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Original Article

Awareness among Physical Education Coaches Regarding Sports Related Orofacial Trauma in Kerala- A Cross Sectional Study

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Abstract

Background: Sports dentistry is an emerging field that focuses on the prevention and management of orofacial injuries related to sports participation. Despite the high incidence of such injuries, limited data exist in India regarding the knowledge and awareness of sports coaches, who play a key role in implementing preventive measures.

Aim: This study aimed to assess the knowledge and awareness of sports coaches in Kerala regarding orofacial injuries and their prevention.

Materials and Methods: A cross-sectional, questionnaire-based survey was conducted among 102 sports coaches across various schools and sports academies in Kerala using semi-purposive sampling. The study included a true representative sample of coaches across the state of Kerala. Data were collected through a structured Google Form comprising demographic details and questions assessing knowledge and awareness of orofacial injury management and protective measures. Descriptive statistics and chi-square tests were used for analysis.

Results: Among participants, 81.4% were male, 90.2% coached in regular schools, and 63.7% trained athletes in strenuous sports. Only 22.5% of coaches demonstrated good knowledge. Awareness levels were comparatively higher, with 49.0% showing good awareness. Although 83% were aware of mouthguard guidelines, only 50% reported encouraging their use during both practice and competition. Gender showed a statistically significant association with awareness (P = 0.007), with male coaches demonstrating higher awareness. Other sociodemographic variables showed no significant association with knowledge or awareness.

Conclusion: The study revealed notable gaps in knowledge and awareness among sports coaches regarding sports-related orofacial injuries, particularly in the emergency management of avulsed teeth and use of appropriate storage media. Despite awareness of preventive guidelines, adherence to protective practices was limited. There is a strong need to incorporate structured training on orofacial injury prevention and management into sports coaches' curricula, along with greater promotion of protective equipment.

Key words: Avulsion, Coaches, Mouthguards, Orofacial injuries, Sports dentistry

INTRODUCTION

Sports dentistry is the most recent and upcoming field in dentistry. Sports-related injuries are typically inevitable, accounting for between 30% and 40% of all events involving children and adolescents. Dental injuries are the most common form of orofacial injury suffered during sports participation. Sports-related dental trauma differs from other types of dental trauma in that it is easily preventable and has the ability to drastically lower occurrence rates by adopting mouthguards to safeguard dental and periodontal structures. The goal of sports dentistry is to prevent oral and facial injuries, along with associated oral diseases and their manifestations. It primarily focuses on two things: first, treating orofacial

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injuries, and second, preventing orofacial injuries caused by sports.[1] There is a need to report the occurrence of orofacial sports-related injuries to establish a valid database that could be used to enhance treatment outcomes, to assist in designing better protective equipment, and to promote better education of coaches, officials, players, and parents.[2]

Despite the high incidence of trauma during sports, sports dentistry has been a neglected field throughout the world, and in India too. A comprehensive literature review revealed scant data on Indian coaches and children's perception of knowledge, understanding, and prevention of dental injuries. Hence, the present study is undertaken to assess the understanding and knowledge of sports coaches in Kerala regarding various aspects of sport-related orofacial injuries, as they have a direct impact on the trainees.

MATERIALS AND METHODS

This is a cross-sectional, questionnaire-based study conducted among sports coaches in Kerala. The study aimed to assess their knowledge and awareness regarding the selected research topic. A total of 102 coaches of different sports academies/schools were selected from different districts of Kerala through semi-purposive sampling. The objectives and nature of the study were clearly explained to all potential participants through an introductory section included at the beginning of the Google Form. Participation was entirely voluntary, and confidentiality of all personal and response data was strictly assured. Data were collected using a structured, self-administered online questionnaire developed through Google Forms. This method provided participants with the flexibility to respond at their convenience and ensured efficient, paperless data collection.

The questionnaire was designed in English and consisted of two sections:

Section I: Demographic Data

This section collected basic demographic information such as age, gender, type of school (regular/special sports school), type of sport coached, and age group of coaching. The type of sport coached is classified based on its strenuous nature into strenuous contact sports (football, lawn tennis, floor hockey, volleyball, basketball, weight lifting, swimming, gymnastics, cycling, squash, martial arts, baseball) moderately strenuous contact sports (cricket, table tennis, badminton, sailing, rowing) or nonstrenuous contact sports (archery, shooting, Golf).

Section II: Knowledge and Awareness Assessment

This section comprised multiple-choice, closed-ended questions specifically aimed at evaluating the participants' knowledge and awareness related to the study topic. Each question included a set of options, some correct and some incorrect. Participants were instructed to select the option they believed to be the most appropriate.

The Google Form was distributed to participants through WhatsApp. Reminders were periodically sent to encourage maximum participation. The form settings ensured that each participant could submit the form only once to avoid duplication of responses. Google Forms automatically recorded and organized all responses. The data were accessible only to the principal investigator and were stored securely with password protection. No personally identifiable information was collected, thereby maintaining complete participant anonymity.

RESULTS

Figure 1 among the participants, 81.4% was male and 18.6% were female. Most coaches (90.2%) worked in regular schools, and the majority (63.7%) coached strenuous sports. A significant proportion (63.7%) handled children in the 16–20 years age group. The majority were involved in strenuous sports, taught children aged 16–20 years, and coached in regular schools.

Table 1 responses show gaps in knowledge, with only 43.1% of coaches aware of the possibility of reattaching a broken tooth and just 22.5% correctly identifying that a knocked-out tooth should be repositioned within 30 min. Awareness was relatively higher; 90.2% reported that sports injuries were included in their curriculum, and 81.4% were aware of guidelines regarding the use of mouthguards. However, 50.0% of coaches reported their students wear protective gear during both practice and competition. A smaller proportion reported usage only during competition (8.8%) or only during practice (5.9%).

Figure 2 illustrates the awareness and reported practices of coaches regarding the use of protective mouthguards

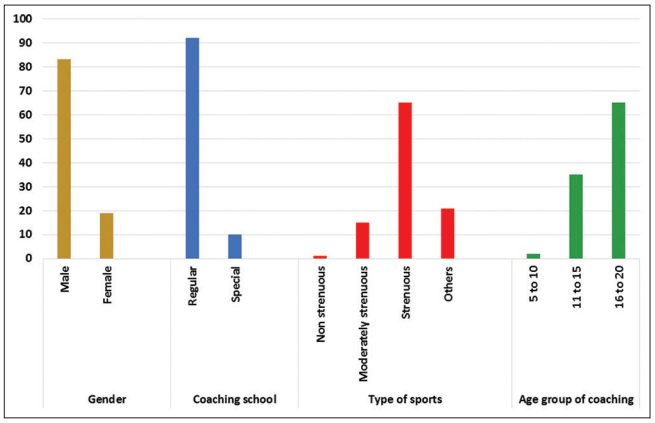

Figure 1: Sociodemographic characteristics of the participants

Table 1: Response to knowledge and awareness questions regarding sports-related orofacial trauma

Serial no	Knowledge	Response	*n*	%
1.	Are you aware that the tooth that has fallen during orofacial injuries can be repositioned back into its original position in the mouth?	Yes	54	52.9
		No	48	47.1
2.	Are you aware that the fragment of a broken tooth can be re-attached?	Yes	44	43.1
		No	58	56.9
3.	In your opinion, within what period of time the fallen tooth should be repositioned	<30 min	23	22.5
		30–60 min	40	39.2
		24 h	39	38.2
4.	How should you carry a knocked-out tooth to the dentist?	Tape water	14	13.7
		Cotton/paper	48	47.1
		Saliva	17	16.7
		Milk	20	19.6
		HBSS	3	2.9
	Awareness			
5.	Is there any chance for orofacial injuries in the sports that you coach?	Yes	54	52.9
		No	48	47.1
6.	Have you interacted with medical or dental experts regarding safety measures to be taken in sports to prevent or for managing orofacial injuries?	Yes	40	39.2
		No	62	60.8
7.	Do your students wear protective mouth guards and face shields?	Yes	50	49.0
		No	52	51.0
8.	Were sports injuries and their prevention a part of your syllabus during the degree/ diploma in physical education?	Yes	92	90.2
		No	10	9.8
9.	Are you aware of guidelines regarding the use of mouth guards among students/ athletes during sports?	Yes	83	81.4
		No	19	18.6
10.	If yes, when does students wear protective mouth guards and face shields?	No	36	35.3
		During practice	6	5.9
		During competition	9	8.8
		Both	51	50.0
11.	What kind of mouthguards do the children in your academy/school wear?	None	35	34.3
		Ready made	54	52.9
		Custom	13	12.7
12.	How often have students/athletes under your care sustained an orofacial or dental injury in the last one year?	None	71	69.6
		5 times	28	27.5
		6 times or more	3	2.9

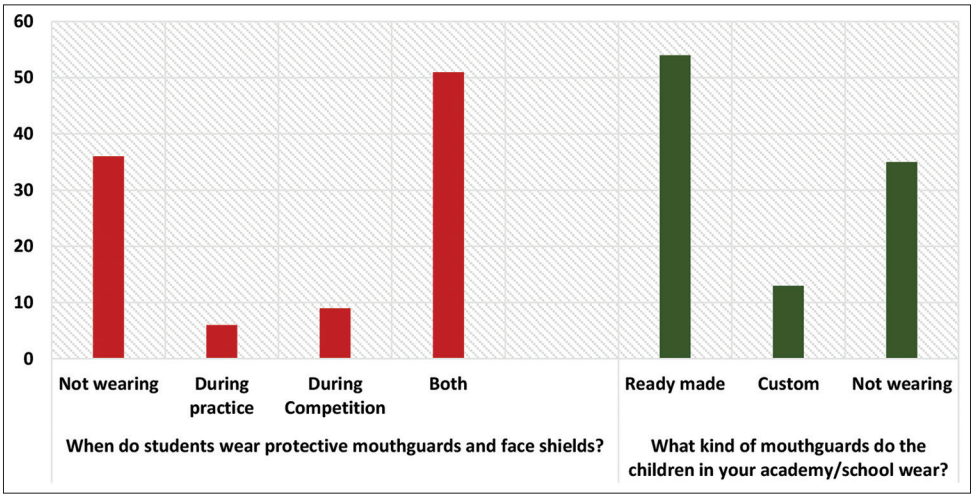

Figure 2: Awareness about protective mouth guards and face shields wearing

and face shields. It shows that 50.0% of coaches reported their students wear protective gear during both practice and competition, while 35.3% stated their students do not use any protective equipment. A smaller proportion reported usage only during competition (8.8%) or only during practice (5.9%). In terms of the type of mouthguard used, 52.9% of coaches indicated their students use ready-made mouthguards, 12.7% reported custom-made mouthguards, and 34.3% reported no use of mouthguards.

Table 2 the assessment of knowledge and awareness among participants revealed that the mean knowledge score was 1.58 ± 1.17, with a median of 2.0 (interquartile range: 1.0–2.0). The minimum score was 0, and the maximum score was 4.

Figure 3 shows that only 22.5% of coaches had good knowledge, while a majority (77.5%) had poor knowledge. In terms of awareness, 49.0% of coaches demonstrated good awareness, whereas 51.0% had poor awareness. This indicates that although awareness levels are comparatively better than knowledge, there remains a substantial gap in in-depth understanding of orofacial protection practices.

Table 3 presents the association between the level of knowledge regarding sports-related orofacial trauma and various sociodemographic characteristics of the coaches. Among male coaches, 24.1% had good knowledge compared to 15.8% of female coaches; however, this difference was not statistically significant ($P = 0.434$). Coaches working in regular schools exhibited better knowledge (23.9%) than those in special schools (10.0%), but the association was not significant ($P = 0.317$). Coaches handling "Other" sports categories had the highest proportion of good knowledge (38.1%), followed by those in moderately strenuous (33.3%) and strenuous sports (15.4%). However, this difference was also not statistically significant ($P = 0.107$). With respect to the age group of children coached, those working with the 16–20 years age group had better knowledge (25.6%) than those coaching younger children, though this difference was also not statistically significant ($P = 0.448$). Overall, none of the sociodemographic variables showed a statistically significant association with the knowledge levels of the coaches.

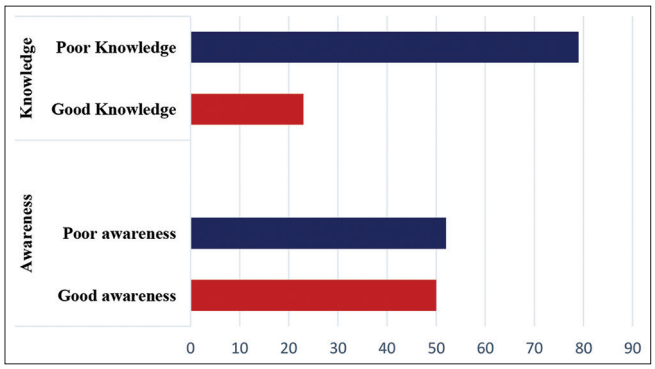

Figure 3: Distribution of knowledge and awareness among coaches

Table 2: Summary statistics and classification of knowledge and awareness scores

Variable	Mean±SD	Median (IQR)	Minimum	Maximum
Knowledge	1.58±1.17	2.0 (1.0–2.0)	0	4
Awareness	3.28±1.18	3.0 (2.0–4.0)	1	5

SD: Standard deviation, IQR: Interquartile range

Table 4 shows the association between the awareness levels of coaches and their sociodemographic variables. A statistically significant association was observed between gender and awareness ($P = 0.007$), with a higher proportion of male coaches (55.4%) showing good awareness compared to female coaches (21.1%). Coaches from regular schools demonstrated slightly better awareness (50%) than those from special schools (40%), though the association was not statistically significant ($P = 0.548$). Regarding the type of sports coached, those involved in strenuous sports had the highest awareness (52.3%), followed by moderately strenuous (46.7%) and "Other" categories (42.9%), but the differences were not statistically significant ($P = 0.661$). Coaches handling children aged 16–20 years showed greater awareness (47.7%) compared to those handling younger age groups, although this too was not statistically significant ($P = 0.660$). Overall, gender was the only sociodemographic

Table 3: Association between knowledge level and sociodemographic variables

Variable	Knowledge		Total	Chi-square	*P*-value
	Good knowledge	Poor knowledge			
Gender					
Male	20 (24.1)	63 (75.9)	83 (100)	0.611	0.434
Female	3 (15.8)	16 (84.2)	19 (100)		
School					
Regular	22 (23.9)	70 (76.1)	92 (100)	1.00	0.317
Special	1 (10.0)	9 (90)	10 (100)		
Type of sports					
Non-strenuous	0 (0)	1 (100)	1 (1.00)	6.107	0.107
Moderately strenuous	5 (33.3)	10 (66.7)	15 (100)		
Strenuous	10 (15.4)	55 (84.6)	65 (100)		
Others	8 (38.1)	13 (61.9)	21 (100)		
Age group of coaching					
5–10	1 (50)	1 (50)	2 (100)	1.608	0.448
11–15	6 (17.1)	29 (82.9)	35 (100)		
16–20	16 (25.6)	49 (75.4)	65 (100)		

Statistically significant $P<0.05$, Chi-square test

Table 4: Association between awareness level and sociodemographic variables

Variable	Awareness		Total	Chi-square	*P*-value
	Good awareness	Poor awareness			
Gender					
Male	46 (55.4)	37 (44.6)	83 (100)	7.308	0.007*
Female	4 (21.1)	15 (78.9)	19 (100)		
School					
Regular	46 (50)	46 (50)	92 (100)	0.361	0.548
Special	4 (40)	6 (60)	10 (100)		
Type of sports					
Non-strenuous	0 (0)	1 (100)	1 (100)	1.59	0.661
Moderately strenuous	7 (46.7)	8 (53.3)	15 (100)		
Strenuous	34 (52.3)	31 (47.7)	65 (100)		
Others	9 (42.9)	12 (57.1)	21 (100)		
Age group of coaching					
5–10	1 (50)	1 (50)	2 (100)	0.814	0.66
11–15	15 (42.9)	20 (57.1)	35 (100)		
16–20	31 (47.7)	34 (52.3)	65 (100)		

Statistically significant $P<0.05$, Chi-square test*

factor significantly associated with awareness levels among coaches.

DISCUSSION

The tremendous popularity of organized youth sports and the high level of competitiveness have resulted in a significant number of dental and orofacial injuries.[3] According to a 2020 health survey, 54.1% of children ages six through 17 years participated in sports during the previous year.[4] One consequence of this is a higher proportion of sports-related injuries. The current prevalence of sports injuries is 19.2–36% among children and adolescents.[5] Dental injuries are the most common type of orofacial injuries sustained during participation in sports. All sporting activities have an associated risk of orofacial injuries due to falls, collisions, contact with hard surfaces, and contact from sports-related equipment. Children are most susceptible to sports-related orofacial injury between the ages of 7 and 11 years as during this age group; their athletic skill levels are not matured.[6]

The study included 102 sports coaches with ages ranging from 24 to 64 years. The mean age was 43.32 years with a standard deviation of 9.259, indicating a wide age distribution among participants.

A sport is considered strenuous when it places significant physical and/or physiological demands on the body. This can involve intense use of muscles, cardiovascular endurance, strength, speed, agility, and mental focus. Among the participants, the majority (63.7%) coached strenuous sports. A significant proportion of the coaches (63.7%) handled children in the 16–20 years age group. Avulsion is one of the most severe forms of traumatic dental injury (TDI) and can be most effectively managed by immediate replantation of the cleaned tooth/teeth in the socket, followed by dental care. Under no circumstances should these teeth or parts be thrown away by the injured player or the coach.[7] Since all these steps require participation and compliance of the people at the location where the TDI occurred, they must have adequate knowledge regarding the emergency management of these injuries.[8] In the present study, a little more than half (52.9%) were aware of replantation of the avulsed tooth back into the socket. Similarly Shah *et al*.,[9] and I Eroje *et al*.,[10] observed in their study that 54% and 80.6% of the coaches were aware of reimplantation, respectively. This finding was inconsistent with the findings of Tokas *et al*.,[11] who found that majority of coaches (65.5%) reported they are unaware of the re-implantation of the tooth after avulsion. The important factor that influences the success of the treatment of an avulsed tooth is extra-oral dry time of an avulsed tooth. Delay in providing emergency dental treatment may lead to an unsuccessful treatment outcome of an avulsed tooth. When asked within what time the avulsed tooth is to be reimplanted only 22.5% of the coaches opted the correct option of <30 min for the reimplantation of the tooth, which is in accordance with other studies conducted on sports coaches.[12-15] On the ideal storage media for transportation of avulsed tooth, the majority of the coaches (47.1%) reported that avulsed tooth should be wrapped in a cloth/cotton. This is in corroboration with the findings by Tokas *et al*., in which 48.8% of the coaches were under the impression that an avulsed tooth should be wrapped in a cloth/cotton. This indicates that the sports coaches who were knowledgeable about the possibility of replantation of an avulsed permanent tooth did not have adequate knowledge about the appropriate storage medium and the crucial time for reimplantation of an avulsed tooth.

Coaches not only bear the responsibility to educate the sportspersons but also motivating them to use various protective measures such as mouth guards and shields. The academy for sports dentistry (ASD) recommends the use of properly fitted custom mouthguards. It encourages the use of a custom-fabricated mouthguard made over a dental model or digitized and delivered under the supervision of a dentist. The ASD recommends that athletes wear properly fitted custom mouthguards to participate in more than forty sports. These sports include, but are not limited to both collision and contact sports. To properly protect all athletes' oral and facial health, the ASD strongly supports and encourages the governing bodies of these sports to mandate the use of a properly fitted Custom Mouthguard in all collision and contact sports.[16] In our study 92% of the coaches had "sports injury and their prevention" as a part of their curriculum during degree/diploma in physical education, and 83% were aware of the guidelines regarding use of mouthguards. Despite having adequate awareness, only 50% of the coaches recommended wearing of mouthguard both during practice and competition, while 6% wore mouthguard only during practice and 9% wore only during competition. This finding is comparable to similar studies where only a few sports coaches with adequate knowledge and awareness practiced the use of protective wear in their trainees.[10,17,18] A review by Ranalli in 2000 showed that correct and properly close-fitting protective aids like mouth guards, headgear, and helmets prevented orofacial trauma, including dental injuries. Mandatory usage of mouth guards reduced football injuries to the face and mouth from 50 to 1.4%.[19] In several countries, mouthguard use is mandatory during contact and non-contact sports.[20] In a study by Onyeaso and Adegbesan, the coaches response to why they require their athletes to use mouthguards revealed that it was due to the government rule.[18] However, in India, there are no such rules mandating the wear of mouthguards during sports.[5] This may be one of the reasons for non-recommendation of protective mouthguard wear by the coaches. Since mouthguards are an important means of protection from sports-related dental injuries, coaches must be made aware of their types, availability, and uses.

The level of knowledge of coaches regarding sports-related orofacial trauma and various sociodemographic characteristics showed no statistically significant association. Significant association observed only between gender and awareness ($P = 0.007$), with a higher proportion of male coaches (55.4%) showing good awareness compared to female coaches (21.1%). 27.5% of the coaches said their students had injuries up to 5 times in the last year, and 2.9% reported six or more incidents.

The results of this study highlight the importance of incorporating emergency management of orofacial injuries into sports coaches' training programs. Even though the curriculum includes guidelines on the prevention of sports injuries and the use of mouthguards, very few coaches had adequate knowledge and awareness – particularly regarding locating the knocked-out tooth from where the injury took place at the earliest, handling and cleaning the knocked out tooth (i.e., holding by its crown and rinsing in running water), usage of appropriate storage medium during the transportation from the trauma site to the dentist for its successful reimplantation. Dentists should be appointed by the education department/school authorities at various sports academies/schools for providing adequate information and training to coaches about protective aids and emergency management of orofacial trauma. Health professional's particularly pediatric and general dentists, in association with sports organizations, should educate physical instructors on the availability and the types of mouth guards and promote its use not only during competition but also during practice. Children engaging in sport activities and their parents should also be counseled regarding wear of protective mouthguard. Such initiatives are likely to positively influence the attitudes of coaches, children, and parents regarding the appropriate use of protective aids, further reducing the rate of orofacial injuries.

Limitations

- The responses provided by sports coaches may have been influenced by social desirability bias, whereby they tended to report attitudes or behaviors that aligned with socially acceptable norms rather than their actual practices.
- Small sample size.

CONCLUSION

The current study included both male and female coaches, coaches who train children and adolescents at regular schools, special schools, and sports academies, and young as well as older coaches (min. age 24–max. age 64). This study underscores the considerable deficiencies in sports coaches' knowledge of managing sports-related orofacial injuries, despite relatively better awareness of preventive measures. Critical gaps were observed in understanding the appropriate management of avulsed teeth and the consistent use of protective mouthguards. While guidelines on injury prevention are included in physical education curricula, their translation into practice remains limited. To address this, structured training programs, integration of dental trauma management into coach education, and stronger collaboration between dental professionals, sports organizations, and educational authorities are essential. Such initiatives can enhance coaches' preparedness, promote the

routine use of protective devices, and ultimately reduce the incidence of orofacial injuries in young athletes.

More studies with a larger sample size, including more coaches training children engaging in strenuous and moderately strenuous sports activities, should be conducted. Qualitative studies giving more insights into the attitude of coaches, children and their parents on injury prevention measures may be undertaken before revising the curriculum for sports coaches on occurrence, prevention, and management of orofacial injuries during sports.

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