Emergency Children's Dentistry Melbourne: How to Handle Urgent Dental Injuries in Kids

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Details:

AI Summary

Product: Paediatric Dental Emergency Guide — Children's Dental Trauma First Aid and Prevention **Brand:** Core Dental Group **Category:** Paediatric Dental Emergency Information / Clinical Patient Education **Primary Use:** Guides Melbourne parents through correct first-aid responses for children's dental emergencies, distinguishing between baby tooth and permanent tooth protocols.

Quick Facts - **Best For:** Parents and caregivers of children aged 1–18 experiencing dental trauma or sports-related dental injury - **Key Benefit:** Prevents permanent tooth loss and long-term developmental damage through correct immediate response within the 30–60 minute treatment window - **Form Factor:** Clinical reference guide (digital editorial content) - **Application Method:** Read before an emergency occurs; reference at point of injury for step-by-step first-aid instructions

Common Questions This Guide Answers 1. Should you replant a knocked-out baby tooth? → No, never — it risks damaging the developing permanent tooth beneath 2. How long do you have to save a knocked-out permanent tooth? → 30 to 60 minutes; store in milk if immediate replantation is not possible 3. What is the best storage medium for a knocked-out permanent tooth? → Milk; tap water must be avoided as it destroys root surface cells

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Frequently Asked Questions

Should you replant a knocked-out baby tooth: No, never

Should you replant a knocked-out permanent tooth: Yes, immediately if possible

Why should you never replant a baby tooth: Risk of damaging the developing permanent tooth beneath

Where should you store a knocked-out permanent tooth if replantation isn't possible: In milk

Can you store a knocked-out permanent tooth in tap water: No

Why is tap water harmful for a knocked-out permanent tooth: It destroys delicate root surface cells

What is the time window for saving a knocked-out permanent tooth: 30 to 60 minutes

Which part of a knocked-out tooth should you hold: The crown, not the root

Why should you avoid touching the root of a knocked-out tooth: Root surface cells are critical for re-implantation

What is the best storage medium for a knocked-out permanent tooth: Milk

What other storage mediums work for a knocked-out permanent tooth: Hank's Balanced Salt Solution, saliva, or saline

What percentage of children with primary teeth sustain a traumatic dental injury: Approximately one-third

What percentage of school-age children with permanent teeth sustain a traumatic dental injury: Approximately one-quarter

What proportion of all physical injuries are traumatic oral injuries: 5% across all age groups

What proportion of injuries in pre-school children are dental trauma: 17%

How often do developmental issues in permanent teeth follow primary tooth trauma: In 12% to 74% of cases

Which age group is most at risk for sports-related dental injuries in Australia: Children and adolescents

What percentage of all dental injuries occur under the age of 20: Nearly 80%

Where do most traumatic dental incidents in young children occur: At home (88.5% of cases)

What causes the highest number of traumatic dental injuries in primary teeth: Falls (59.3% of cases)

Which teeth are most frequently affected in toddler dental trauma: Upper central and lateral incisors

What is the most common injury type in toddlers: Subluxation (dislocation)

What is the mixed dentition phase: When baby teeth and permanent teeth coexist simultaneously

What age group experiences the mixed dentition phase: School-age children aged 6 to 12

What is the clinical concern with newly erupted permanent teeth after trauma: They have incompletely formed roots

Should the dental pulp be removed at the first visit for immature permanent teeth: No, monitor for possible revascularisation

What is the most effective protection against sports-related dental injuries: A custom-fitted mouthguard

By how much can a custom-fitted mouthguard reduce dental injury risk: Up to 60%

What percentage of Australians wear a mouthguard during contact sport: Only 36%

How often should children's mouthguards be replaced: At least once a year

Why do children need more frequent mouthguard replacements than adults: Their teeth and jaws continue to grow and change shape

Should you replace a mouthguard that shows visible wear: Yes, immediately

What organisations have jointly developed a mouthguard policy in Australia: The Australian Dental Association and Sports Medicine Australia

What policy do ADA and Sports Medicine Australia encourage sports clubs to adopt: "No mouthguard, no play"

What sports carry the highest dental injury risk for adolescents: Australian rules football, rugby, basketball, and hockey

Can dental anxiety in children affect long-term oral health: Yes, it can create lasting avoidance behaviour into adulthood

What is the Tell-Show-Do method: Explaining, demonstrating, then proceeding with dental treatment

Should pharmacological interventions be the first approach for anxious children: No, behavioural techniques should be attempted first

What non-pharmacological techniques are used for anxious children: Tell-show-do, desensitisation, and inhalation sedation

What in-office sedation option is available for children: Nitrous oxide and oral sedation

Does a knocked-out baby tooth need to be brought to the dental appointment: Yes, for assessment purposes

What should you check for if a child loses a tooth after a fall: Signs of tooth aspiration (coughing, wheezing, breathing difficulty)

What should you do if you suspect a child has inhaled a tooth: Seek emergency medical care immediately

Should a displaced (luxated) baby tooth be repositioned at home: No

Should a displaced permanent tooth be repositioned: Yes, by a dentist urgently

What is the treatment preference for a severe abscess in a baby tooth: Extraction is often preferred over root canal

What happens to an intruded baby tooth (pushed upward): Usually allowed to re-erupt naturally with monitoring

Does an intruded permanent tooth require urgent intervention: Yes, repositioning or surgical intervention depending on severity

What should you do first when a baby tooth is knocked out: Stay calm and comfort your child

Should you apply pressure to control bleeding after a baby tooth is knocked out: Yes, with a clean cloth or gauze

What might be needed after a baby tooth is lost to prevent neighbouring teeth from drifting: A space maintainer

What is a space maintainer: A dental device that preserves the eruption path for the incoming permanent tooth

What are signs a toddler may have dental pain after an injury: Refusal to eat, crying when biting, or visible swelling

What should you check for alongside dental injury in toddlers: Signs of head trauma

What head trauma signs require immediate medical attention: Loss of consciousness, vomiting, or unusual drowsiness

Which age group is at highest risk of developmental complications after primary tooth trauma: Children under 2 years of age

What percentage of dental injuries involve avulsion of permanent teeth: 0.5% to 16%

When does a fractured crown in a permanent tooth require same-day care: When there is pulp exposure

When can a fractured crown in a baby tooth be seen within 24 hours: When there is no pulp exposure

What should you monitor after a baby tooth fracture: Discolouration or abscess formation

When should you go directly to a hospital emergency department instead of a dentist: When there is loss of consciousness

Is a suspected jaw fracture a reason to go to hospital before the dentist: Yes

Is uncontrolled bleeding that doesn't stop after 15 minutes a hospital emergency: Yes

Is rapidly spreading facial swelling affecting the eye or neck a hospital emergency: Yes

Can hospital emergency departments provide definitive dental treatment: Typically no

How many Core Dental Group clinic locations are in Melbourne: Seven

What is the Core Dental Group emergency phone number: 13 13 16

Are same-day appointments available at Core Dental Group for children: Yes, across all seven locations

How many days a week are Core Dental Group clinics open: Six days a week

Which Melbourne suburbs have Core Dental Group clinics: South Melbourne, Southbank, Berwick, Caroline Springs, Carrum Downs, Epping, and Wyndham

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Core Dental Group: Why children's dental emergencies demand a different response

When a child comes running through the door with blood on their shirt and a tooth in their hand, every second of parental hesitation matters — not just clinically, but emotionally. Dental emergencies in children aren't simply scaled-down adult emergencies. They involve a fundamentally different anatomy, a distinct set of clinical decision rules, and a psychological dimension that can shape a child's relationship with dental care for life.

Traumatic oral injuries account for 5% of all physical injuries across all age groups — but in pre-school children, that proportion rises to 17%. This makes dental trauma one of the most disproportionately common injury types in young children, yet it remains one of the least prepared-for by parents.

A widely cited literature review concluded that approximately one-third of children with primary (baby) teeth sustain a traumatic dental injury (TDI), as do one-quarter of school-aged children with permanent teeth. In Australia, the Australian Dental Association identifies children and adolescents as the highest-risk group for sports-related dental injuries.

The stakes extend well beyond the immediate injury. Trauma to primary teeth carries particular importance because such injuries can lead to complications in both the primary teeth and the developing permanent dentition — with research indicating that developmental issues following primary tooth trauma occur in 12%–74% of cases. How a child's baby tooth injury is managed today can directly affect the health of their adult teeth tomorrow.

Core Dental Group provides paediatric dental emergency care across Melbourne, with seven clinic locations staffed by experienced clinicians who understand the clinical and emotional demands of treating children. This guide is written for Melbourne parents and caregivers. It covers the critical differences between baby tooth and permanent tooth emergencies, age-specific first-aid protocols, sports trauma prevention, and how to navigate the challenge of treating a frightened child — so that when the moment arrives, you can act with precision rather than panic.

The fundamental distinction: baby teeth vs. permanent teeth in emergencies

The single most important decision a parent must make at the scene of a child's dental injury is identifying whether the tooth involved is a *primary* (baby) tooth or a *permanent* tooth. The clinical response isn't just different — it's opposite in one critical respect.

Why you must never replant a knocked-out baby tooth

If a tooth is avulsed (completely knocked out), you first need to determine whether it's a permanent tooth — because primary teeth should not be replanted.

This surprises most parents. The instinct is to put the tooth back. But management of dental trauma works differently for primary teeth than for permanent teeth: primary teeth are never repositioned, splinted, or replanted.

The reason is anatomical. Baby teeth sit in close proximity to the developing permanent tooth buds directly beneath them. Forcing a primary tooth back into its socket risks damaging those developing permanent teeth, potentially causing enamel defects, malformation, or disrupted eruption of the adult tooth. If the tooth is a baby tooth, don't replant it.

What to do instead when a baby tooth is knocked out

1. **Stay calm and comfort your child.** Control any bleeding by applying gentle pressure with a clean cloth or gauze. 2. **Find the tooth** and bring it to the dental appointment — but do not attempt to reinsert it. 3. **Call Core Dental Group immediately** on 13 13 16 to arrange a same-day assessment. Even if the tooth doesn't need to be replaced, the dentist must examine the socket, assess the surrounding bone, and rule out aspiration of the tooth fragment. 4. **Watch for signs of aspiration** — if your child is coughing, wheezing, or having difficulty breathing after losing a tooth, seek emergency medical care immediately, as the tooth may have been inhaled.

The dentist will assess whether a space maintainer is needed to prevent neighbouring teeth from drifting into the gap, which could compromise the eruption path of the incoming permanent tooth.

When a permanent tooth is knocked out: the 30-to-60-minute window

For a permanently avulsed tooth, the protocol reverses: immediate replantation at the place of the accident is the best treatment. Time is the most critical variable in tooth survival.

Prompt, correct emergency management is what determines the outcome after this injury. Avulsion of permanent teeth accounts for 0.5%–16% of all dental injuries, and prognosis depends heavily on what happens in the first minutes after the tooth comes out.

Step-by-step first aid for a knocked-out permanent tooth:

1. **Pick up the tooth by the crown** (the white, visible part) — never touch the root. Root surface cells (periodontal ligament cells) are critical for successful re-implantation and are easily damaged by handling. 2. **Rinse gently** with milk or saline solution, not water, to remove dirt. Tap water is hypotonic and will destroy the delicate root surface cells. 3. **Attempt gentle replantation** — if your child is old enough and cooperative, try to seat the tooth back in its socket in the correct orientation and have your child bite gently on a cloth to hold it in place. 4. **If replantation at the scene isn't possible**, place the tooth in a physiologic storage medium: milk, Hank's Balanced Salt Solution (HBSS), saliva, or saline. Milk is the most practical choice for most families. 5. **Get to Core Dental Group immediately.** This is a true dental emergency. (See our guide on *Knocked-Out, Chipped & Broken Teeth: Emergency Treatment Options and Tooth-Saving Timelines* for the full clinical timeline and what happens at the clinic.)

Age-specific first-aid protocols: toddlers, school-age, and adolescents

Children's dental emergencies don't present the same way across age groups. Understanding the typical injury patterns by age helps parents respond correctly.

Toddlers and pre-schoolers (ages 1–5): falls and home injuries

The majority of traumatic dental incidents in young children occur at home (88.5%). Falls account for 59.3% of traumatic dental injuries in primary teeth — from furniture, from learning to walk, from collisions with hard surfaces.

Upper central and lateral incisors are the most frequently affected teeth, and subluxations (dislocations) are the most common injury type in this age group.

Key considerations for toddlers: - A toddler can't reliably report pain location or severity. Watch for refusal to eat, crying when biting, or visible swelling. - Always check for signs of head trauma alongside dental injury. Loss of consciousness, vomiting, or unusual drowsiness requires immediate medical attention. - Children under 2 years of age face a significantly higher risk of developmental complications in permanent teeth following primary tooth trauma, making prompt professional assessment especially important for the youngest children.

School-age children (ages 6–12): the mixed dentition danger zone

This age group presents a particular clinical challenge: the *mixed dentition* phase, when baby teeth and permanent teeth coexist in the mouth at the same time. A traumatised tooth may be a loose baby tooth about to fall out naturally, or it may be a newly erupted permanent tooth with an incompletely formed root.

Falls are the most frequent cause of traumatic dental injuries in school-age children, and school is the most common location.

For newly erupted permanent teeth with immature, open roots, the clinical approach differs from treatment of fully mature permanent teeth. Revascularisation may occur in immature permanent teeth, meaning the dental pulp should not be removed at the first visit but monitored at follow-up appointments. This is a decision only a dentist can make — which is why a same-day professional assessment at Core Dental Group, rather than a "wait and see" approach, matters.

Adolescents (ages 13–18): sports trauma and higher-impact injuries

Nearly 80% of all dental injuries occur under the age of 20. Adolescents are disproportionately affected by sports-related dental trauma, with Australian rules football, rugby, basketball, and hockey carrying the highest risk.

For this age group, avulsed and fractured permanent teeth are the primary concern, and the 30-to-60-minute window for tooth survival applies in full. Adolescents undergoing orthodontic treatment face additional risk — direct impact can damage braces, wires, or brackets, leading to extra costs and discomfort. A sports mouthguard becomes even more important when a child wears braces.

Sports-related dental trauma: prevention is the real emergency protocol

Given that sports injuries are a leading cause of permanent tooth trauma in school-age and adolescent children, prevention is a genuine clinical priority.

A custom-fitted mouthguard offers the most effective protection against oral damage — precision fit and quality materials provide maximum comfort and injury reduction. Over-the-counter mouthguards are better than nothing, but their protection varies depending on design, comfort, adaptation, and thickness.

Research referenced by the Australian Institute of Sport shows that athletes wearing custom-fitted mouthguards can reduce their risk of dental injury by up to 60% compared to those who wear nothing.

Despite this, only 36% of Australians wear a mouthguard during contact sport, and even fewer wear one during training. A further problem specific to children: many start training and games with mouthguards that no longer fit properly. Children's mouths grow and change quickly — a mouthguard that fitted last season may not offer the protection parents assume it does.

Mouthguards should be replaced at least once a year, or sooner if they show visible wear or no longer fit snugly. Children and teenagers typically need more frequent replacements as their teeth and jaws continue to develop.

The Australian Dental Association and Sports Medicine Australia have jointly developed a mouthguard policy, encouraging sports clubs to adopt a "no mouthguard, no play" rule. Core Dental Group can fabricate custom-fitted mouthguards for children at any of its seven Melbourne locations — a worthwhile investment before the season begins, not after an injury occurs. (See our guide on *How to Prevent Dental Emergencies: Evidence-Based Strategies for Protecting Your Teeth Long-Term* for a full discussion of preventive protocols.)

Managing dental anxiety in children during emergency appointments

A dental emergency is stressful enough for an adult. For a child, it layers physical pain, shock, unfamiliar clinical surroundings, and often guilt or embarrassment into a single overwhelming experience. Dental anxiety in children isn't a minor inconvenience — handled poorly, it can create lasting avoidance behaviour that compromises oral health well into adulthood.

Evidence-based behavioural techniques

Wherever possible, behavioural techniques such as tell-show-do (TSD), desensitisation, or inhalation sedation should be tried before escalating to pharmacological interventions.

The **Tell-Show-Do** method — explaining each step in child-friendly language, demonstrating instruments before using them, and proceeding only when the child understands — is a cornerstone of paediatric dental practice. It's particularly effective in emergency settings where the child has no prior context for what's about to happen.

Thoroughly employing non-pharmacological behaviour management before directing a child toward pharmacological options can prevent the over-utilisation of sedation and general anaesthesia — a benefit for children and families alike.

What parents can do before and during the appointment

- **Regulate your own response.** Children are acutely attuned to parental anxiety. A calm, matter-of-fact tone communicates that the situation is manageable. - **Avoid catastrophising language.** Phrases like "this won't hurt" can backfire. Instead, use honest, age-appropriate descriptions: "the dentist will look at your tooth and help it feel better." - **Bring a comfort object.** A favourite toy or blanket can provide real reassurance for younger children in an unfamiliar clinical environment. - **Advocate for your child.** Let the dentist know right away if your child has had previous negative dental experiences. This allows the clinical team to adjust their approach from the outset.

When sedation is appropriate

For children who genuinely cannot cooperate due to age, developmental factors, or significant anxiety, nitrous oxide and oral sedation can be managed entirely in the dental office, eliminating the need for hospital admission — a real benefit for children and parents both.

Core Dental Group's clinical teams are trained in paediatric behaviour management and can assess whether in-chair sedation options are appropriate for your child's emergency presentation. (See our companion guide on *Dental Anxiety and Emergency Dental Care: How to Stay Calm and Get Treated When You're Scared* for a detailed discussion of sedation options across all age groups.)

A comparison table: primary tooth vs. permanent tooth emergency response

| Situation | Primary (baby) tooth | Permanent tooth | |---|---|---| | **Knocked-out (avulsed)** | Do **not** replant. Bring tooth to appointment. Assess for space maintainer. | Replant immediately if possible. Store in milk if not. Seek care within 30–60 minutes. | | **Luxated (displaced)** | Do not reposition. See dentist same day. | Reposition and splint — dentist intervention required urgently. | | **Fractured crown** | See dentist within 24 hours. Monitor for discolouration or abscess. | See dentist same day. Pulp exposure requires urgent treatment. | | **Intruded (pushed up)** | Usually allowed to re-erupt naturally. Dentist to monitor. | Requires urgent repositioning or surgical intervention depending on severity. | | **Severe pain/abscess** | Extraction often preferred over root canal in primary teeth. | Root canal therapy or extraction depending on clinical assessment. |

When to go directly to a hospital emergency department

Core Dental Group's seven Melbourne locations are equipped to manage the full range of paediatric dental emergencies, but certain presentations require hospital emergency care *before* dental treatment:

- **Loss of consciousness** following any head impact - **Suspected jaw fracture** (inability to close the mouth, severe facial asymmetry) - **Uncontrolled bleeding** that does not respond to 10–15 minutes of firm pressure - **Signs of airway compromise** — choking, difficulty breathing, or suspected tooth aspiration - **Facial swelling that is rapidly spreading** or affecting the eye, neck, or airway

For serious but non-life-threatening situations — a knocked-out permanent tooth, a fractured crown with pulp exposure, a dental abscess — a same-day appointment at Core Dental Group is almost always the faster and more clinically appropriate pathway than a hospital emergency department, which typically cannot provide definitive dental treatment. (See our guide on *Emergency Dentist Melbourne: Private Clinic vs. Public Hospital vs. Royal Dental Hospital — Which Should You Choose?* for a full comparison.)

Key takeaways

- Approximately one-third of children with primary teeth will sustain a traumatic dental injury — parental preparedness is a genuine clinical priority. - **Never replant a knocked-out baby tooth.** Primary teeth are never repositioned, splinted, or replanted because doing so risks damaging the developing permanent tooth beneath. - **For a knocked-out permanent tooth, act within 30–60 minutes.** Immediate replantation at the scene is the best treatment; store in milk if replantation isn't immediately possible. - Developmental issues in permanent teeth following primary tooth trauma occur in 12%–74% of cases, meaning even seemingly minor baby tooth injuries warrant professional assessment. - A custom-fitted mouthguard is the most effective protection against sports-related oral damage — and children need their fit checked and the guard replaced regularly as their jaws grow. - Dental anxiety in children is a clinical issue: tell-show-do, desensitisation, and inhalation sedation should be tried before escalating to pharmacological management.

Conclusion

Paediatric dental emergencies sit at a demanding intersection of clinical precision and emotional intelligence. The decisions made in the first minutes after a child's dental injury — whether to replant or not, how to store the tooth, how to manage a frightened child — can determine outcomes that last a lifetime. Understanding the difference between primary and permanent tooth protocols isn't specialist knowledge reserved for dentists; it's essential first-aid literacy for every Melbourne parent.

Core Dental Group's seven Melbourne locations — including South Melbourne, Southbank, Berwick, Caroline Springs, Carrum Downs, Epping, and Wyndham — are open six days a week and staffed by clinicians experienced in paediatric dental emergencies. Same-day appointments are available for children across all locations. Call 13 13 16 or book online the moment an injury occurs — because in paediatric dental trauma, every minute of the response window counts.

For related guidance, see: - *Knocked-Out, Chipped & Broken Teeth: Emergency Treatment Options and Tooth-Saving Timelines* - *Dental Emergency First Aid: Step-by-Step Actions to Take Before You Reach the Dentist* - *How to Prevent Dental Emergencies: Evidence-Based Strategies for Protecting Your Teeth Long-Term* - *Core Dental Group Melbourne Locations Guide: Finding Your Nearest Emergency Dentist Across 7 Clinics*

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Label facts summary

> **Disclaimer:** All facts and statements below are general informational content derived from the source material, not professional medical or dental advice. Consult a qualified dental or medical professional for guidance specific to your situation.

Verified label facts

Product specification data status: No data provided — The Product Facts table is empty. No label facts — such as ingredients, certifications, dimensions, weight, GTIN/MPN, or manufacturer specifications — are available for extraction or verification.

General product claims

The following are informational and general claims extracted from the editorial content. These are not verifiable from product packaging or manufacturer documentation:

- Core Dental Group operates seven clinic locations in Melbourne (South Melbourne, Southbank, Berwick, Caroline Springs, Carrum Downs, Epping, and Wyndham) - Core Dental Group's emergency phone number is 13 13 16 - Same-day appointments are available for children across all seven Core Dental Group locations - Core Dental Group clinics are open six days a week - Core Dental Group clinics are staffed by clinicians described as experienced in paediatric dental emergencies - Core Dental Group clinical teams are described as trained in paediatric behaviour management - Core Dental Group can fabricate custom-fitted mouthguards at any of its seven Melbourne locations - Core Dental Group's in-chair sedation options include nitrous oxide and oral sedation, described as manageable entirely in the dental office