risk of dental injuries. They also provide specialized care for dental emergencies and manage dental trauma in young athletes.⁸Endodontists specialize in diagnosing and treating diseases and injuries that affect the dental pulp and tissues inside the tooth. In sports dentistry, they play a role in preserving injured teeth through root canal therapy, which can salvage teeth that have suffered trauma or fracture during sports activities.⁵ Collectively, these dental specialists contribute to the field of sports dentistry by providing preventive care, immediate treatment during emergencies, and rehabilitative services for athletes who experience dental and oral injuries. Their expertise ensures that athletes receive comprehensive dental care tailored to their specific needs, helping to maintain oral health and optimize performance in sports. This article highlights preventive measures, treatment options, and dentists' role in sports medicine teams, focusing on awareness and injury management.¹⁰

II. Discussion:

The prevalence of orofacial injuries in sports varies widely across different studies and sports disciplines. Pasternack et al. reported that 27% of baseball players experience orofacial injuries during contact sports.¹¹ Wenli M found much higher rates in basketball, with 80.6% among professional players and 37.7% among semi-professionals.¹²

Caglar et al. noted a prevalence of 16.6% among football athletes, while Galic et al. reported 21.8% for handball players.¹³ Praveena et al. demonstrated a prevalence rate of 33.8% for hockey players.¹⁴ These variations underscore the influence of factors such as age, gender, coaching quality, developmental stage, body proportions, orthodontic history, and prior injuries on the incidence of orofacial injuries in sports.¹⁵Psychological factors and the nature of sports significantly influence injury rates, with rising participation correlating with increased trauma, particularly impacting the less protected face compared to other body parts. Dental injuries, linked to sports at rates of 13-39%, and maxillofacial injuries involved in 11-18% of sports-related accidents, underscore the risks athletes' face.¹⁶The National Youth Sports Foundation reports a 10% likelihood of face or mouth injuries during a playing season, with males twice as vulnerable, often affecting the maxillary anterior teeth. Soft tissue injuries and fractures often affect the "T-zone" bones (nose, zygoma, mandible), particularly involving the maxillary lip, maxilla, and maxillary incisors, accounting for 50-90% of dental injuries in sports.¹⁷The prominent location of the nasal bone increases injury frequency in this area. Vulnerable populations include children, adolescents, middle-aged athletes, and women, who may endure lasting psychological effects from oral and maxillofacial injuries.¹⁸Greater awareness and dissemination of knowledge in dentistry regarding sports trauma are crucial given its high incidence. Risk factors for sports injuries vary by sport type and age.¹⁹Contact sports like boxing, judo, karate, wrestling, sumo, soccer, basketball, and football, as well as fast-moving sports such as cycling and car racing, pose heightened risks. In young children, trauma often leads to luxation injuries in primary dentition due to their resilient, pliable, and less mineralized bone structure. Conversely, young permanent dentition is more prone to crown fractures.²⁰ Robey et al. and Blyth and Mueller noted increasing injury risk in high school football with age.²¹

Most sports injuries occur in adolescents and young adults, with risks generally decreasing with age.²² Men and boys are more likely to engage in aggressive and contact sports, while girls may face higher accident risks relative to their participation rates.²³ Previous injuries do not always predict future incidents if managed

effectively. Factors like muscular imbalances, cerebral palsy, or epilepsy can predispose individuals to sports injuries. Effective coaching, emphasized by Ranalli and Lancastar, plays a critical role in injury prevention.²⁴Larger body size, including height and weight, can increase joint stress and susceptibility to injuries. Specific orthodontic conditions such as Class II molar relationships or mouth breathing can heighten susceptibility to sports-related trauma.²⁵Psychological factors like stress, anxiety, performance pressure, or low self-confidence, as noted by Kerr and Fowler, can impair athletes' focus, leading to fatigue and potential injuries.²⁶ Mental state significantly influences concentration and overall performance.²⁷Sports drinks, particularly carbonated ones used for rehydration can harm teeth due to their acidity and citric acid content, affecting the colour and integrity of dental composite resin restorations. Chlorination of swimming pools, aimed at reducing bacterial and algal growth, may lead to bio corrosion of enamel in swimmers, especially in water sports athletes, causing enamel loss in their anteriorteeth within two weeks.²⁸Dentists play a crucial role in sports settings by conducting comprehensive evaluations, identifying risks, and developing preventive strategies to mitigate sports-related injuries. Helmets and mouth guards are essential preventive measures in reducing injury risks. Sports dentistry, a growing field, focuses on managing and preventing athletic oral injuries, with dentists integrating into sports medical teams internationally. Postgraduate courses in sports dentistry emphasize orofacial trauma treatment and prevention.²⁹Early participation in school sports often leads to common orofacial injuries, primarily affecting the oro-maxillofacial region.

Dentists manage various injuries, including bone fractures, tooth-related issues like intrusion, luxation, crown, and root fractures, as well as temporomandibular joint injuries, tooth wear, abrasions, and lacerations. Protective measures such as mouth guards, helmets, and specialized gear significantly reduce these risks.³⁰School sports coordinators should understand potential dental injuries and preventive strategies. Training sessions for sports teachers and trainers should highlight sports-related dental injuries, particularly concerning maxillary central incisors. These injuries can be influenced by factors like training errors, inadequate competition preparation, weather conditions, playing surface quality, age, gender, co-morbidities like cerebral palsy and epilepsy, increased body mass, and nutritional status.³¹Dental professionals should engage with the sports community to integrate dentistry into sports settings, advocated by Jackson for "team dentists" across all sports levels. This approach ensures thorough care and timely intervention for sports-related dental injuries.³²Advancing sports dentistry in India requires a multifaceted approach to increase awareness and preparedness for orofacial injuries among athletes. Systematic reviews and meta-analyses focused on these injuries can provide comprehensive, evidence-based information essential for developing effective preventive strategies and treatments.³³Currently, awareness of sports dentistry as a specialized field in India is inadequate, leading to a lack of readiness for managing sports-related dental traumas. To address this, it's crucial to implement training programs for teachers and coaches on recognizing and handling dental emergencies. Equipping them with emergency dental kits can ensure prompt response during critical situations in sports settings. Regular off-season dental assessments for athletes are also essential preventive measures.³

These assessments help identify pre-existing dental issues that could be exacerbated during sports activities, allowing for timely interventions to minimize risks. Dental professionals play a pivotal role in advocating for sports dentistry. They should educate colleagues, athletes, coaches, and parents about the importance of oral health in sports and the use of protective equipment like custom mouth guards.³⁵Prosthodontists and orthodontists are particularly instrumental in developing and producing highquality mouth guards tailored to athletes' needs. There is potential for innovation in oro-maxillofacial gear that could administer substances like glucose or analgesics to prevent dehydration and manage pain during sports activities. Increasing awareness among medical professionals and athletes about such advancements is critical for improving overall safety and performance. In sports where there's a high risk of orofacial injuries, like football and boxing, it's important to mandate the use of helmets, face masks, and mouth guards.³⁶ Mouth guards, originally known as "gum shields," were first developed in 1890 by London dentist Woolf Krause to protect boxers from lip lacerations during common boxing matches of that time. They are effective in safeguarding teeth against fractures and luxation injuries, as well as preventing soft tissue bruises and cuts.³⁷ Additionally, mouth guards help reduce the likelihood of concussions and neck injuries by providing a barrier between the condylar head and the base of the skull. Their protective features, such as high impact absorption and distribution, also help prevent jaw fractures, dislocations, and other temporomandibular joint injuries.³⁸ The prevalence of mouth guards among athletes is growing, especially in sports like boxing, rugby, football, and ice hockey, where they are mandatory. There are three main types of mouth guards. Stock mouth guards are premade from materials such as rubber or polyvinyl acetate copolymer. While affordable and readily available, they are bulky, non-adjustable, uncomfortable, and can hinder breathing and speech.

Mouth-formed protectors come in two types. Shell-liner mouth guards involve applying ethyl methacrylate onto a hard shell, while thermoplastic lining, or "boil and bite," provides better fit and comfort by

molding to the teeth after being immersed in boiling water. Custom-made mouth guards, created by dentists from dental impressions, offer superior fit, stability, and comfort despite being more expensive.³⁹ Helmets are crucial for protecting the scalp, ears, and skull from injuries like fractures and concussions, using materials like polycarbonate and advanced polymers with inner padding for impact absorption. Face guards shield facial areas from impacts using materials such as plastic, rubber, or metal tubing coated with vinyl.⁴⁰ Nasal shields made from ethylene vinyl acetate reduce the risk of nasal fractures, while protective evewear prevents eye injuries without compromising vision clarity. To advance sports dentistry, integrating it into dental education and offering specialized courses can enhance dental professionals' awareness and skills in managing sports-related orofacial injuries. Collaborative efforts among dental teams dedicated to sports dentistry ensure comprehensive care, encompassing prevention, education, and tailored emergency responses.⁴¹ These initiatives are crucial for promoting oral health and reducing the incidence of sports-related traumatic injuries on a global scale. In sports dentistry, dentists play a pivotal role in advocating for the proper use of protective equipment such as mouthguards, helmets, and face masks. They conduct educational outreach and deliver training on correct device usage to athletes, coaches, and guardians. Emergency management kits are prepared to facilitate swift intervention in dental injury cases, containing essentials like saline solutions, sterile gloves, and spare mouth guards.Athletes wearing braces are particularly vulnerable to oral injuries during sports due to the brackets potentially causing cuts inside the mouth upon impact. Common injuries include cuts to the cheeks, lips, and tongue, which may vary in severity.⁴²

Immediate care is crucial for managing these injuries, with minor cases often treated using saltwater rinses. Severe injuries, such as cracks extending into the dentin or pulp of the tooth, require urgent dental attention. Avulsion, where a tooth is completely knocked out, is a critical dental emergency ideally managed by immediate replantation or preservation in media like saline or milk until professional care is available.⁴³Dislocation of the temporomandibular joint is another potential injury requiring prompt evaluation and treatment to restore normal function and prevent long-term complications. Orthodontic emergencies, including root fractures and broken brackets or bands, frequently occur due to impacts during sports activities or contact with other players. These incidents can lead to irritation of surrounding tissues, such as cuts in the cheeks or gums, or loose wires that can poke and irritate the mouth.⁴⁴ To mitigate such risks, wearing a mouth guard is highly recommended during sports activities. Orthodontic mouth guards typically made of silicone, offer cushioning for the lips and protection against impacts that could dislodge braces or damage teeth. They are preferred for their comfort and ability to accommodate braces, unlike traditional hard plastic mouth guards that may not fit well and can exacerbate injuries if impacted. Treatment options for sports-related mouth injuries include temporary removable appliances for healthy adjacent teeth, conventional removable partial dentures, or fixed prostheses.⁴⁵ Athletes in contact sports may benefit from clip bar over dentures, while osseointegrated implants provide effective tooth replacement options. Immediate placement in avulsed tooth sockets requires careful patient selection for successful outcomes. During the sports season, resilient prostheses and protective appliances are essential, transitioning to screw-retained non-removable prostheses during the off-season. Osseointegrated implants using the Branemark method are considered conservative and effective for both partially and fully edentulous patients.⁴⁶

Endodontic treatment plays a significant role in managing dental injuries that affect the dental pulp and root canal system. Traumatic injuries such as fractures, luxations, and avulsions often necessitate prompt endodontic intervention to save the tooth and restore function. Diagnostic tests such as pulp vitality testing and radiographic examinations help determine the extent of the injury. If the dental pulp is irreversibly damaged due to trauma, root canal treatment is performed to remove the infected or damaged pulp tissue, disinfect the root canal system, and seal it to prevent further infection. Revascularization procedures may be considered for immature teeth to encourage the growth of new tissue inside the root canal.Following endodontic treatment, the tooth may require restoration, such as placement of a dental crown, especially if it has suffered extensive damage or requires cosmetic improvement. Sports dentistry emphasizes preventive strategies to minimize the risk of dental trauma, advocating for the use of custom-made mouth guards to reduce the impact of facial blows and protect teeth during sports activities. Education and awareness campaigns led by dentists and sports medicine professionals are crucial in promoting dental trauma prevention and ensuring prompt dental care following injuries.⁴⁷

III. Conclusion

Today's sports demand peak performance and well-being. Integrative practices merge physical therapy, sports psychology, nutrition, and technology to meet athletes' complex needs. This approach not only aids recovery and boosts performance but prevents future injuries. It shifts focus from reactive to proactive care, promoting resilience and longevity through athlete education on prevention, recovery, and lifestyle adjustments.

Innovations like wearables and data analytics revolutionize sports medicine, offering real-time insights for personalized interventions and informed decision-making. Embracing this multidimensional approach optimizes athlete care, deepens performance understanding, and advances sports science.

Financial support and sponsorshipNil

Conflicts of interest There are no conflicts of interest

References

- Andreasen JO, Ravn JJ. Epidemiology of traumatic dental injuries to primary and permanent teeth in a Danish population sample. Int J Oral Surg. 1972; 1:235–9.
- [2]. Andersson L, Andreasen JO, Day P, Heithersay G, Trope M, Diangelis AJ, et al. International Association of Dental Traumatology guidelines for the management of traumatic dental injuries: 2. Avulsion of permanent teeth. Dent Traumatol. 2012; 28:88–96.
- [3]. Meadow D, Lindner G, Needleman H. Oral trauma in children. Pediatr Dent. 1984; 6:248–51. Kumamoto D, Maeda Y. Global trends and epidemiology of sports injuries. J Pediatr Dent Care. 2005; 11:15–25.
- [4]. Kumamoto DP, Maeda Y. A literature review of sports-related orofacial trauma. Gen Dent. 2004; 52:270–80.
- [5]. Takeda T, Ishigami K, Nakajima K, Naitoh K, Kurokawa K, Handa J, et al. Are all mouthguards the same and safe to use? Part 2. The influence of anterior occlusion against a direct impact on maxillary incisors. Dent Traumatol. 2008; 24:360–5.
- [6]. Meade, Maurice. Sports mouthguards and orthodontic treatment. Dental Update.2018; 45: 848-858.
- [7]. Berger TD, Kenny DJ, Casas MJ, Barrett EJ, Lawrence HP. Effects of severe dentoalveolar trauma on the quality-of-life of children and parents. Dent Traumatol. 2009; 25:462–9.
- [8]. Adirim TA, Cheng TL. Overview of injuries in the young athlete. Sports Med. 2003; 33:75-81.
- [9]. García Bengoechea E, Sabiston CM, Ahmed R, Farnoush M. Exploring links to unorganized and organized physical activity during adolescence: The role of gender, socioeconomic status, weight status, and enjoyment of physical education. Res Q Exerc Sport. 2010; 81:7–16.
- [10]. Onyeaso CO, Adegbesan OA. Knowledge and attitudes of coaches of secondary school athletes in Ibadan, Nigeria regarding orofacial injuries and mouth guard use by the athletes. Dent Traumatol. 2003; 19:204–8.
- [11]. Francisco SS, de Souza Filho FJ, Pinheiro ET, Murrer RD, de Jesus Soares A. Prevalence of traumatic dental injuries and associated factors among Brazilian schoolchildren. Oral Health Prev Dent. 2013; 11: 31–38.
- [12]. Cortes MI, Marcenes W, Sheiham A. Impact of traumatic injuries to the permanent teeth on the oral health-related quality of life in 12-14-year-old children. Community Dent Oral Epidemiol. 2002; 30:193–8.
- [13]. Bauss O, Röhling J, Schwestka-Polly R. Prevalence of traumatic injuries to the permanent incisors in candidates for orthodontic treatment. Dent Traumatol. 2004; 20:61–6.
- [14]. Bauss O, Freitag S, Röhling J, Rahman A. Influence of overjet and lip coverage on the prevalence and severity of incisor trauma. J Orofac Orthop. 2008; 69:402–10.
- [15]. Forsberg CM, Tedestam G. Etiological and predisposing factors related to traumatic injuries to permanent teeth. Swed Dent J. 1993; 17:183–90.
- [16]. Nguyen PM, Kenny DJ, Barrett EJ. Socio-economic burden of permanent incisor replantation on children and parents. Dent Traumatol. 2004; 20:123–33.
- [17]. Coto NP, Meira JBC, Dias RB, Driemeier L, Roveri GO, Noritomi PY. Assessment of nose protector for sport activities: finite element analysis. Dent Traumatol. 2012; 28:108-13.
- [18]. American Academy of Pediatric Dentistry. Policy on prevention of sports-related oro-facial injuries. Pediatr Dent 2003. 2002; 24:32.
- [19]. Tuna EB, Ozel E. Factors affecting sports-related orofacial injuries and the importance of mouthguards. Sports Med. 2014; 44:777– 83.
- [20]. Sane J. Maxillofacial and dental injuries in contact team sports. Proc Finn Dent Soc. 1988; 84 (Suppl 6-7):1–45.
- [21]. Robey JM, Blyth CS, Mueller FO. Athletic injuries. Application of epidemiologic methods. JAMA. 1971; 217:184-9.
- [22]. Deroche T, Stephan Y, Castanier C, Brewer BW, Le Scanff C. Social cognitive determinants of the intention to wear safety gear among adult in-line skaters. Accid Anal Prev. 2009; 41:1064–9.
- [23]. Gift HC, Reisine ST, Larach DC. The social impact of dental problems and visits. Am J Public Health. 1992; 82:1663–8.
- [24]. Ranalli Denis, Lancaster N, Diana M. Attitudes of College Football Coaches regarding NCAA mouth guard regulations and player compliance. J Public Health Dentistry. 1995; 55(3):139-142.
- [25]. Takahashi M, Koide K, Mizuhashi F, Sato T. Investigation of vacuum forming techniques for reduction of loss in mouth guard thickness: Part 2 – Effects of sheet grooving and thermal shrinkage. Dent Traumatol. 2015; 31:314–7.
- [26]. Kerr G, Fowler B. The relationship between psychological factors and sports injuries. Sports Med. 1988; 6:127-34.
- [27]. Heintz W. The case for mandatory mouth protectors. Phys Sportsmed. 1975; 3:61-3.
- [28]. Cantu RC, Mueller FO. The prevention of catastrophic head and spine injuries in high school and college sports. Br J Sports Med. 2009; 43:981–6.
- [29]. Chaconas SJ, Caputo AA, Bakke NK. A comparison of athletic mouthguard materials. Am J Sports Med. 1985; 13:193-7.
- [30]. Mihalik JP, Blackburn JT, Greenwald RM, Cantu RC, Marshall SW, Guskiewicz KM. Collision type and player anticipation affect head impact severity among youth ice hockey players. Pediatrics. 2010; 125:e1394–401.
- [31]. Auerbach SM, Laskin DM, Kiesler DJ, Wilson M, Rajab B, Campbell TA. Psychological factors associated with response to maxillofacial injury and its treatment. J Oral Maxillofac Surg. 2008; 66:755–61.
- [32]. Kaba AD, Maréchaux SC. A fourteen-year follow-up study of traumatic injuries to the permanent dentition. ASDC J Dent Child. 1989; 56:417–25.
- [33]. Andreasen JO. Etiology and pathogenesis of traumatic dental injuries. A clinical study of 1,298 cases. Scand J Dent Res. 1970; 78:329–42.
- [34]. Andreasen JO. Effect of extra-alveolar period and storage media upon periodontal and pulpal healing after replantation of mature permanent incisors in monkeys. Int J Oral Surg. 1981;10:43–53.
- [35]. Wallkamm B, Ciocco M, Ettlin D, Syfrig B, Abbott W, Listrom R, et al. Three-year outcomes of Straumann bone level slactive dental implants in daily dental practice: A prospective non-interventional study. Quintessence Int. 2015; 46:591–602.
- [36]. Ma S, Fenton A. Screw- versus cement-retained implant prostheses: A systematic review of prosthodontic maintenance and complications. Int J Prosthodont. 2015; 28:127–45.

- [37]. Jivraj S, Chee W. Treatment planning of implants in the aesthetic zone. Br Dent J. 2006; 201:77-89.
- [38]. Handelsman M. Surgical guidelines for dental implant placement. Br Dent J. 2006; 201:139–52.
- [39]. Schatz JP, Hakeberg M, Ostini E, Kiliaridis S. Prevalence of traumatic injuries to permanent dentition and its association with overjet in a Swiss child population. Dent Traumatol. 2013; 29: 110–114.
- [40]. Mizuhashi F, Koide K, Takahashi M. Variations in mouthguard thickness according to fabrication method. Dent Traumatol. 2015; 31:130–5.
- [41]. Bastone EB, Freer TJ, McNamara JR. Epidemiology of dental trauma: a review of the literature. Aust Dent J. 2000; 45: 2-9.
- [42]. Nguyen Q, Bezemer P, Habets L, Prahl-Andersen B. A systematic review of the relationship between overjet size andtraumatic dental injuries. Eur J Orthod. 1999; 21: 503-515.
- [43]. Salam S, Caldwell S. Mouthguards and orthodontic patients. J Orthod. 2008; 35: 270-275.
- [44]. Tommasone BA, Valovich McLeod TC. Contact sport concussion incidence. J Athl Train. 2006; 41:470-2.
- [45]. O'Malley M, Evans DS, Hewson A, Owens J. Mouthguard use and dental injury in sport: a questionnaire study of national school children in thewest of Ireland. J Ir Dent Assoc. 2012; 58: 205–211.
- [46]. Kola MZ, Shah AH, Khalil HS, Rabah AM, Harby NM, Sabra SA, et al. Surgical templates for dental implant positioning; current knowledge and clinical perspectives. Niger J Surg. 2015; 21:1–5.
- [47]. Newsome PR, Tran DC, Cooke MS. The role of the mouthguard in the prevention of sports-related dental injuries: a review. nt J Paediatr Dent. 2001;11: 396–404.
- [48]. McClelland C, Kinirons M, Geary L. A preliminary study of patient comfort associated with customised mouthguards. Br J Sports Med. 1999; 33:186–189.