Research Article

Journal of Surgery and Surgical Care

Facial Injuries in Athletes: Diagnosis, Management, and Prevention

Siniša Franjić

Independent Researcher

Received Date: 03 Feb 2026;
Accepted Date: 26 Apr 2026;
Published Date: 15 May 2026.

[*]***Correspondence:*** *Siniša Franjić, Independent Researcher, Croatia.*

Citation: Siniša Franjić. Facial Injuries in Athletes: Diagnosis, Management, and Prevention. J Surg Surg Care. 2026; 2(1): 1-12.

ABSTRACT

Head trauma encompasses injuries affecting the skull and its internal components. Such injuries are typically classified as either open or closed, with open injuries further divided into penetrating and non-penetrating types depending on the dura mater's status. Depending on how the injury occurred and which structures are harmed, head injuries might lead to alterations in consciousness.

Keywords: *Facial trauma; Sports injuries; Maxillofacial fractures; Concussion; Dental injuries; Athletes.*

Introduction

Although the extensive adoption of enhanced safety gear, including helmets, face shields, eye protection, and mouthguards, has considerably decreased the frequency of injuries in the head and neck area, it has not completely eradicated the frequent occurrence of both severe and minor injuries to the essential components of this region [1]. Concerns have been raised that, in certain sports, advancements in head protection have given players a misleading sense of safety, resulting in riskier play and a shift in injury locations from facial areas to the central nervous system or cervical spine. However, the high number of athletes engaged in sports where facial protection is either not standard or inadequately utilized, and the presence of injuries even with complete protective headgear, highlight the necessity for comprehensive knowledge of maxillofacial injuries among doctors, sports physiotherapists, and athletic trainers assisting such athletes.

Bleeding

Critical bleeding resulting from maxillofacial trauma is infrequently solely attributed to facial injuries [2]. Instances of significant bleeding stemming from facial injuries are observed in 1 to 11 percent of affected individuals. The source of this bleeding is intricate due to the facial vascular anatomy, which includes branches from both the internal and external carotid arteries. Moreover, various anastomoses exist amongst the external and internal carotid branches. Bleeding from facial trauma can arise from both hard and soft tissue sources, complicating the identification of the precise origin. Typically, the internal maxillary artery and its intraosseous branches are involved in bleeding related to maxillofacial trauma. The pathway of the maxillary artery lies within the boundaries of common complex facial fractures. Additionally, branches of the external carotid artery, including the lacrimal, zygomatic, and ethmoidal arteries, may significantly contribute to the bleeding source.

Timely resuscitation followed by posterior nasal packing is usually adequate to manage most bleeding incidents. Immediate reduction of fractures is crucial for controlling bleeding originating from the intraosseous branches. While ligation of the external carotid artery has been proposed, this technique seldom succeeds due to the presence of collateral blood supply. Angiography combined with selective embolization of the bleeding vessels frequently proves to be beneficial.

Examination

Numerous soft tissue injuries affecting the face arise from trauma to the maxillofacial skeleton, thus necessitating a comprehensive examination with this context in mind [3]. A methodical approach is crucial to avoid mistakes in both diagnosis and treatment. Every healthcare provider involved in the care of trauma patients must adhere to ATLS (Advanced Trauma Life Support) protocols, irre-

spective of their specific role in the treatment process. Implementing a systematic strategy utilizing the ABCDE mnemonic (airway, breathing, circulation, disability, exposure) during primary and secondary assessments guarantees that the most critical conditions are prioritized and that nothing important is overlooked. While careful evaluations make it uncommon to miss facial injuries, their oversight can lead to serious consequences. An apparently minor forehead cut in the emergency department that is quickly forwarded to the "facial trauma service" might obscure hidden intracranial or cervical spine injuries based on the mechanism of injury - an issue that may be overlooked if attention is solely on treating the laceration rather than the patient's overall condition. Caution is necessary when dealing with patients referred from other facilities, and seasoned surgeons are aware that assessments conducted by transferring physicians may lack the thoroughness of their own detailed examination.

The examination commences with a detailed assessment of airway, breathing, and circulation issues - the ABCs - which may be immediate or on the verge of becoming critical. While airway obstruction is uncommon with just superficial soft tissue trauma, serious bleeding that collects in the upper airway can quickly jeopardize the ABCs, especially in patients who are either combative or unresponsive. Securing the airway involves managing hemorrhage either by applying direct pressure or by locating and ligating the injured vessel. Nevertheless, this process must be carried out with care to prevent harm to other significant structures, such as the facial nerve or parotid duct, when attempting to halt bleeding by clamping a vessel in the wound area. Another condition that necessitates prompt action is corneal exposure caused by eyelid laceration or avulsion. Prompt protection of the cornea is essential to avert potentially severe ocular injury.

A comprehensive evaluation of surface anatomy involves examining the scalp and facial characteristics while they are at rest to identify asymmetries that may indicate hidden skeletal or neurological injuries. The rest of the the assessment is performed in an organized manner. The specific order of the assessment is not critical, but a consistent sequence should be followed each time to guarantee a thorough evaluation of any injuries. Frequently employed methods consist of examinations that start at the top and methodically move from the head and scalp to the ears, face, eyes, nose, mouth, neck, and throat. The facial bones are examined for irregularities, steps, and movement; this examination encompasses the entire skull, orbit, zygomatic bone, maxilla, palate, and mandible. Imaging techniques like computed tomography (CT) scans and regular X-rays are insufficient for this assessment. While most visible traumatic injuries to the facial soft tissues are apparent upon first assessment, specific regions need detailed scrutiny to exclude more serious injuries. Otoscopy often reveals a canal filled with blood in patients with facial cuts when they are moved lying down. After the blood and debris are cleaned, a more thorough examination may uncover cuts in the ear canal associated with a skull base fracture, even if there is no presence of hemotympanum. A detailed evaluation of the eyes and surrounding areas involves the inner canthus, fornix, conjunctiva, cornea, and orbital edges. Close inspection of these regions becomes even more essential in patients who are unresponsive and cannot express symptoms related to visual impairment, foreign bodies in the eye or conjunctiva, or double vision. In cases where there are cuts on the upper or lower eyelids in the inner canthal region or excessive distance between the eyes, the healthcare provider must check for any damage to the tear drainage system or a nasoorbitoethmoid fracture.

The long-term consequence of disrupting the canalicular system, which leads to blocking the tear drainage route into the nasal passage, is epiphora, which may not be immediately noticeable. A successful fluorescein instillation test (Jones test) can effectively eliminate the possibility of drainage pathway disruption, although safely and reliably probing the lacrimal punctum and ducts with probes while inspecting the wound before suturing is feasible and straightforward. Every patient is required to have their visual fields tested, along with assessments of motility and visual acuity, which should be recorded. Patients experiencing periorbital or ocular injuries should also be referred to an ophthalmologist for a thorough evaluation, including a dilated retinal exam.

All findings from the examination, whether positive or negative, ought to be documented, along with the times when these findings were observed. Simple errors in the medical records can lead to major challenges in ongoing diagnosis and treatment, as well as unnecessary legal liability.

Skeleton

The facial skeleton consists of two sections [4]. The top section is rigidly attached to the front of the cranial base. The lower section, the mandible, is able to move freely at the temporomandibular joints. The bony structure of the upper facial skeleton is intricate and comprises the cavities of the mouth (in part), the nose, the sinuses, and the orbits. Consequently, injuries to the facial skeleton and the related soft tissues may affect the functions of sight, breathing, smell, chewing, and taste.

The facial and oral soft tissues are quite intricate, with potential injuries to muscles and nerves alongside the more apparent harm to the skin and mucous membranes. The primary sensory nerve in this area is the trigeminal nerve, also known as the fifth cranial nerve. Its branches, located within the bony passages of the jaw and cheekbone, are particularly susceptible to damage when these bones are fractured. The facial nerve, or seventh cranial nerve, supplies the muscles responsible for facial expressions and provides animated movement to the face. Its branches may be endangered during certain facial lacerations and surgical procedures aimed at repairing specific fractures of the face.

Injuries to the face are quite common and can affect the soft tissue, the bony structure of the face, or both simultaneously. The most frequent causes of facial injuries include:

- Assault
- Sports injuries
- Road traffic accidents

Understanding the cause and context of the injury is crucial, as it can affect how the injury is managed. A high-speed automobile accident results in different forces compared to those experienced during an assault. A dog bite often leads to a wound that is contaminated by bacteria not typically found in humans. Cases of domestic violence may require involvement from social services before the affected individual is released.

Facial Bone

Sports can be categorized into various types to gain insights into how injuries occur in facial bone fractures related to sports activities [5]:

- Team sports: soccer, rugby, basketball, football, handball
- Vehicular sports: cycling, mountain biking, equestrian activities, skiing, snowboarding, ice hockey, inline skating
- Sports using small balls: tennis, baseball, cricket, golf
- Combat sports: boxing, karate, kung fu, wrestling
- Individual sports: swimming, diving, gymnastics, bodybuilding, etc.

In team sports, the leading cause of facial bone fractures typically arises from collisions with other players, often occurring when athletes use their foreheads to play the ball. This can lead to impacts between elbows and heads or between two heads. An investigation into where facial fractures happen during team sports indicated that fractures most frequently affect the jaw, followed by the zygomatic area. Football players experience orofacial injuries less frequently than other athletes, thanks to the requirement for faceguards and mouthguards. This may also contribute to the lower frequency of facial injuries noted in contact sports such as boxing.

In non-automobile vehicular sports, the predominant form of impact reported involves falls to the ground. Similar to team sports, mandibular and zygomatic fractures are common in vehicular activities, yet it is not unusual for the frontal sinus and central midface to be affected as well. Generally, mountain bikers suffer more severe maxillofacial injuries compared to standard cyclists. While cyclists often endure zygomatic fractures, mountain bikers are more prone to significant midface injuries, including Le Fort I, II, and III fractures. In equestrian sports, being struck by a horse is linked with more serious injuries.

A head injury resembling a missile type caused by a ball or similar object is frequently referenced in sports involving smaller balls, like baseball. Injuries in this category often happen due to contact with equipment such as bats, clubs, or racquets.

Diving in sports introduces specific risks to the facial area. Unusual pain in the face and issues with the jaw joint can arise from the frequent use of the regulator's mouthpiece. Changes in surrounding pressure can lead to issues like paranasal sinus barotrauma, damage to cranial nerves, and barodontalgia.

Given the crucial aesthetic and functional roles of the face, while facial bone fractures are seldom life-threatening, they should ideally be addressed by surgeons proficient in facial injuries and reconstruction [6]. The success of the surgery is enhanced when it occurs shortly after the injury, ideally within the first week, as delays make reconstruction significantly harder.

Typically, facial bone fractures result from blunt force trauma, like a punch or a heavy object, or from violent impact with a steering wheel, dashboard, or windshield in a car crash. In such scenarios, it is essential to evaluate the patient for other possible injuries. For instance, cervical spine injuries can be found in as many as 12% of patients involved in car accidents and must be treated or stabilized before addressing facial injuries. Injuries to the brain, eyes, chest, abdomen, and limbs should also be examined and may necessitate prompt intervention.

The identification of facial fractures primarily relies on clinical assessment. Ideally, this evaluation should occur immediately to avoid any obscuring caused by swelling. Understanding the mechanism and direction of the injury is vital. If the individual is awake, it is important to inquire about any past facial injuries, specific areas of discomfort or numbness, the proper function of the jaw, how well the teeth align, and whether vision is clear in all areas.

Most facial fractures can be felt during examination, or at minimum, the abnormal alignment of bones can be observed. Starting at the edges of the mandible, one can check for any irregularities in the facial bones. The alignment of dental occlusion is also assessed. By using bimanual palpation - placing thumbs inside the mouth - one can detect bony crepitus if a fracture is present. The maxilla and midface can be gently rocked forward and back between the thumb and index finger if a midfacial fracture exists. Nasal fractures are often identifiable through palpation, and any irregularities or steps along the infraorbital border, lateral rim of the orbit, or zygomatic arch suggest a zygomatic fracture may be depressed.

Radiologic examinations serve as valuable tools for accurately diagnosing fractures in the face. It is uncommon for a major fracture to appear on an X-ray without corresponding clinical signs. Beneficial imaging techniques include Waters and submentovertex angles, along with angled views of the mandible. The Panorex image of the mandible offers crucial insight into the condyle areas. CT imaging of facial bones, with suitable biplanar and three-dimensional reconstructions for multi-plane viewing, has effectively replaced standard X-rays in assessing patients with facial injuries. These scans are essential for evaluating the severity of fractures, especially in the rear regions, such as the ethmoid area, the medial and inferior orbit, pterygoid plates, and the skull base.

The nasal bones are the facial bones that experience fractures most frequently. Following them, the mandible, zygomatic-malar bones, and maxilla rank high in frequency of fractures.

Fractures

Facial trauma is often encountered in young athletes [7]. In general, the rate of facial bone fractures is less prevalent in children

compared to adults, as evidenced by one significant national study indicating that only 14.7% of all facial fractures involve pediatric patients. The occurrence of facial fractures tends to rise with age: merely 5.6% affect children below the age of five, while 55.9% of pediatric facial fractures are found in those aged 15 to 17.

Several factors are believed to contribute to these disparities, including a larger head-to-face ratio in younger populations, the underdevelopment of paranasal sinuses, the presence of unerupted permanent teeth, which help stabilize the mandible and maxilla, comparatively flexible bones in children relative to adults, and thicker layers of fat and muscle in children's facial structures.

Even with these protective attributes, sports activities are often responsible for facial fractures and nosebleeds among youth. The rate of these sports-related injuries in teenagers is similar to that of adults. One investigation revealed that 42% of all facial fractures in children are tied to sports. These injuries are significantly more common in boys than in girls, with over 88% of youth sports-related facial fractures occurring among boys. Common sports that lead to facial injuries in children typically involve either balls as projectiles or contact-focused games, such as baseball, basketball, football, martial arts, racquetball, rugby, skiing or snowboarding, soccer, and softball.

Fractures occurring in the nasal area rank as the third most frequent bone breaks throughout the body, while the nasal structure is the most frequently fractured facial bone. In high school sports, nasal fractures represent the predominant type of traumatic injury; statistics reveal that, in certain studies, 77 percent of nasal injuries were fractures, and the nose accounted for more than 7 percent of all fracture types recorded within this demographic. Among young athletes, the sport of softball stands out as the leading contributor to nasal fractures linked to sports activities. The mandible ranks as the second most commonly fractured bone in the facial region. This area is often the one that necessitates surgical intervention for fractures in high school athletes; around 65 percent of these fractures require some surgical procedure. Injuries to the orbit often occur in sporting contexts, and they may coincide with trauma to the eye. In the United States, sports-related eye injuries are reported to reach up to 600,000 each year. Although less frequent compared to other types of maxillofacial fractures, fractures to the frontal bone are still significant injuries, with sports injuries ranking second in causes, following motor vehicle accidents. Nosebleeds, known as epistaxis, are prevalent, particularly in contact sports, and represent non-bony injuries of the nasal region.

Evaluation starts with gathering a comprehensive history. It is essential to identify the sport involved, specifics of the injury, the duration between the injury and the assessment, as well as any related signs and symptoms. Even though the history may often be clear, it is important to consider the potential for assault or abuse when young individuals suffer facial injuries. If warranted, relevant questions should be raised.

Effective management of such a variety of injuries begins with conducting a primary assessment, since the airway might be endangered due to nasal or oral injuries. Practitioners should follow the core "ABCs" of trauma care: ensuring the airway is unobstructed, confirming stable breathing and circulatory conditions, and implementing necessary interventions as needed. After confirming that airway, breathing, and circulation are intact, it is essential to proceed with a secondary assessment. About one-third of pediatric patients who experience facial fractures also have concussions, so vigilance is essential when a young athlete has a facial fracture. If necessary, the Standardized Concussion Assessment Tool 3 (SCAT3) should be utilized, and the correct management protocols followed. Cervical spine precautions need to be applied for any athlete who is unconscious, reporting ongoing neurological symptoms in their limbs, or experiencing tenderness in the cervical area. Given the possibility of eye injuries, a basic ophthalmological assessment should be considered, which at minimum includes evaluating visual acuity and pupillary responses. A formal ophthalmology consultation may be required in some cases.

It is crucial to recognize that facial fractures often do not occur in isolation. Therefore, when evaluating a young athlete for a specific injury, a comprehensive examination of the entire maxillofacial region is required. In cases of maxillofacial fractures, healthcare providers should also check the individual's tetanus immunization status. A booster dose of tetanus toxoid should be administered if the last vaccination was received more than five years ago for deep or contaminated wounds or more than ten years ago for other types of wounds.

Nasal Fractures

Due to its prominent location on the face, the nose often sustains injuries in contact sports [1]. A common effect of blunt force trauma to the nasal region is a simple nosebleed, known as epistaxis. Typically, applying pressure by pinching the nostrils together effectively halts the bleeding. If bleeding continues or recurs, placing petrolatum gauze packs within the nose or utilizing silver nitrate cauterization under direct observation may be necessary. A thorough examination of the inside of the nose is essential to exclude the presence of a septal hematoma, where blood collects beneath the mucosal layer over the septal cartilage. It is crucial to drain such hematomas promptly to prevent infection and the potential death of the septal tissue associated with this type of injury if not addressed quickly.

Initial assessment of the injured nose involves checking its outward appearance to identify any misalignment of the nose's tip or bridge. Following this, the nose is touched to check for any signs of crepitus, deformities, or uneven bone structures. Lastly, the ability to breathe through each nostril is tested individually. A visual check of the nasal cavity is conducted to see if there is any displacement of the septum.

This examination of the injured nose, which emphasizes external abnormalities and the condition of the nasal passages, typically indicates if any intervention is necessary. Radiographic imaging is seldom beneficial for treating singular nasal fractures.

When nasal fractures require alignment, this is generally done immediately, most often with local anesthesia. If swelling obstructs a proper assessment of the injury, treatment may be postponed for up to a week without negatively affecting the results. If treatment is delayed longer than this, a formal rhinoplasty may be needed to address the injury-related deformity.

To perform a closed reduction on the nasal fracture, intranasal packing is typically inserted, and an external splint is placed. The packing is usually kept in for 3 to 7 days; during this period, the athlete's ability to breathe is reduced, and they should avoid strenuous activities. The external splint can be taken off after about 7 to 10 days, although it might be left on longer for the protection of the athlete's nose when resuming competition. If returning to full activity is not urgent, a cautious interval of 2 to 3 weeks away from high-risk competition is advisable. Competitors who rejoin sporting events ought to wear some form of protective facial covering.

Zygomatic Fractures

Collisions involving heads, fists, elbows, racquets, and flying objects are prevalent in sports contests, leading to frequent occurrences of fractures in the cheekbones [1].

In athletic injuries, the zygoma stands out as the midfacial bone most susceptible to fracture. More intricate midfacial fractures are categorized as high-energy injuries and are seldom encountered in typical sports-related traumas. Impacts to the cheeks or the eye socket often lead to fractures of the zygoma and its connections to the frontal, temporal, sphenoid, and maxillary bones. Given the zygoma's crucial role in the formation of the orbital rim and floor, fractures involving this area can have serious implications for vision. Moreover, the zygoma's arch, which constitutes the outer side of the cheek, is closely associated with the underlying temporal muscle and the coronoid process of the mandible, where the muscle is attached.

Identifying zygomatic or maxillary fractures through physical assessment can be challenging right after the injury due to swelling. Swift physical evaluation is essential.

If the fracture affects the orbital floor, symptoms such as double vision, difficulty moving the eye upward, and enophthalmos, which is the sunken appearance of the eye, may become evident. When fractures are limited to the zygomatic arch, they typically present with a localized depression of the cheek in the arch area and discomfort in moving the jaw because the arch may press against the temporal muscle attached to the mandible. The presence of cerebrospinal fluid leaking from the nasal passage or ear, or blood from the ear, often indicates a significant LeFort-type fracture, necessitating specialized investigation and treatment.

Non-displaced zygomatic fractures usually do not need intervention, but a thorough examination of the eyes is crucial to exclude potential globe injuries.

The reasons for surgically correcting displaced fractures of the zygomatic complex connect to issues concerning function, such as visual problems, restrictions in jaw movement, or infraorbital nerve issues, along with cosmetic concerns. Assessing cosmetic outcomes often involves waiting a few days for swelling to decrease. Repairing can be safely postponed for a period of 7 to 10 days without affecting the final outcome.

Restoration to complete athletic participation after midfacial fractures relies on the alleviation of double vision, discomfort, and swelling. The resolution of double vision holds the utmost importance. Engaging in activities without protective headgear should be avoided for a minimum of 6 weeks, where there is a high chance of additional injury.

Fractures of the Mandible

Lower jaw fractures can happen in any sport where collisions may occur, whether between players or with equipment [1]. Athletes who appear to have facial protection, such as those wearing helmets and face masks, can still sustain mandibular fractures from impacts coming from below the face mask.

The primary indicators of these fractures include malocclusion, which is the difficulty in re-aligning the teeth to their pre-injury positions as noted by the affected athlete, alongside pain when moving the jaw. Observational signs for the examiner include the jaw's deviation and noticeable malocclusion that deviates from the patient's typical bite, as shown by wear on the teeth, crepitus (detectable movements along the lower edge of the jaw), movement of segments of the tooth-supporting regions of the jaw in relation to each other (distinct from the movement of single teeth or parts of teeth that can move independently of the jaw), and the observation of bleeding or bruising found between teeth or on the floor of the mouth near the jaw.

Special focus should be given to the inspection of the condyles, particularly if the injury has impacted the area around the chin. Neither discomfort in the joints nor misalignment of teeth can definitively indicate a condylar fracture, since traumatic effusion (blood entering the joint due to a chin impact) may lead to either symptom without a fracture being present. Conversely, a fracture typically results in both pain before the ear and misalignment, along with restricted jaw movement and a tendency for the jaw to shift toward the side of the fracture when the mouth opens. During a physical exam, feeling the condyle by putting a finger just in front of the ear or in the ear canal will indicate lack of motion in the fractured condyle as the jaw is opened.

It is crucial to differentiate a fracture of the mandible from a traumatic dislocation or subluxation of the jaw. A dislocation is identified by a persistent opening in the jaw, preventing the patient from closing it. Feeling the condyles will reveal an absence of condyles in their typical location right in front of the tragus of the ear and the presence of a bony mass situated 1 to 2 cm (0.4 to 0.8 inches) in front of the standard position of the joint.

Early intervention for a dislocated jaw is the most effective course of action, as postponing this procedure can lead to complications such as increased pain and muscle spasms, which might require medications to relax the muscles or even anesthesia. During the initial phase, the jaw can be repositioned through the following steps:

1. The healthcare provider should be positioned directly in front of the patient who is seated in a robust chair.
2. The provider's thumbs should be placed inside the mouth, beside the back teeth, avoiding contact with the teeth, while their fingers wrap around the outside edge of the jaw.
3. A twisting motion is exerted to lower the back of the jaw while simultaneously moving the chin forward.
4. Once the condyle has rotated far enough to exit the front edge of the joint, the jaw will naturally shift backward, allowing the teeth to come together gently.

Athletes should be advised to restrict how wide they open their jaws for several days, and the use of anti-inflammatory medications is suggested to alleviate the joint swelling that can follow such an injury.

Upon confirming a jaw fracture, it is essential to refer the patient to specialized medical care. Treatment options vary, from a soft food diet and pain relief for those with minor fractures to surgical repair for more severe injuries. While many lower jaw fractures can be successfully managed with closed reduction, this approach requires the jaw to be immobilized by wiring the upper and lower teeth together for at least four weeks. This method significantly affects the athlete's ability to participate in sport due to challenges in nutrition and the necessity of not engaging in mouth breathing during physical activity. An alternative procedure is surgical treatment using rigid plates to stabilize the broken bone. Although this approach is more complicated surgically, it allows for quicker mobilization of the jaw, improved nutrition and breathing, and an earlier return to competition might be expected once pain and swelling decrease and protective gear is utilized.

Concussion

A sport-related concussion is classified as a Mild Traumatic Brain Injury [8]. It is frequently observed in settings prior to hospital care, particularly in sports involving contact and collisions. This injury can be caused by a direct blow to the head or by a hit to the body that causes the head to move rapidly back and forth.

In about 10% of instances, there is a loss of consciousness. More commonly, symptoms are subtle, or due to the distances involved, the individual may appear to have partially recovered by the time a first responder arrives.

Headaches and dizziness are often reported as primary symptoms; however, factors like language barriers or players knowingly or unknowingly minimizing their symptoms can lead to inaccuracies in reporting. Sole reliance on the Maddocks Questions (such as which venue we are at or which half it is) is also not recommended.

Despite extensive studies, there is still no definitive objective test that can diagnose a concussion, so healthcare providers must utilize their clinical judgment along with a thorough evaluation of the athlete. This assessment may be augmented by information from video analysis, observations from fellow players about behavior, and insights from coaches about performance.

When dealing with a concussion, it is crucial to be alert for any signs of the injury. Especially in situations involving facial injuries, medical personnel often feel pressured to quickly get the player back into the game. Nonetheless, it is vital to recognize that the force needed to cause such injuries can also lead to a concussion.

Next, having a very low threshold for taking a player out of the game when a concussion is suspected is essential. Continuing to participate in sports after experiencing a concussion can lead to a decrease in performance; there is a direct correlation between continued activity and a longer recovery period following the injury, and specifically among adolescents, there may be occurrences of "Second Impact Syndrome." This uncommon and somewhat debatable condition arises when additional head injury occurs soon after the initial event, causing severe brain swelling and frequently resulting in death.

Furthermore, given that the symptoms and signs of a concussion might not appear immediately, the possibility of a concussion should be kept in mind for at least 48 hours following the initial head impact.

For this reason, if a concussion is suspected, players should be immediately removed from the game and should not return until they have been assessed by a medical professional. This assessment typically does not involve brain imaging but primarily focuses on neurological evaluations, cognitive function tests, and subjective symptom reporting.

Every athlete who experiences a concussion must undergo a period of complete rest, followed by a carefully phased return-to-play strategy. This approach aims to gradually introduce athletes to increasing mental and physical demands to ensure a safe transition back to competitive sports. The extent to which successfully completing this return process signifies brain recovery is widely discussed and debated.

Head Injuries

Injuries to the head are a significant contributor to severe disability and death, often resulting in longer-lasting consequences compared to injuries affecting limbs [9]. Acute head trauma is often called traumatic brain injury (TBI). The primary causes of TBI include accidents involving vehicles and incidents related to contact sports. Incidents of head and facial trauma in contact sports have existed since ancient fighters and wrestlers began engaging in competitions thousands of years ago. Although rare, the risk of significant head injuries in athletes leading to death, lasting brain damage, or paralysis is consistently linked to sports like American

football, ice hockey, boxing, water sports, motorcycle riding, and gymnastics.

The most prevalent type of head injury in athletics is a minor traumatic brain injury (MTBI) or concussion. Data from the National Health Interview Survey (NHIS) indicates that over 300,000 MTBIs occur annually in the US due to sports or leisure activities. More than 100,000 concussions are specifically attributed to American football. While estimates vary, the chance of an athlete in a contact sport sustaining a concussion could be as high as 19%. Additionally, it is now understood that the repercussions of concussions accumulate, even if the impacts sustained are relatively mild. Recent findings indicate that college football players with two or more prior concussions perform worse on cognitive ability assessments, including speed and problem-solving skills, compared to those with either one or no past concussions.

In the realm of boxing, the incidence of MTBI among amateur fighters is reported at 5%, while this percentage increases to 6.3% for professionals. Many concussions are relatively mild; however, some can lead to significant and lasting brain impairments. A pressing concern in athletics is the prevalence and cumulative neurological harm caused by repeated concussions. It is widely acknowledged that experiencing a second concussion while still recovering from an earlier one can have disastrous or even deadly results. This condition, known as second impact syndrome, is increasingly being documented in sports medicine and can have a mortality rate as high as 50% in the most severe instances. Awareness of the dangers associated with repeated concussions has only recently begun to rise, particularly after high-profile players suffered career-ending injuries.

Even though head injuries have posed a significant issue since humanity's beginning, there remains limited understanding of the fundamental mechanisms behind these injuries. The field of biomechanics explores how forces and movements impact the body, as well as the resilience of biological tissues.

Eye Injuries

Eye injuries can occur from impacts where a finger or elbow comes into contact with the eye [10]. Small spheres (like squash balls or shuttlecocks) can lead to eye harm, while larger balls (such as those used in cricket or hockey) pose a greater risk of orbital fractures. Particles such as dirt, sand, or small stones can penetrate the eye, resulting in irritation and injury. It is noteworthy how fast a ball can travel. In squash, it can move at speeds of up to 140 miles per hour, in cricket it reaches about 110 miles per hour, and in soccer, it ranges from 35 to 75 miles per hour. An object moving at such velocities undoubtedly generates significant force, which can lead to injury. This is evidenced by the unfortunate statistic that more than 10% of eye injuries in sports result in blindness in the affected eye.

When a foreign object is lodged in the eye, it is advisable to use large amounts of water to flush out the item (a squeeze bottle is particularly effective). The athlete should be seated and instructed to gaze upward, to the right, to the left, and downward while clean or sterile water is poured into the inner corner of the eye. Probing the eye should be avoided, as this could cause the object to scrape the cornea.

In certain cases, especially if the foreign object is an eyelash, the eyelid might be inverted. This process begins by having the athlete look downward. The practitioner then gently pulls the upper lid's lashes down and outward away from the eye. A cotton swab is placed against the outer lid at the fold. The lashes are then lifted over the swab to expose the inner eyelid, allowing the foreign item to be flushed away. Once the athlete looks up and blinks, the eyelid will return to its normal position.

A foreign body in the eye is among the most frequently encountered issues in sports settings. The typical response is discomfort and tearing. If the foreign object is not removed, blinking may lead to corneal scratches and severe pain lasting around 48 hours. It is crucial to prevent the athlete from touching the foreign body, as this will only exacerbate the abrasion. If the object cannot be easily flushed out, place a sterile dressing over the eye and transport the athlete to a medical facility. It is important to advise the athlete to keep their eyes still, as movement of the unaffected eye can also shift the injured one, resulting in further tissue damage.

Contact lenses may lead to various complications. Rigid lenses can shatter or become scratched or rough, potentially damaging the cornea. Soft lenses can tear easily. If the eye has sustained an injury or has become infected, a contact lens should not be reinserted until the eye has completely healed for a minimum of 24 hours.

Dental Injuries

Main factors leading to dental injuries due to trauma primarily include falls and collisions with others or objects, and sometimes, both [11]. Injuries to the teeth and face resulting from trauma frequently occur in athletic activities, often leading to aesthetic, functional, psychological, and financial issues. The injuries sustained during sports are typically the most prevalent form of facial injuries encountered. It is increasingly recognized that engaging in sports involves a significant likelihood of experiencing dental injuries. Research highlights the threat of possible facial injuries resulting from trauma during sports, particularly in those involving physical contact. With the growing popularity of contact sports and the encouragement of youth participation, the importance of dental professionals in the prevention of dental and other facial injuries is being acknowledged. Contact sports refer to those in which players physically engage with one another to thwart the other team or participant from achieving victory. A considerable amount of dental and oral injuries arise from contact sports, which include American football, baseball, basketball, rugby, ice hockey, soccer, boxing, wrestling, and stick sports. Competitive events are noted to pose a higher risk compared to practice sessions.

The facial area is among the most unprotected regions of the body and is often the least safeguarded. About 11 to 40 percent of all sports injuries are related to the face. Such injuries commonly re-

sult from impacts with an object, ball, or contact between players. A blow to the facial area can lead not only to dental or soft tissue damage but may also cause fractures in the jaw or facial bones and even cerebral injuries. The intricate structure of the face presents challenges for healthcare providers regarding the diagnosis and management of these injuries. As the evaluation of the aesthetic, functional, psychological, and economic consequences of facial injuries becomes more important, the need for preventive measures grows. The most frequent forms of trauma associated with sports include injuries to soft tissues and fractures of the bones of the face (such as the nose, zygomatic bone, and mandible). Injuries sustained during sports can lead to serious fractures affecting facial bones and teeth. The literature distinguishes between macro-trauma and microtrauma. Macro-trauma encompasses injuries caused by sudden, intense forces, for example, bone fractures, strains, bruises, concussions, fractures of teeth, avulsions, and cuts. Microtrauma refers to injuries that result from long-term, repetitive stress over time, incorporating stress fractures, bursitis, tendinitis, dental wear, and temporomandibular joint issues. Each contact sport appears to have its unique patterns of injuries.

While some studies have reported the rates of dental injuries associated with sports, the information available is often insufficient. There is a pressing need for a standardized system to document facial injuries related to sports, which would facilitate the creation of a robust database that could enhance treatment results. Such a database could support the advancement of protective gear design and foster improved education for coaches, officials, players, and parents. According to the International Academy for Sports Dentistry, the term "sports dentistry" encompasses the prevention and management of oral and facial injuries related to sports, in addition to oral health issues that stem from these injuries. It also includes the gathering and sharing of data on dental injuries that occur in sports and promotes research aimed at preventing such injuries.

Maxillofacial Trauma

In cases of maxillofacial trauma, oral suction devices are beneficial for clearing blood from the airway [12]. An athlete with facial injuries should remain seated upright with their neck held back to help keep the airway open. Cricothyrotomy must be conducted only by individuals who are trained and have the authority to perform this procedure if all other airway management attempts have been unsuccessful.

Blunt force trauma to the front part of the neck can lead to bruising and/or fractures in the trachea, larynx, and hyoid bone, which can significantly obstruct the airway. Such injuries are often seen in sports like field hockey, ice hockey, rugby, fencing, netball, basketball, and lacrosse. Many of these sports require players to wear neck protection extensions on their helmets to safeguard this crucial area. Initial signs of laryngeal injury may present as hoarseness, shortness of breath, coughing, difficulties with swallowing, and pain. An examination might reveal subcutaneous emphysema, crackling sounds, and a detectable fracture. Laryngospasm and acute respiratory distress can also occur. Soft tissue swelling typically reaches its peak within six hours but can develop as late as 24 to 48 hours post-injury, making it essential to monitor the athlete closely during this period, as internal bleeding and localized swelling could obstruct the airway at any time. A sudden loss of breath can trigger immediate panic and anxiety in the athlete, complicating airway management. The team physician should provide reassurance to the athlete and prioritize maintaining an unobstructed airway. In mild to moderate instances, positioning the athlete upright aids in keeping the airway open. Applying ice gently to the injured region and using nebulized adrenaline can reduce swelling. In cases of severe neck trauma or spasms, potential cervical spine injuries must be considered. It is crucial to stabilize the athlete's neck in a neutral position and apply a rigid cervical collar. Perform the jaw-thrust maneuver as described earlier to lift the hyoid bone and surrounding soft tissues away from the vocal cords to clear the airway. Once laryngospasm subsides, usually within a minute, a pronounced inspiratory crowing noise may be audible. If respiratory arrest seems to be imminent after performing the jaw-thrust maneuver, nasotracheal or endotracheal intubation should be contemplated. If the laryngeal structure is compromised and the cricothyroid membrane is not palpable, cricothyroidotomy is not an option; however, in cases of total airway obstruction, needle cricothyroidotomy and jet insufflation might be attempted. All individuals with laryngeal injuries should be promptly referred for specialized evaluation and laryngoscopy.

Facial injuries can take place on their own or alongside other types of injuries [13]. No matter where the damage occurs, it leads to both localized and systemic consequences. Trauma results in harm to either soft or hard tissues and triggers an inflammatory response, which manifests as pain, tenderness, swelling, and decreased functionality. It is also common for the physical structure at the injury location to be compromised: skin may be scraped, cut, or lost, while bones and teeth could endure stress that results in fractures or dislocations. Although indirect soft-tissue injuries are uncommon, they can happen due to traction on the skin from blunt force and tearing at remote areas. Indirect trauma is a more typical reason for fractures; for instance, a hit to the mandibular symphysis can trigger a fracture in the distant subcondylar region.

Grasping the cause of an injury is crucial for multiple reasons. It directs attention to injury prevention strategies; it may assist in recognizing common injury patterns (such as a hit to the symphysis connected with a condylar fracture or head injury), and it can increase awareness of potential future injuries (for instance, in incidents of domestic abuse). There are various distinctive aspects of injuries to the face due to its role in the senses of sight, smell, taste, and hearing. Moreover, functions such as eating, drinking, speaking, and expressing emotions depend on the health of the maxillofacial framework. Disruption of the maxillofacial bones may endanger the airway.

For individuals with maxillofacial wounds, it is also vital to take into account the chance of injuries affecting the base of the skull, the cranial vault, the brain, the cervical spine, and the upper aerodigestive tract. Indirect impacts on the upper aerodigestive system can include blockages or partial blockages of the airway

due to blood, saliva, or pieces of teeth and bones. Airbag-related injuries might involve both the neck and facial regions simultaneously. The presence and severity of brain injuries can affect the likelihood of distant complications in the aerodigestive tract, as a state of coma could make inhalation of dislodged teeth and blood more likely.

There is some indication that the face serves as a "crumple zone" (similar to how the front end of a car absorbs shock that would otherwise affect the passenger area), which means it may provide some protection against brain injuries. Facial injuries and brain trauma frequently occur together because they are located in the same anatomical zone. Generally, the more severe the facial injury, the higher the chances of sustaining a brain injury.

Wounds

Contusions accompanied by different extents of ecchymosis are the facial injuries that are most frequently observed [14]. These injuries occur due to blunt force trauma that results in bleeding beneath the skin. In cases of contusions, the skin and mucosal surfaces above remain unbroken. To reduce inflammation, ice should be applied promptly. Nonsteroidal anti-inflammatory medications can be effective for alleviating pain and reducing swelling, but caution is advised if there is a risk of significant bleeding. If a contusion is associated with a cut and there is a possibility of necrosis at the wound edges, the edges might need to be refined prior to closure. Athletes are permitted to resume play as long as their ability to compete safely remains unaffected.

Abrasions refer to minor injuries to the top layer of the skin, occurring more frequently on prominent areas of the face. Occasionally, more severe abrasions can reach the dermis, making them hard to distinguish from lacerations. It is crucial to thoroughly cleanse these injuries before any repair or dressing is applied. Initially, the wound should be cleaned using a gentle soap, followed by extensive irrigation with normal saline or a balanced salt solution, such as Ringer's lactate. It is important to avoid the use of harsh soaps, iodophors, or alcohol, as these can be harmful to cells and may impede the healing process. After cleaning and debridement, the wound might bleed. It is advisable to apply an antibiotic ointment and cover the area with a sterile dressing. Athletes should receive guidance on fundamental wound care and may be allowed to return to competition if they can do so safely. Any open wounds should be covered prior to engaging in contact sports.

A laceration is defined as a wound that penetrates the full layer of the skin, commonly caused by sharp objects or the compression of skin against bone with a blunt object. Lacerations rank among the most prevalent injuries in sports. There may be considerable bleeding if blood vessels have been cut. The objectives of initial treatment include cleaning the wound and stopping the bleeding. Applying direct pressure can help control bleeding and prevent the formation of a hematoma, which increases the risk of infection, wound failure, and scarring. Wounds can generally be closed primarily within 48 hours of injury. If there is a facial bone fracture, substantial facial swelling, or a hematoma, delayed primary closure may be necessary. Access to some facial bone fractures can be gained via the laceration, which will be closed during the repair of the fracture.

The approach to treating tongue lacerations depends on their size, position, and degree of bleeding. Small lacerations at the back of the tongue without significant blood loss may not require treatment, while larger lacerations that may lead to noticeable scarring or that need to control bleeding should be sutured. Inspection of tongue lacerations may also be necessary to check for foreign objects like tooth fragments.

Wounds that have been tainted by external substances need careful assessment and cleaning. Cuts that affect the area where the lip meets the skin, facial nerve impairments, cartilages of the ear or nose, the eyebrow, eyelid, and those that are significantly deep face a risk of undesirable cosmetic or functional results, thus requiring a specialist's referral for proper treatment. Timely care for soft tissue injuries can reduce scarring and lessen possible negative psychological impacts. A pulsating irrigation device can assist in the removal of residues or other loose substances. Tetanus vaccination should be administered for wounds that are contaminated. While infections in uncomplicated soft tissue injuries of the head and neck are uncommon, there are cases that may require preventative antibiotics. Cuts that are well-controlled and correctly bandaged may permit a return to sports. Athletes who need intricate repairs for their cuts typically cannot resume playing. The strength of a wound gradually improves with the healing process. By three weeks, wound strength increases to 20% and reaches 50% by four weeks. Between three to six months, a wound can reach its peak strength, which is about 70-80% of its initial strength. Avulsion injuries involving actual tissue loss are rare in sporting incidents and may necessitate multiple or staged surgeries.

Diagnosis

Injuries to the face related to sports are rarely life-threatening [15]. However, the growing use of advanced sports gear, including in-line skates, snowboards, and all-terrain bicycles, has complicated the nature of injuries. Consequently, primary care providers often encounter more serious injuries. Following the initial evaluation of breathing, circulation, and airways, as well as an assessment for potential cervical spine injuries, the examination of the facial structure can commence. Improper treatment of facial injuries may lead to either functional or aesthetic complications. A referral to the correct specialist and a detailed clinical examination are essential to decide if a patient with a facial injury requires further imaging studies to rule out fractures.

If a patient experiences a significant facial injury, their airway might be blocked by foreign objects, blood clots, loose teeth, bone fragments, or a misplaced mouthguard. Immediate care on-site involves securing the airway and controlling bleeding. If these steps prove difficult, intubation of the patient is necessary. In some emergencies, a cricothyrotomy might be required.

Applying direct pressure to a wound is a straightforward first response to manage bleeding. However, controlling bleeding in the throat, mouth, and nose can be challenging. Various techniques, such as nasal packing, using an epistaxis catheter, and placing compressive dressings in the mouth, may be employed. Severe facial bleeding may necessitate intubation, utilizing an epistaxis catheter, and packing the throat and mouth with compresses, along with applying compresses over the face and using circumfacial elastics to compress the entire facial structure. Imaging through angiography might be required, followed by surgery or interventional radiology to manage the bleeding.

The purpose of the clinical assessment during the acute stage is to determine if a soft-tissue injury exists or if there is a more complicated injury that necessitates intervention from a specialist. Patients suspected of having fractures should be directed to the emergency department for imaging studies. All individuals with dentoalveolar injuries require immediate treatment from a dentist. If the primary differential diagnoses can be ruled out through a clinical assessment, further investigations for this matter are not needed.

The mechanism of injury is crucial for accurately diagnosing and assessing the severity of the injury. Typically, in cases involving facial injuries, the affected athlete can describe how the injury occurred. Most patient histories fall into one of two categories: either the individual struck their own face or they were struck by someone else. Insights from other players may play a significant role in achieving an accurate diagnosis. Injuries in the oral cavity frequently result from direct impact to the lips or teeth, which can happen from a blow or a kick by an opponent or from sporting equipment like a hockey stick, an ice hockey puck, a bandy ball, or a ski pole.

Surgical Intervention

The scheduling of reconstruction in the event of a brain injury needs meticulous planning [16]. Performing surgical procedures while there is elevated intracranial pressure can lead to negative outcomes. To prevent secondary damage during any kind of intervention, it is essential to maintain oxygenation and blood flow to the brain, and to minimize hypotension caused by anesthetics and surgical bleeding. Prolonged operations on patients who are physiologically unstable may exacerbate the effects of brain retraction and increase the risk of additional brain injuries by causing swelling. Sometimes, delaying the definitive treatment of facial injuries is required for patient stabilization. This postponement may affect the final soft tissue appearance, as the healing process and scarring may have already begun. The timing of the surgical intervention is therefore contingent on:

Severity of the injury

Complex procedures are not warranted if survival is highly improbable.

Intracranial pressure

It is advisable to wait for intracranial pressure to stabilize. While some advocate for early aggressive treatment, this could lead to higher morbidity and mortality rates.

Facial swelling

Pronounced facial swelling makes it difficult to perform early interventions, as it complicates the making of incisions and the evaluation of facial shape. Additionally, handling the soft tissues becomes challenging in a swollen state.

Anaesthetic considerations

Intubating patients ensures proper airway management and regulation of intracranial pressure. As the patient's condition improves and they are transitioned away from anesthesia for neurological function evaluation, the tolerance for intubation decreases, leading to the necessity for extubation or placement of a tracheostomy tube. Otherwise, coughing may further aggravate intracranial pressure issues. This could be the optimal moment to proceed with surgery.

For successful repair of panfacial fractures, intermaxillary fixation could be necessary. Typically, nasal intubation would be preferred, but it may not be viable due to fractures of the midface and skull base; in such cases, a tracheostomy may present a better solution.

Availability of the surgical team

Adequate time in the operating room and the presence of all groups participating in the repair will also affect the schedule since collaborative operation will be required.

Administration of antibiotics throughout the waiting period is essential due to the elevated infection rates that occur after midfacial trauma.

Helmet Use

Both serious head traumas and minor traumatic brain injuries, also known as concussions, frequently occur in both contact sports, such as football, and non-contact sports, including baseball, cycling, and in-line skating [17]. The ways in which head injuries happen in these sports encompass falls associated with cycling, skiing, or skating, collisions with other players in football or soccer, crashes with fixed equipment like goal posts, and getting hit by a moving object in sports such as baseball or soccer. Studies have demonstrated that helmets are quite effective in lowering the likelihood of injuries across various sports. Research focusing on two collision sports indicates that wearing a helmet substantially lessens the chances of head injuries in the sport where helmets are mandatory.

While football helmets are designed to protect against minor head and facial injuries and to shield players from severe head trauma, they do not eliminate all risks. Advances in helmet design have led to players increasingly using their heads during contact situations. This practice has led to axial loading, heightening the potential for severe cervical spine injuries caused by spearing. To mitigate the risks associated with neck injuries, it is crucial to instruct players to refrain from making head-first contacts and to avoid using their

heads for initial impact. Furthermore, leagues should implement penalties for spear tackles to deter such behaviors. Players should be advised to prioritize shoulder contact first while keeping their heads up to reduce the likelihood of significant neck injuries.

Annually, a significant number of fatalities, emergency room admissions, and considerable financial expenditures arise from head injuries associated with cycling. Head injuries account for one-third of total cycling-related injuries and contribute to 80% of deaths connected to bicycle accidents. As a sport or leisure activity, cycling has been the subject of extensive research regarding helmet usage, which has proven effective in significantly lowering the incidence of head injuries. Wearing a bicycle helmet represents a straightforward intervention that can greatly lessen the chance of sustaining head injuries. A case-control study indicated that helmet use led to an 85% decrease in the likelihood of head injuries and an 88% reduction in the risk of brain injuries. Increasing helmet usage can be achieved through both legislative measures and educational efforts. The use of helmets is mandatory in races organized by the US Cycling Federation and triathlons. Primary care physicians and sports medicine specialists can significantly influence the promotion of bicycle helmet utilization.

Helmets have been found to lower the incidence of head injuries in equestrian activities. Although there remains a risk of riders being fatally injured if a horse rolls onto them, helmets can help diminish the likelihood of head injuries from other types of incidents in this sport. Research into helmet adjustments and developments continues with the aim of further decreasing the risk of fatalities from head injuries caused by crushing incidents.

Other sports in which the use of helmets should be encouraged include ice hockey, bull riding, and baseball. Even though football helmets have been found to lessen the force of a soccer ball when players head the ball, these helmets have not gained acceptance in either youth or adult soccer programs. Soccer headbands have been demonstrated to alleviate some impact from head-to-head collisions, but they do not significantly affect the impact between the ball and the head. Future studies that illustrate a reduced likelihood of head injuries for those using headbands are essential for proving their protective benefits and fostering greater acceptance among athletes and organizations.

Prevention

Anyone engaged in physical activity runs the risk of injury [18]. While certain injuries, like a sprained ankle or a fracture, can be challenging to avoid, numerous other injuries can be prevented. Following a few straightforward guidelines can help minimize injuries, including muscle strains, tendonitis, and overuse injuries.

Each exercise session should start with a warm-up and conclude with a cool-down. A warm-up is essential in preparing the body for exercise by raising the heart rate and enhancing blood circulation to active muscles. It should commence gradually and gently, focusing on general cardiovascular activities, such as walking, jogging, or cycling. The aim is to induce sweating. Following 5 to 10 minutes, the warm-up should zero in on specific muscles and movements related to the planned exercise session. Ensuring a seamless transition from warm-up activities to specific workouts is an excellent way to prevent injuries. For instance, a soccer player might pass, dribble, and shoot the ball, while a weightlifter may lift lighter weights before progressing to heavier ones.

Incorporating flexibility exercises into an effective warm-up is crucial. Once the muscles are warmed up, they become more pliable and ready for stretching. Whether opting for static stretches (holding each position for 10 to 30 seconds) or dynamic stretches (moving the body through functional ranges), flexibility work prepares the muscles, tendons, and joints for exertion by enabling them to move smoothly through a full range of motion. The better prepared the body is, the lower the likelihood of injury.

A commonly overlooked aspect is the cool-down phase following physical activity. Just as the warm-up preps the body for effort, the cool-down helps return it to its regular state. Spending 5 to 10 minutes engaging in low-intensity cardiovascular activities followed by stretching right after exercising will help reduce muscle soreness and facilitate recovery, both of which assist in preparing the body for subsequent workouts.

Once an exercise regimen is established, several important considerations must be kept in mind. Begin gradually: individuals frequently rush into exercise and overdo it initially, leading to unnecessary muscle discomfort and stiffness. The key to avoiding injuries lies in appropriate progression. Gradually extend the duration of each session, the workout's intensity, and the weights being used. A safe way to progress is to increase by 5% once the exercise becomes too easy. Engage in physical activities that suit your age and fitness capabilities. A younger athlete competing against older peers might lack the same strength, which could result in a higher injury risk. This is also applicable to a recreational athlete who participates in a game alongside individuals who have consistently trained throughout the week. If your workout routine includes equipment, ensure you have the correct gear, it fits well, and it adheres to safety regulations. Frequently, the use of outdated, faulty, or ill-fitting gear such as shoes, mouthguards, helmets, protective eyewear, or shin guards can lead to injuries.

One effective method to avoid injuries is by paying attention to the signals your body sends you. Disregarding minor discomforts in muscles and joints can result in significant injuries. Pain indicates that something is amiss with your body! The popular saying "no pain, no gain" fosters a major misunderstanding. It is entirely feasible to achieve cardiovascular and strength improvements in your exercise routine without experiencing pain. If you are feeling fatigued or excessively sore from previous sessions, take a break, engage in cross-training, or reduce the intensity of your workout. To avert overuse injuries, it is essential to incorporate diversity into your exercise regimen. Transitioning between activities such as running to cycling, aerobics to resistance training, or swimming to spinning allows muscles and joints that are over-exerted in your usual routine to rest while still challenging different body areas.

Conclusion

Facial injuries result from direct impact due to falling on the face or by an object colliding with it. Because there is minimal subcutaneous fat to cushion the impact, damage to the skin and blood vessels, along with increased bleeding at the site of injury, is quite common. Facial fractures often necessitate surgical intervention due to the potential for bone misalignment and risk of obstructing the airway.

Conflict of Interest and Funding

The author declares no conflict of interest and received no specific funding for this work.

References

1. Kelly JP. Maxillofacial injuries. In: Magee DJ, Manske RC, Zachazewski JE, Quillen WS, editors. Athletic and sport issues in musculoskeletal rehabilitation. Saunders Elsevier Inc.; 2011. p. 581-593.
2. Jeroukhimov I, Cockburn M, Cohn S. Facial trauma: overview of trauma care. In: Thaller SR, McDonald WS, editors. Facial trauma. Marcel Dekker Inc.; 2004. p. 10-11.
3. Hill JD, Stoddard DG Jr, Hamilton GS III. Facial trauma: soft tissue lacerations and burns. In: Flint PW, Francis HW, Haughey BH, Lesperance MM, Lund VJ, et al., editors. Cummings otolaryngology - head and neck surgery. 7th ed. Elsevier; 2021. p. 270.
4. Yates C. A manual of oral and maxillofacial surgery for nurses. Blackwell Science Ltd; 2000. p. 160.
5. Bernaerts A, Ehlinger P, Chapelle K. Maxillofacial injuries in sports. In: Vanhoenacker FM, Maas M, Gielen JL, editors. Imaging of orthopedic sports injuries. Springer-Verlag Berlin Heidelberg; 2007. p. 402-404.
6. Vasconez HC, Buseman J. Plastic & reconstructive surgery. In: Doherty GM, editor. Current diagnosis and treatment - surgery. 14th ed. McGraw-Hill Education; 2015. p. 1174.
7. MacDonald JP, Sando JP. Facial fractures and epistaxis. In: O'Brien M, Meehan WP III, editors. Head and neck injuries in young athletes. Springer International Publishing; 2016. p. 167-168.
8. Cooke M, Vishnubala A, O'Halloran P. Emergency medicine. In: Eastwood D, Vishnubala D, editors. Sport and exercise medicine - an essential guide. CRC Press, Taylor & Francis Group LLC; 2023. p. 221.
9. Zhang L, Yang KH, King AI, Engebretsen L. Head. In: Kjær M, Krogsgaard M, Magnusson P, Engebretsen L, Roos H, et al., editors. Textbook of sports medicine - basic science and clinical aspects of sports injury and physical activity. Blackwell Science Ltd; 2003. p. 639.
10. Norris CM. Managing sports injuries - a guide for students and clinicians. 4th ed. Churchill Livingstone, Elsevier; 2011. p. 325.
11. Dursun E, Dönmez G, Dilicikik U, Dursun CK, Doral MN. Traumatic dental injuries in sports. In: Doral MN, Karlsson J, editors. Sports injuries - prevention, diagnosis, treatment and rehabilitation. 2nd ed. Springer-Verlag Berlin Heidelberg; 2015. p. 3015-3016.
12. Holtzhausen LM, Hanna C. Emergency sports medicine. In: Schwellnus MP, editor. The Olympic textbook of medicine in sport. Blackwell Publishing Ltd, John Wiley & Sons Ltd; 2008. p. 509-510.
13. Shepherd JP. Maxillofacial trauma. In: Pedlar J, Frame J, editors. Oral and maxillofacial surgery. 2nd ed. Churchill Livingstone, Elsevier; 2007. p. 184.
14. Thomson F, Gelfman S. Facial trauma. In: Herrera JE, Cooper G, editors. Essential sports medicine. Humana Press, Springer Science + Business Media LLC; 2008. p. 27-28.
15. Skjelbred P, Maron G, Gassner R. Facial injuries. In: Bahr R, McCrory P, LaPrade RF, Meeuwisse W, Engebretsen L, editors. The IOC manual of sports injuries - an illustrated guide to the management of injuries in physical activity. Wiley-Blackwell, John Wiley & Sons; 2012. p. 79-80.
16. McArdle P. Craniofacial trauma: injury patterns and management. In: Whitfield PC, Thomas EO, Summers F, Whyte M, Hutchinson PJ, editors. Head injury - a multidisciplinary approach. Cambridge University Press; 2009. p. 190-191.
17. Bernhardt DT. Protective sports equipment. In: Hebestreit H, Bar-Or O, editors. The young athlete. Blackwell Publishing Ltd; 2008. p. 164-165.
18. Larsen L, editor. Sports injuries sourcebook. 4th ed. Omnigraphics Inc.; 2012. p. 84-85.