We have three types of splinting :

1 Direct composite splinting: by using acid etch on corner of the traumatized tooth then put composite

In splinting we should take one tooth mesially and one distallay to the traumatized tooth )).

Splint neaghbring with traumatized tooth

Again: make some acid etch on the corners then we put composite and curing then finishing and polishing for restoration , we can put some bonding agent with the composite to make it more flowable , the neighboring teeth hold the splinted tooth on its right place

 2-splinting with orthodontic wire that is difficult in manipulation

Dr prefer to use clips so u can manipulate and adapt it as you want

 note:the tooth with trauma is the last tooth to be fixed with the wire when we make the splint so we fixed the distal and the mesial tooth first with the wire then we fixed the traumatic tooth( because this tooth could be extruded or intruded so we level it according to the adjacent teeth)

-3-quartz-fiber splint :it is like a strip,we don’t need to make a curvature or a u shape loop and as the first two type we make etching put composite to fixed it with tooth structure then curing

4- removable splint that is better than the fixed splint

Case: having erupted of central incisor and central in contralateral side is under eruption and two laterals are lost

Ife u want to do splint from c to c its difficult so the best choice is removable splint

Take alginate impression and be careful when u remove the tray to avoid remove the tooth with impression so for this reason we don’t care about details we just want area to make acrylic plate or horseshoe design extends from area of trauma to the incisal one third of the tooth (the acrylic cover the 2 thirds labially –in order to fix the teeth in their position

Note : Before we remove the splint u have to do ur filling (root canal filling …instrumentation etc )

Case : The doc show a case of a sever root fracture where a coronal part is out of its’ socket , so we have to clean the area with normal saline and try to replace the coronal part to its’ original socket.

in order to replace the coronal part of the tooth into the socket, we use a tool “carver” to achieve that, we place the head of the carver beneath the cervical margin, and push it upwards into the socket, then we do a sliding movement to the coronal part of the fractured tooth, using our thumb, upwards and forwards being guided by the carver. After that we do splinting for the tooth by direct composite

Before removing the splint we do root canal treatment for the coronal part only, without pass the corona part of the root, don’t touch apical part because it stays vital since it is getting its neurovascular supply from the apex which is intact in our case.

Extrusive luxation: incomplete avulsion of the tooth out of the socket " not completely detach from periodontal socket

Clinically :1-displacement of tooth from socked and elongation

2- bleeding from socket

3- dull sound on percussion

Viva Q: which fibers carry the tooth after extrusion and from which sides?

Always palatal fibers or cervical palatal fibers that carry extrusive tooth

All fibers will tear except palatal fiber

Increase in periodontal space . Radiographically

Treatment : push the tooth upward .. and if the child uncooperative give anesthesia then splint it

Lateral Luxation: “Fracture in alveolar plate”

Eccentric displacement of the tooth accompanied with comminuted fracture or fracture of the alveolar socket.

 Clinically :1-metallic sound on percussion

2-, little mobility

3-pulp necrosis

4- sometimes breakdown in the alveolar bone

We can finf metallic sound in :

Intrusion,ankylosis,lateral luxiation,anything locked inside socket

Radiographically, space apical to the tooth

Treatment :fixations for 2 months and more

Note :when we have locked part of root so local anesthesia is amust

So we give the patient anesthesia first, the we have to re-fix the tooth in its original place in the socket, we crush the bone in the apical area, then we push the coronal part from the palatal side forwards and upwards, and then we can splint the tooth

Dr showed us xray : ( w r7 tegena bl viva )

Called ant..lateral position : we can see alveolar fracture labially "bs msh had el mohm, el ahm when we have intruded primary tooth , and if it is palatally we have to extract it immediately. But if it is labial we don’t have any problem

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