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## Aapd guidelines for avulsed tooth

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They were subsequently reviewed and approved by the members of the IADT Board of Directors. The purpose of these guidelines is to provide doctors with the most widely accepted and scientifically reliable approaches to immediate or urgent care of avulsed permanent teeth. The IADT does not and cannot guarantee favourable results from compliance with the guidelines. However, the IADT believes that their use can maximize the likelihood of beneficial results. Avulsion of solid teeth is observed in 0.5%-16% of all tooth injuries.<sup>1, 2</sup> Numerous studies have shown that this injury is one of the most serious tooth injuries, and the prognosis is very dependent on the actions taken at the site of the accident and immediately after avulsion.<sup>3-17</sup> Refilling is in most cases the treatment of choice, but it can not always be carried out immediately. Proper crisis management and treatment plan are important for a good prognosis. There are also individual situations where re-planting is not advisable (eg, severe periodontal disease or disease, patient reluctant to cooperate, serious cognitive impairment requiring sedation, severe diseases such as immunosuppression, and severe heart disease), which must be considered individually. Although replanting can save the tooth, it is important to realize that some of the avulsed teeth have a low probability of long-term survival and may be lost or doomed to extraction at a later stage. However, not replanting a tooth is an irreversible decision and therefore it is necessary to try to save it. Therefore, recent studies have shown that avulsed teeth are more likely to survive long-term after following IADT treatment guidelines compared to previous studies.<sup>18</sup> Guidelines for managing sudden oral injuries are useful for providing the best possible care in an effective way. International Association Dental Practice (IADT) has developed a consensus statement following an update of the dental literature and a discussion between Group. The groups included experienced international scientists and clinicians from various specialties and general dentistry. In cases where the data did not appear conclusive, the recommendations were based on the best available evidence, consensus opinions and, in some situations, majority decisions of the IADT Board members. The guidelines should therefore be seen as up-to-date best evidence and practices based on research into literature and professional opinion. The guidelines should help dentists, other healthcare professionals and patients make decisions. In addition, they should be clear, understandable and practical in order to provide adequate care as effectively and effectively as possible. The guidelines are to be applied together with a doctor's assessment of specific clinical circumstances and patient characteristics, including but not limited to compliance, finances and understanding of the immediate and long-term results of alternative treatments compared to treatment. IADT cannot and does not guarantee favorable results with strict adherence to the guidelines, but believes that their use can maximize the chances of a favorable outcome. The guidelines are periodic. The following guidelines of the International Association of Dental Traumatology (IADT) provide an overview and update of previous guidelines, which were published in 2012.<sup>19-21</sup> In these IADT guidelines for the management of avulsed permanent teeth, literature has been searched using Medline and Scopus databases using search words: avulsion, lubrication and replanting. The Task Force discussed treatment in detail and reached consensus on what should be recommended as current best practice in crisis management. The purpose of this text is to provide concise and necessary advice on emergency treatment. The final decision on patient care remains primarily with the attending physician. However, it is up to the patient, parent or guardian to agree to the final decision. For ethical reasons, it is important that the dentist provides the patient and caregiver with relevant treatment information to ensure maximum involvement in the decision-making process. Dentists should be prepared to give appropriate advice to the public on first aid for avulsed teeth.<sup>2, 11, 22-27</sup> Avulsed permanent tooth is one of the few real emergency situations in dentistry. In addition to raising public awareness through mass media campaigns or other means of communication, parents, carers and teachers should be given information on how to deal with these serious and unexpected injuries. In addition, instructions can be given by phone to people in the emergency area. Immediate replanting of the avulsed tooth is the best treatment at the site of the accident. If for some reason this cannot be done, there are such as using different types of storage media. If the tooth is avulsed, make sure that it is a permanent tooth (primary teeth should not be replanted) and follow the recommended instructions: Keep the patient calm. Find the tooth and lift it behind the crown (white part). Avoid touching the root. Try to put it back in the jaw immediately. If the tooth is soiled, it should be gently rinsed with milk, saline or saliva of the patient and re-planted or restored to its original position in the jaw.<sup>28, 29</sup> It is important to encourage the patient/caregiver/teacher/other person to immediately replant the tooth at the emergency site. When the tooth returns

to its original position in the jaw, the patient should bite gauze, handkerchief or napkin to keep it in place. If repainting at the site of the accident is not possible, or for other reasons, when it is not possible to repaint the avulsed tooth (e.g. unconscious patient), place the tooth as soon as possible in a carrier or transport medium that is immediately available at the emergency site. This should be done quickly to avoid dehydration of the root surface, which begins to happen in a few minutes. In descending order of preference, milk, HBSS, saliva (after spitting into a glass for example), or saline are suitable and convenient storage carriers. Although water is a weak medium, it is better to leave the tooth to dry in the air.28, 29 Tooth can then be brought with the patient to the emergency clinic. Immediately Sat. dentist or dentist. The Save a Tooth poster is available in many languages: Arabic, Basque, Bosnian, Bulgarian, Catalan, Czech, Chinese, Dutch, English, Estonian, French, Georgian, German, Greek, Hausa, Hebrew, Hindi (India), Hungarian, Icelandic, Indonesian Bahasa, Italian, Kannada (India), Korean, Latvian, Marathi (India), Persian, Polish, Portuguese, Russian, Synga, Slovenian, Spanish, Thames (India), Thai, Turkish, Ukrainian and Vietnamese This educational resource can be obtained from the IADT website: [dentaltrauma.org](http://dentaltrauma.org) The free IADT app, ToothSOS for mobile phones, is another useful source of information for patients, providing instructions on what to do in an emergency after a tooth injury, including permanent tooth ovulation. The choice of treatment is related to the maturity of the root (open or closed vertex) and the condition of the periodontal ligament (PDL). The condition of PDL cells depends on the time outside the mouth and on the media in which the collapsed tooth was stored. Minimizing dry time is crucial for the survival of PDL cells. After a 30-minute drying time, most PDL cells are incapable of life.30, 31 For this reason, it is very important to get information about the dry tooth time before overdosing or before placing them in storage media. From a clinical point of view, it is important that your doctor assesses the condition of PDL cells by classifying the annunciated tooth into one of the three groups before treatment: PDL cells are most likely to be able to live. The tooth was transplanted immediately or in a very short time (about 15 minutes) at the site of the accident. PDL cells can be cost-effective, but at risk. The tooth was stored in a storage environment (e.g. milk, HBSS (Save-a-Tooth or similar product), saliva or saline, and the total extra-oral dry time was 81t:60 minutes). PDL cells may be unprofitable. The total extra-oral dry time is more than 60 minutes, regardless of whether the tooth was stored in the substrate or not. These three groups provide guidance from the dentist on tooth prognosis. Although there are exceptions to the prognostication, treatment will not change, but it can guide the doctor's decisions. Clean the affected area with water, saline or chlorhexidine. Check the correct position of the tooth, both clinically and radiographically. Leave the tooth/teeth in place (except where the tooth is positioned incorrectly; incorrect positioning should be corrected with little digital pressure). Administer local anesthesia, if necessary, and preferably without vasodilators. If the tooth or teeth have been exaggerated in the wrong nest or rotated, consider changing the position of the tooth/teeth to the right place up to 48 hours after the traumatic incident. Stabilize the tooth for 2 weeks with a passive elastic rail, such as a wire up to 0.016 or 0.4 mm32 in diameter connected to the tooth and adjacent teeth. Keep composite and binding agents away from gingival tissues and proximal areas. Alternatively, the nylon line (0.13-0.25 mm) can be used to create an elastic rail, using a composite to connect it to the teeth. Nylon (fishing line) rails are not recommended for children when there are only a few solid teeth to stabilize the traumatic tooth. This stage of development may cause loosening or loss of the rail.33 In the case of the associated fracture of the extrusion-maxillary follicle, a more rigid rail is indicated, which should remain in place for about 4 weeks. Gum seams lacerations, if present. Start channel therapy within 2 weeks after repacking (see Endodontic Considerations). Administer systemic antibiotics.34, 35 (see Antibiotics) Check tetic state.36 (see Teter) Postoperative instructions should be given. (see patient's instructions) Next steps. (see Follow-up procedures) Physiological storage carriers include tissue culture carriers and cellular transport. Examples of sustainable osmolality carriers are milk and a sustainable Hanks salt solution (HBSS). In the event of visible contamination, rinse the surface of the roots with a stream of saline or osmolality carriers to remove impurities. Check that the tooth is hairy for surface impurities. Remove any impurities by gently stirring them on the carrier, a stream of saline can be used to rinse its surface for a short time. Place the tooth or leave it in the media while making history by examining the clinically and radiologically and preparing the patient for repacking. Administer local anesthesia, preferably without a narrowing blood vessel.37 Irrigate the socket with sterile saline. Examine the socket of the extrusion-dental follicle. If there is a fracture of the cavity wall, change the position of the cracked fragment to its original position with the help of a suitable instrument. Removing the coagulum with a stream of saline can allow for a better position of the tooth. Transplant the tooth slowly with little digital pressure. Excessive force should not be used to re-plant the tooth back to its original position. Check the correct position of the tooth, both clinically and radiographically. Stabilize the tooth for 2 weeks with a passive, flexible wire up to 0.016 or 0.4 mm.32 Keep composite and binding agents away from gingival tissues and proximal areas. Alternatively, the nylon line (0.13-0.25 mm) can be used to create an elastic rail, using a composite to connect it to the teeth. Nylon (fishing line) rails are not recommended for children when there are only a few solid teeth to stabilize the traumatic tooth. This stage of development may cause loosening or loss of the rail.33 In the case of the associated fracture of the deep follicle or jaw bone, a more rigid rail is indicated, which should remain in place for about 4 weeks. Gum seams lacerations, if present. Start channel therapy within 2 weeks after re-re-treatment (see Endodontic considerations).38, 39 Administer systemic antibiotics.34, 35 (see Antibiotics) Check tetic state.36 (see Tetic cord) Postoperative instructions should be given. (see postoperative instructions) Next steps. (see Follow-up procedures) Remove loose impurities and visible impurities by mixing the tooth in a physiological storage medium or with gauze saturated with saline. The tooth can be left in the carrier while making history, examining the patient clinically and radiographically, and preparing the patient for reemploying. Administer local anesthesia, preferably without vasodilators. Irrigate the nest with sterile saline. Examine the socket of the extrusion-dental follicle. If necessary, remove the coagulum. If there is a fracture of the wall of the nest, change the position of the cracked fragment with the help of a suitable instrument. Transplant the tooth slowly with little digital pressure. The tooth should not be forced back into place. Check the correct position of the tooth, both clinically and radiographically. Stabilize the tooth for 2 weeks40 with a passive elastic wire up to 0.016 or 0.4 mm.32 Keep composite and binding agents away from gingival tissues and proximal areas. Alternatively, a nylon line (0.13-0.25 mm) can be used to create an elastic rail, with a composite to tie it to the teeth. A more rigid rail is indicated in case of a fracture or jaw bone and should remain in place for approximately 4 weeks. Gum seams lacerations, if present. Canal therapy should be carried out within 2 weeks (see Endodontic Endodontic Administer systemic antibiotics.34, 35 (see Antibiotics) Check tetic state.36 (see Teter) Postoperative instructions should be given. (see Postoperative instructions) Next steps. (see Follow-up procedures) Delayed repacking has a weak long-term prognosis.41 Periodontal ligament becomes necrotic and is not expected to regenerate. The expected result is root resorption associated with stiffening of stiffening. The purpose of repainting in these cases is to restore, at least temporarily, aesthetics and functions while maintaining the contour of the extrusion-recessed bone, width and height. Therefore, the decision to replant a fixed tooth is almost always the right decision, even if the extra-auche dry time is more than 60 minutes. Repeating will keep future treatment options open. The tooth can always be extracted, if necessary, and at the right time after a quick interdisciplinary assessment. Parents of pediatric patients should be advised that decoronation or other procedures, such as self-transplantation, may be necessary later if the transplanted tooth is stiffened and placed in infrared, depending on the patient's growth rate41-46 and the likelihood of possible tooth loss. The rate of stiffening and resorption varies greatly and can be unpredictable. Clean the area with water, saline or chlorhexidine. Check the correct position of the tooth, both clinically and radiographically. Leave the tooth in the jaw (except when the tooth is positioned incorrectly; incorrect positioning should be corrected with little digital pressure). Administer local anesthesia, if necessary, and preferably without vasodilators. If the tooth or teeth have been exaggerated in the wrong nest or rotated, consider changing the position of the tooth/teeth to the right place up to 48 hours after the injury. Stabilize the tooth for 2 weeks with a passive and flexible wire up to 0.016 or 0.4 mm.32 Short immature teeth may require a longer sewing time.47 Keep composite and bonding agents away from gingival tissues and proximal areas. Alternatively, the nylon line (0.13-0.25 mm) can be used to create an elastic rail, using a composite to connect it to the teeth. In the case of the associated fracture of the extrusions-maxillary follicle, a more rigid rail is indicated, which should remain in place for 4 weeks. Gum seams lacerations, if present. Revascularization of pulp, which can lead to further development of the roots, is the goal when repacking immature teeth in children. The risk of root resorption associated with external infection should be considered in relation to the chances of revascularization. Such resorption is very rapid in children. If there is no spontaneous revascularisation, apex, revitalisation/revascularisation of the yak,48, 49 or treatment should be started immediately after the identification of pulp necrosis and infection (see Endodontic considerations). Administer systemic antibiotics.34, 35 (see Antibiotics) Check tee condition.36 (see Teter) Post-operative instructions must be provided. (see postoperative instructions) Next steps. (see Follow-up procedures) In immature teeth with open apices, there is a possibility of spontaneous healing to occur in the form of new connective tissue from vascular supplies. This allows further development and maturation of the roots. Therefore, endodontic treatment should not be started unless there are clear signs of parasitic necrosis and infection of the ductal system in subsequent meetings. Examples of physiological carriers or weighted osmolalities are milk and HBSS. Check the hairy tooth and remove debris from its surface by gently stirring it in the carrier. Alternatively, a stream of sterile saline or physiological medium can be used to rinse its surface. Place or leave the tooth in the carrier while taking the history, examining the patient clinically and radiologically and preparing the patient for reemploying. Administer local anesthesia, preferably without vasodilators. Irrigate the nest with sterile saline. Examine the socket of the extrusion-dental follicle. If necessary, remove the coagulum. In case of fracture of the cavity wall, change the position of the cracked segment with the help of a suitable instrument. Transplant the tooth slowly with little digital pressure. Check the correct position of the tooth, both clinically and radiographically. Stabilize the tooth for 2 weeks with a passive and elastic wire up to 0.016 or 0.4 mm.32 Keep composite and binding agents away from gingival tissues and proximal areas. Alternatively, a nylon line (0.13-0.25 mm) can be used to create an elastic rail, with a composite to tie it to the teeth. In the case of the associated fracture of the extrusions-maxillary follicle, a more rigid rail is indicated, which should remain for about 4 weeks. Gum seams lacerations, if present. Revascularization of pulp space, which can lead to further development of the roots, is the goal when repacking immature teeth in children. The risk of root resorption associated with external infection should be considered in relation to the chances of revascularization. Such resorption is very rapid in children. If spontaneous revascularisation, apex, revitalisation/revascularisation of the parasei or canal treatment does not occur, treatment should be started immediately after the identification of myecavity necrosis and infection (see Endodontic Considerations). Administer systemic antibiotics.34, 35 (see Antibiotics) Check tetic state.36 (see Teter) Postoperative instructions should be given. (see postoperative instructions) Next steps. (see Follow-up procedures) Delayed repacking has a weak long-term prognosis.41 Periodontal ligament becomes necrotic and is not expected to regenerate. The expected result is root resorption associated with stiffening of stiffening. The purpose of repainting in these cases is to restore aesthetics and function, at least temporarily, while maintaining the contour of the extrusion bone, width and height. Therefore, the decision to replant the tooth is almost always the right decision, even if the overtime time is more than 60 minutes. Repeating will keep future treatment options open. The tooth can always be extracted later, if necessary, and at the right time after a quick interdisciplinary assessment. Parents should be advised that decoronation or other procedures, such as self-transplantation, may be necessary if the depleted tooth is stiffened and placed on infrared depending on the patient's growth41-46 and the likelihood of tooth loss. The rate of stiffening and resorption varies greatly and can be unpredictable. The best treatment for a hairy tooth is immediate repainting at the site of an accident, which is usually not painful. While local anesthesia is not available when teeth are transplanted at the site of injury, when the patient to a dental or medical institution, pain control with local anesthesia is always recommended.50-55 There are concerns as to whether there is a concern if there is a risk of deterioration of healing by the use of a narrowing blood vessel in an anesthetic solution. However, there is little evidence to support the omission of constricting blood vessels in the oral and maxillofacial region. Regional anaesthesia (e.g. Intraoral nerve block) can be considered as an alternative to infiltration anesthesia in more severe cases of injuries and must be determined by the doctor's experience in providing such block injections.51, 52 Although the value of systemic antibiotic administration is highly questionable, periodontal dental ligaments often become contaminated by bacteria from the mouth, memory carrier or the environment in which ovulation occurred. Therefore, it is recommended to use systemic antibiotics after ovulation and re-planting to prevent infection-related reactions and reduce the occurrence of inflammatory root resorption.34, 35 In addition, the patient's health status or concomitant injuries may justify antibiotic coverage. In all cases, the appropriate dose should be calculated for the patient's age and weight. Amoxicillin or penicillin remain the first choice due to their effectiveness in the form of oral flora and the low incidence of side effects. Alternative antibiotics should be considered in patients with penicillin allergy. The efficacy of tetracycline administered immediately after ovulation and re-planting has been demonstrated in animal models.35 In particular, proxicin is an appropriate antibiotic for use due to its antibacterial, anti-inflammatory and anti-reinixtic effects. However, prior to systemic administration of tetracycline in young patients, the risk of permanent tooth discoloration should be considered. Tetracycline or doxycycline is not generally recommended in patients under the age of 12 years.56 The topical effect of antibiotics placed on the root surface prior to residuality with regard to revascularisation of the lumbar remains controversial.8, 57, 58 While animal studies have shown great potential,59-61 human studies have not shown improvements in the revascularization of the lumby clumsy when teeth are soaked in topical antibiotics.62 Therefore, a specific antibiotic cannot be prescribed, duration of use or methods of use based on human studies (see future areas of research). Although most people receive tectitics and booster vaccinations, it cannot be assumed that this is always the case.36, 63, 64 Refer the patient to the doctor to assess the need for tee tee tee booster. Pinched teeth always need stabilization to keep the exaggerated tooth in the right position, provide patient comfort and improve functions.32, 47, 65-72 Current evidence supports short-term, passive and flexible rails to stabilize resettled teeth. Studies have shown that periodontal and pulp healing is promoted if the exaggerated tooth is subjected to little mobility and function,66 achieved by stainless steel wire with a diameter of 0.016 or 0.4 mm32 or nylon (0.13-0.25 mm) and combined with composite resin teeth. Exaggerated solid teeth should be stabilized for a period of 2 weeks depending on the length and degree of maturation of the root. An animal study has shown that that more than 60% of the mechanical properties of the injured PDL return within 2 weeks after injury.69 However, the likelihood of successful periodontal healing after the relantation must not affect the duration of the rail.47 Wire (or nylon line) and composite stabilization should be placed on the playable surfaces to avoid occlusive disturbances and allow access to palace/linguistic procedures for endodontic procedures. Various types of wire (or nylon line) and acid etching glued stabilization have been used to stabilize avulsed teeth because they allow for good oral hygiene and are well tolerated by patients.72 It is extremely important to keep composite and binding agents away from marginal gingiva and interproximal areas to avoid plaque retention and secondary infection, and allow relatively easy cleaning by the patient. The patient and parent should be informed that after removal of the rail, the injured tooth can be mobile. An additional week of sewing is suitable only if excessive injuries from the opposite dentition can further offend the tooth or if the curled tooth is not able to remain in the correct position. This assessment should be carried out after removal of the rail and checking the octopus. Patient compliance with follow-up visits and home care contributes to satisfactory post-injury treatment.2, 24, 25, 27, 29 Both patients and parents or caregivers of young patients should be advised to care for the tooth to optimally treat and prevent further injuries. They should be advised: Avoid participating in contact sports. Maintain a soft diet for up to 2 weeks according to the patient's tolerance.65 Brush your teeth with a soft toothbrush after each meal. Use chlorhexidine (0.12%) twice daily for 2 weeks. When endodontic treatment is indicated (teeth with a closed vertex),17, 73-81 treatment should be started within 2 weeks after re-rest. Endodontic treatment should always be undertaken after isolation with the dental mother. This can be achieved by placing the dental barrier holder on adjacent undimled teeth to avoid further injuries to injured teeth/teeth. Calcium hydroxide is recommended as an endopental medicine for up to 1 month, and then filling with root canal.82, 83 If a mixture of corticosteroids or corticosteroids/antibiotics is selected as an anti-inflammatory and anti-reinixtic drug, it should be placed immediately or shortly after re-installation and left in place for at least 6 weeks.76, 78, 84 Drugs should be carefully applied to the root canal system with due care to avoid placing in the crown of the tooth. It has been shown that drugs discolor teeth, which leads to dissatisfaction of patients.77 In the teeth with spontaneous revascularisation of the cellulose space may occur. Canal therapy should therefore be avoided unless there is clinical or radiographic evidence of parasitic necrosis and infection of the root canal system during follow-up studies. The risk of root resorption associated with infection should be considered in relation to the chances of achieving revascularisation of cellulose space. Such resorption is very rapid in children. In cases where pulp necrosis and ductal system infection are diagnosed, ductal treatment, apex or revascularisation/revitalisation of cellulose space should be performed. In cases where ankylosis is expected and decoration is foreseen, due consideration should be given to the materials used inside and their duration. Removed teeth should be monitored clinically and radiologically after 2 weeks (after removal of the rail), 4 weeks, 3 months, 6 months, one year, and then every year for at least five years.2, 6-9, 25, 26, 85 Clinical and radiological examination will provide information to determine the outcome. The evaluation may include the results described below. In the case of open vertex teeth where spontaneous revascularisation of cellulose space is possible, clinical and radiographic reviews should be more frequent due to the risk of infection-related (inflammatory) resorption and rapid loss of tooth and support bone when this is not quickly identified. Evidence of root and/or bone resorption anywhere on the root circumference should be interpreted as infection-related resorption (inflammatory). Radiographic lack of space of periodontal ligaments, replacement of the root structure with bone, along with metal sound for drums, should be interpreted as a resorption associated with stiffness. It is worth noting that two types of resorption can occur simultaneously. For these reasons, exaggerated open-vertex teeth should be monitored clinically and radiologically after 2 weeks (after removal of the rail), 1, 2, 3, 6 months, one year, and every year thereafter for at least five years.2, 6-9, 25, 26, 85 Asymptomatic, functional, normal mobility, lack of sensitivity to percussion and normal percussion sound. No radiolucencies and no radiographic evidence of root resorption. Lamina dura seems normal. Asymptomatic, functional, normal mobility, lack of sensitivity to drums and normal drum sound. Radiographic evidence for further root formation and tooth eruption. Obliterate of the cellulose channel is expected and can be radiologically diagnosed sometime in the first year after the injury. It is believed that this is the mechanism by which the pulp is treated after re-re-re-evaluation of the ovulated, immature solid teeth.86 The patient may or may not have symptoms; the presence of edema or sinus tract; the tooth may have excessive movement or lack of mobility (stiffening) with high-tone (metallic) drum sound. The presence of radiolucencies. evidence of resorption associated with infection, infection, (replacement) of resorption or both. When an anaesthesia occurs in an increasingly rare patient, the infrared position of the tooth is highly likely to cause disorders of the growth of the alveost and facial vesicles in the short, medium and long term. The patient may or may not have symptoms; the presence of edema or sinus tract; the tooth may have excessive mobility or lack of mobility (stiffening) with tweeter drum sound. In the case of the tooth notebook can gradually become infrared. The presence of radiolucencies. Radiographic evidence of resorption associated with infection (inflammatory), resorption associated with antacids or lack of further formation of roots. When an anaesthesia occurs in an increasingly rare patient, the infrared position of the tooth is highly likely to cause disorders of the growth of the alveost and facial vesicles in the short, medium and long term. Complementary care requires good coordination between the initial treatment provider and secondary care specialists (e.g. interdisciplinary team such as an orthodontist and a pediatric dentist and/or endodontic surgeon) with appropriate experience and training in holistic management of complex dentine-follicular injury. The team will benefit from other specialists who will provide long-term care, such as a bridge, transplant or implant. In situations where access to an interdisciplinary team may not be possible, dentists can be expected to provide follow-up care and treatment only within their experience, training and competence. Patients or parents and children must be fully informed about the prognosis of the hairy tooth as soon as possible. They should be fully involved in the decision-making process. In addition, the potential costs and time needed for different treatment options should be discussed openly. In cases where teeth are lost in the emergency phase after injury, or are likely to be lost later, discussions with relevant colleagues who have experience in managing these cases are cautious, especially in growing patients. Ideally, these discussions should take place before the tooth shows signs of infrared position. Suitable treatment options may include sanitizing, autotransplantation, resin-exploded bridge, removable partial denture, or orthodontic space closure with or without composite resin modification. Treatment decisions are based on a full discussion with the patient or child and parents and the doctor's knowledge to keep all options open to maturity. The decision to perform decronation is made when the glazed tooth shows evidence of obstruction, which is considered unacceptable and can not be corrected by simple restorative treatment.41, 45 After the end of the growth, implant treatment may be considered. Readers shall be referred to the relevant manuals and articles in the journals for further reading of these procedures. developed a recent basic set of results (COS) for traumatic tooth injuries (TDI) in children and adults.87 adults.87 is one of the first COS developed in dentistry and is based on a robust consensus methodology and is based on a systematic review of the results used in the traumatic literature.88 A number of results were found to be repeated in different types of injuries. These results were then taken into account as general, which is relevant for all TDI. Results for the injury concerned were also established as these results concerned only one or more specific TDI. Additionally, the study determined what, how, when and by whom these results should be measured. Further information for each result is described in the original article.87 General results: Treatment of periodontal pulp healing space (for open teeth vertex) Pain discoloration Loss of teeth Quality of life Esthetics (patient perception) Trauma associated with dental anxiety Number of visits to the clinic Injury-specific results: Several promising procedures for treating annunciated teeth have been discussed in the consensus group. Some of these treatment suggestions have some experimental evidence and some are used in clinical practice. According to the members of the working group, there is currently insufficient mass or quality of clinical and/or experimental evidence for some of these methods to be recommended in these guidelines. The group advocates further research and documentation for the following: Cellulose Space Revascularization — see guidelines published by the American Endodontist Association (AAE)89 and the European Society of Endodontology (ESE).90 Optimal rail types and length of time for periodontal and pulp treatment. Effects on healing when a local anesthetic containing vasodilators is used. Effects of topical and systemic antibiotics on root healing and resorption. Effect of intracanal corticosteroids on root healing and resorption. Long-term development or establishment of an extrusion-dental comb after re-rest and decoration. The effect of periodontal regeneration on the restoration of normal functioning. Healing of periodontitis after re-re-re-relantation of teeth. Home care after replanting teeth. The authors confirm that they have no conflict of interest. No ethical approval was required for this document. These guidelines are intended to provide information to healthcare providers caring for patients with oral injuries. They are the current best evidence based on studies of literature and professional opinion. As with all guidelines, the healthcare provider must apply a clinical assessment based on the conditions in the traumatic situation. IADT does not guarantee favorable results from following the guidelines, but using recommended procedures can maximize your chances of success.1Glendor U, Halling A, Andersson L, Eilert-Peterson E. Incidence of traumatic tooth injuries in children and adolescents in Vastmanland County, Sweden. *Swed Dent J*. 1996; 20: 15–2Andreasen JO, Andreasen FM, Avulsion's TG. Andreasen. W: JO Andreasen, FM Andreasen, L Andersson, Andersson, Manual and color atlas of traumatic tooth injuries. Oxford: Wiley Blackwell, 2019; p. 486–520. 3Andreasen JO, Hjørring-Hansen E. Teeth replanting. I. 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