Facial injuries in children are much less common than in adults particularly in the first five years of life. The canine population also subjects the child to dog bites, sometimes resulting in considerable soft tissue disorganization and loss.

During preschool years, parental supervision reduces the risk of serious injuries; although falls are frequent they are usually from a small height. The small volume of facial skeleton not yet weakened by the air sinuses are protected also by the cheek adipose tissue i.e. less subject to fracture than the cranium & lower third of the face.

Children have increased elasticity of the bone & a short thick condylar neck which also resists fracture, however the presence of deciduous &permanent teeth results in a higher tooth to bone ratio and encourages fracture through the developing tooth crypts. Facial deformity may result not only from the displacement of bony structures but also from impaired growth which is attributable to injury.

Techniques used to treat fractures in children are modified by certain anatomical, physiological & psychological factors related to childhood. Fear apprehension & strange surroundings from the children requires considerable technique & patience from the attending doctor to do a thorough clinical & radiographic evaluation of the injury. Under these circumstances treatment should be designed to incorporate a minimum number of separate procedures.

A one stage technique is preferred & considerable care must be exercised during treatment if miniplates or transosseous wiring is used to avoid the developing tooth buds. Condylar fractures & injuries should be viewed with concern in the growing child because of the possibility of ankylosis of the joint & impaired facial growth.

Soft tissue injuries resulting in densely scarred areas may require reconstructive procedures for such untreated areas may interfere with subjacent bony growth & loss of soft tissue should be remedied using standard reconstructive techniques as used in an adult.

REFERENCES