MOUTHGUARDS, AN EVALUATION OF TWO TYPES FOR RUGBY PLAYERS

N. UPSON, LDS, DOth, DDPHRCs

Kingston and Esher Health Authority, 17 Upper Brighton Road, Surbiton, Surrey

ABSTRACT

At the beginning of the 1983/84 Rugby season a dental examination was carried out on 120 players, 55 of whom were fitted with the mouth-fitted type of mouthguard and 65 the laboratory-made type of mouthguard.

At the end of the season only 98 players were available for the completion of the study. A further dental examination showed that there was no damage to the teeth when either type of mouthguard was worn.

Variations in the attitudes of the players to each type of mouthguard were also recorded.

INTRODUCTION

Mouthguards protect both hard and soft tissues. Damage to cusps and restorations of posterior teeth, and fractures of anterior teeth can be avoided. Tongue biting and damage to lips and cheeks from fractured teeth can also be reduced. Pain, reduced masticatory function and an unsightly appearance can also be prevented. In turn, preventive measures can reduce the cost of replacement dentures, crowns and bridges. The wearing of a mouthguard can produce a cushioning effect from blows to the mandible, and act similarly with regards to blows to the base of the skull.

It is important when constructing mouthguards to ensure that they give adequate retention and protection to the teeth and soft tissues. Ideally they should extend over all the tooth surfaces, and to the periphery of the labial and buccal sulci. On the palatal surface they should extend about 1 cm. Extending the mouthguards beyond the first permanent molars is not necessary. If they are extended too far back they can cause a feeling of nausea. The mouthguards should be of sufficient bulk to absorb the force of any reasonable localised blow. A thickness of 4 mm over incisal and occlusal edges is recommended. Mouthguards that are too bulky can "gag" the bite and make breathing and speech difficult. The manufacture of mouthguards with indentations to accommodate the lower incisors should be avoided as they do not allow for the free movement of the mandible against a blow.

Mouthguards should not readily distort as retention is then reduced, and they should be tasteless and odourless. They should be easy to clean and have antiseptic properties. They should be aesthetically acceptable. They should not be expensive to purchase.

There are basically three main groups of mouthguards.

The stock type which can be bought from sports shops and are made of thermoplastic material (Fig. 1).

The mouth-fitted type are made of preformed shells into which a soft material (obtained from a mixture of powder and liquid) is placed and allowed to set (Figs. 2 and 3).

The laboratory-made type are constructed from 4 mm thermoplastic sheets that are vacuum formed over stone models obtained from impressions of the mouth (Figs. 4 and 5).

In a previous paper by the author (Upson, 1982) it was shown that out of a total of 100 players who were interviewed,
Fractured teeth were classified under three headings
Type 1 — involved enamel only
Type 2 — extended into dentine
Type 3 — showed exposure of the pulp.

The presence of crowns and bridges was also recorded.

Impressions for laboratory-made mouthguards and the
construction of mouth-fitted Coe Dental Guards (Editorial
report, 1983) were carried out at the same time.

The following week both types of guards were returned to
the players and examined for fit. Written instructions were
given to all players on the care of their mouthguards.

Also at the second visit any players who were not present
the previous week had a dental inspection and a mouthguard
constructed.

At the end of the season the player’s teeth were again
examined, and they were asked questions about their mouth-
guard wear.

RESULTS
120 players had a dental examination, 55 were fitted with the
mouth-fitted type of mouthguard (MFT) and 65 had the
laboratory-made type of mouthguard (LMT).

At the end of the season only 74 players were available at
the clubs for a dental examination and completion of the
questionnaire.

Twenty-four players were later contacted by telephone, as
shown in Table 1.

<table>
<thead>
<tr>
<th></th>
<th>MFT</th>
<th>LMT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examined</td>
<td>37</td>
<td>37</td>
<td>74</td>
</tr>
<tr>
<td>Telephoned</td>
<td>11</td>
<td>13</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
<td>50</td>
<td>98</td>
</tr>
</tbody>
</table>

Sixteen players had moved from the area and could not be
contacted. Four players were injured soon after the season
began and did not play again.

One player lost his mouthguard after the first game and did
not contact the author for a replacement.

Thus out of a total of 120 players, the results in regard to
98 (82%) were available for analysis. 48 out of 55 (87%) had
the MFT and 50 out of 65 (77%) had the LMT. At the initial
dental examination the upper and lower labial segments only
were examined. Table II indicates the results of the examina-
tion of each player.

Some players already had more than one missing or
fractured tooth. The results from the initial examination
formed the base line for any change that might be found at the
final examination. At the final examination and following
telephone calls there was no change in the number of missing
or fractured teeth.

The players were asked whether they had worn their
mouthguard for every game, occasionally or never. The results
are shown in Table III.

The main problems which may be associated with the
wearing of mouthguards are:—
Inadequate retention
Nausea.
All the players were asked whether they had worn a mouthguard before and their comments were noted.

From the results (Table V) most of the players who wore their mouthguards all the time had previously had a mouthguard. The stock type bought from sport shops was the most common type to have been worn by players.

The players’ comments are discussed in the next section.

DISCUSSION

From the results of the dental examination it would be reasonable to accept that both types of mouthguards had a preventive effect against damage to teeth. At the time it was not necessary to consider a control group who had not been issued with a mouthguard.

An overall assessment of the mouth-fitted mouthguards showed that although speech was a problem with the players who wore their mouthguards all the time it was not sufficient to deter them from wearing the guards, whilst nausea and speech difficulties proved a problem with the occasional wearers. The problems associated with this type of mouthguard may be due to the fact that the shells are all the same size and the shells with the filler are bulky.

The total number of difficulties experienced by the players who wore the laboratory-made mouthguards either every game or occasionally was far less, and this may be due to the fact that these mouthguards are less bulky and can be constructed accurately to the individual model of each player.

With all players, there are different levels of tolerance to the presence of objects in the mouth, and this is shown by the feeling of nausea and dryness of mouth with both types of mouthguards and speech and difficulty with breathing only with the laboratory-made type of mouthguard.

It is interesting to note that out of a total of 81 players who wore their mouthguards all the time 59 had worn a mouthguard previously, with the stock-type of mouthguard being the predominate type. Seven players out of 14 who wore their mouthguards occasionally had a previous mouthguard, with 4 players having had a stock type and 3 a laboratory-made type. Again a degree of tolerance to the presence of objects in the mouth may be an important factor in this group. The players who did not wear their mouthguards reported not having had a previous mouthguard.

When the players were asked for their comments about their mouthguards it was agreed by the players who wore their mouthguards either all the time or occasionally that they were far superior to the stock type with improved retention and a reduction of a feeling of nausea being the main comments.

There were complaints that the mouth-fitted mouthguards soon discoloured and the white appearance of the shells made them too conspicuous.
SUMMARY
Whilst there was no damage to the teeth, a comparison of both types of mouthguards showed that the laboratory-made mouthguards were more acceptable than the mouth-fitted type, although the laboratory-made type was more expensive than the mouth-fitted mouthguard.

ACKNOWLEDGEMENTS
I would like to thank the South West Thames Regional Health Authority for their financial support for this project. Mr. G. Tucker, District Dental Officer, Kingston and Esher Health Authority, Miss E. Stearns for typing the manuscript and the officials and players of the Kingston, Old Tiffinian, Old Emmanuel and Old Wandsworthian Rugby Clubs.

References
Upson, N., 1982 "Dental injuries and the attitudes of Rugby players to the wearing of mouthguards". Br. J. of Sports Medicine 16: 241-244.

OBITUARY
Henry Noel Cummings Bleasdale, MBE, MB, ChB

We were very saddened to learn of the death of Doctor Bleasdale on 7th May, 1985. He qualified at Liverpool University in 1940, and after various house jobs, specialised in Tuberculosis and Chest Medicine. He held the position of Physician Superintendent at the Cleaver Hospital, Liverpool, and subsequently was a Consultant Physician for the Liverpool Central Chest Services and Occupational Health Services (Chest diseases) for the City of Liverpool.

He joined BASM in 1954, soon after its foundation, as representative of the Amateur Swimming Association, already being established as one of the Senior Medical Advisers for the ASA and in the middle 1960's he succeeded Dr. Hume Kendall as Chief Medical Adviser to the ASA. He was also a member of the International Swimming Association (FINA) and well-known throughout the world for his knowledge and enthusiasm in this sport. He served many times on the Executive Committee of BASM and was elected Vice-President in 1978.

I first met Noel in 1959 when he was looking after a group of young, potential international swimmers, during the ASA Easter Coaching Course at the then Loughborough College of Education. He had a wonderful manner with these teenage children and showed me what a Team Doctor should do for the physical and mental welfare of his charges, as well as spending a large amount of his time at the pool side, in the gymnasium and the common room, where every swimmer and coach felt they had immediate access for the doctor’s help or advice, even regarding the trivialities that upset an athlete so easily. One of Noel’s main interests was the supervision and encouragement of the young asthmatic patients and he spent a great deal of time looking after them and other handicapped patients in the swimming pool and elsewhere. Apart from his sound advice at many BASM Executive Meetings where his wisdom and experience proved invaluable, he was one of the most conscientious and efficient book reviewers that this Journal has ever had. I shall miss an old friend of long standing, who throughout his long and painful illness, gave us no indication of its severity. He shall be missed by many of his friends in our Association and in swimming circles world-wide. We extend our sincere condolences to his wife and family.

Henry Robson