Orofacial Myology News

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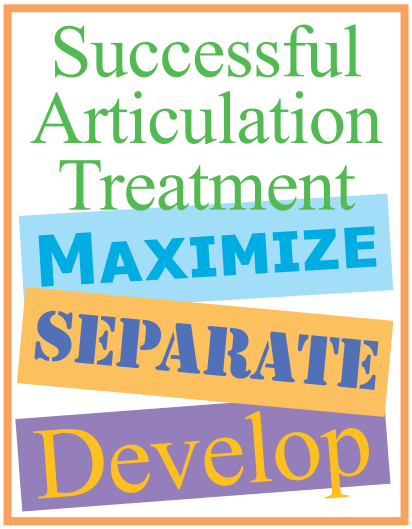
Each time I believe it cannot get better, it somehow does! Orofacial Myology is more popular worldwide than ever before. More professionals and members of the general public know what we do and are insisting that our services become part of their ongoing orthodontic and therapy programs. This is very exciting and encouraging for those of us who have been involved with Orofacial Myology for a long time. The increased recognition of orofacial myology carries with it a burden, also. We must remain vigilant in maintaining the standards and integrity of our specialty area. Quality vs quantity must be our key words. This obligates us to focus on the depth of our current knowledge before attempting to spread out in too many peripheral areas, tempting though they might be. The future looks very bright for us as long as we continue to clarify our objectives, scrutinize research studies for validity before incorporating their findings, and create effective treatment plans that reflect current best practice objectives.

When we talk about standards and integrity, a name immediately comes to mind….Dr. Robert M. Mason, known to many as "Dr. Bob." Considered controversial by some, a pure genius by others, there is no doubt that he has played a critical role in nearly every aspect of orofacial myology. From co-authoring Orofacial Myology: International Perspectives to serving as the IAOM Medical Director; from mentoring dozens of IAOM members and certification candidates to creating guidelines and principle statements; from responding to hundreds of emails from the public sector to providing materials to the IAOM for distribution ….the list is endless of examples of his dedication toward the advancement of the specialty area of orofacial myology. For these reasons and more, we are pleased to announce Dr. Bob's Pearls, our newest newsletter section, dedicated to providing you with meaningful information that can only come from someone with his level of expertise and devotion to orofacial myology.

What is the relationship between a solid program of orofacial myology and various speech disorders including misarticulation?"



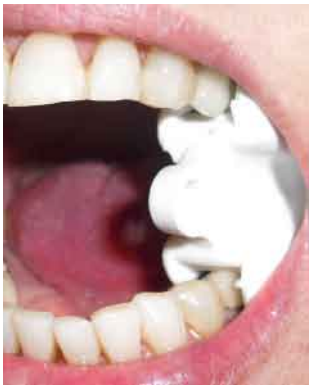
An interesting topic was raised in the IAOM list/serv recently. It involves a topic that has come up many times over the years among IAOM members…. "What is the relationship between a solid program of orofacial myology and various speech disorders including misarticulation?" We on the IAOM Board of Directors and Board of Examiners have stressed to our non-speech pathology members the importance of avoiding any "promise" that their service will improve the speech of their patients. But let's get to the basics here and be very honest about what really CAN happen regardless of the background of the orofacial myologist. The resting postures of the tongue, lips, and mandible are most definitely related to articulation. They provide the "home base" from which speech production begins and ends. If we do the following in a sensible sequential order, can we deny that it sets the stage for successful articulation treatment?

1) Maximize the shaping skills and excursions of the tongue within the oral cavity.
2) Separate/differentiate the movements of the tongue, lips and mandible.
3) Develop adequate skills to suction and release the tongue.

Being conscientious in teaching these three early areas of a thorough orofacial myology program will set the stage for successful speech therapy, even before the "swallowing" aspects are targeted. It matters not whether it is a highly skilled RDH who gets them to this point or an SLP….because the patient who reaches this level is automatically on the road to success for speech. When the RDH refers the patient to a speech pathologist after this phase of treatment, the detailed muscle coordination part is done. Lucky is the SLP who takes the reins at that point.

Voice Instructors and Orofacial Myologists… a Very Harmonious Connection!

At my office we have been perplexed lately at the number of 2- and 3-Way Mouth Props being ordered, many from those who are not orofacial myologists. We solved the problem when two voice instructors contacted us to explain how they use them. I thought it appropriate to share the information with you because I doubt most of us realize how our specialty area overlaps with vocal training.



Here is what I learned:

It is important for classically trained singers to open their mouths widely and to be able to differentiate the movements of the tongue and mandible. They use jaw stabilization exercises to help accomplish this. As one instructor put it, their students "have to learn that the use of the tongue to articulate consonants and form vowels must be independent of jaw movement." A New York instructor explains, "Very often, students think they are opening the mouth widely; then they look in the mirror and see that they are not. I used to give them corks, but corks pop out unless you hold them there." She said that a nicely fitting, inexpensive mouth prop that she can give to her students was a solution.

People come to her for voice lessons and in the process she unearths serious problems related to mouth breathing and "tongue thrusting." She, like many of us in the past felt she was alone in her quest to do something for those needing "oro-facial exercises," as she describes it. I have done some further research about the methods used by her and others and realized that some of those approaches hold possibilities for us orofacial myologists. Wouldn't it be interesting and informative to have a similarly trained voice instructor speak to us at a future convention?

IAOM Related News

Good news! The long anticipated and "new improved" IAOM proficiency exam is about to arrive. Last minute changes are waiting for approval, and the goal is to have it available before the upcoming IAOM convention in Washington DC in October of this year. Additionally, The Certification Procedures have been revised to reflect the new exam changes as well as details related to modern technology and various other options for the certification candidate.

The list/serve continues to be a busy place, where important exchanges of information are share daily by IAOM members. Recent topics include:
- Where can we find evidence to support our referring clients for ankyloglossia ?
- Are pacifiers ever ok, and if so, when should be they be eliminated?
- What is a posterior tongue tie?

If you are not signed for the list serve, you might want to consider doing so as it is active and deals with topics that are very specific to our concerns as Orofacial Myologists. For more information, contact Kris Gatto at krisgatto@sbcglobal.net

Come Join Us at the International Convention

The International Association of Orofacial Myology is holding its Annual Convention in Historic Washington, DC. Come learn about Treatment, Ankyloglossia, Orofacial Muscle Exercises and Treatment, Research, the Orofacial Complex, Buteyko and Beyond, Upper Airway Management, Videotape Measurements, Telepractice, and Utilization of Social Media, and more.

Members $300 prior to 9/9; $350 after 9/9; Non-Members: $350 prior/ $400 after 9/9

October 11, 12, 13

The Washington Court Hotel in Historic Washington DC

525 New Jersey Avenue, NW Washington, DC 20001

Register via the website: www.iaom.com

Tips From Colleagues

Hi Sandra! I hope all is well! Thank you for passing along the April newsletter! I wanted to tell you about a helpful app I found on the iPhone called Counter +. It will tally the client's "good swallows"and can be used in place of the knitting or golf counter. The app can be downloaded for free, the color scheme can be changed to be tailored to a boy or girl, and the clients can email you the count so you can track their progress. The kids love that they have an excuse to use their iPhone and makes the carryover activity a little bit more enjoyable! I hope you find the app helpful and hope to talk to you soon!

Thanks!
Jane

The secret of getting ahead is getting started.

Sally Berger

Dr. Bob's
CLINICAL PEARLS

AN EXPLANATION OF A TONGUE THRUST DISORDER FOR PATIENTS/PARENTS

A normal relaxed or rest position of the mouth would include having the lips together, teeth slightly parted rather than touching, and tongue resting behind the front teeth – usually on the palate tissue just behind the upper teeth, or in some cases, behind the lower teeth.

A tongue thrust is a condition where the tongue becomes a prominent feature either when talking, swallowing, or eating. The term 'thrust' is misleading, since it implies that the tongue is forcefully pushed against the teeth, leading to a change from the normal position of the front teeth. Actually, the amount of pressure exerted by the tongue against or between the teeth during a swallow is not sufficient to cause them to move out of a normal position. In many cases, a misalignment of teeth is already there and the tongue moves forward into the space available as a way of sealing the front of the mouth during swallowing. In this case, the tongue is said to be 'opportunistic' or filling in an available space.

Many dental practitioners and others see a tongue thrust and dental malocclusions (or teeth out of normal alignment) and presume that the tongue thrust is the cause. What is often missed in oral evaluations is the rest position of the tongue, especially the tongue tip. It is well documented in dental science that a forward rest position of the tongue tip against or between the teeth can, over time, result in dental changes when there is a long period (at least 4-6 hours per day) of an abnormal tongue rest position. It does not take a lot of pressure for a forward rest position of the tongue tip to move some teeth to a new, abnormal position.Only light, continuous pressure is needed to move teeth, whether by orthodontic appliances or a forward tongue rest position. In the same way, sucking habits, when a digit pressure is applied hours per day, can cause a change in the shape of the dental arches.

A tongue thrust and a forward rest position of the tongue tip often occur together. When they do, a malocclusion (malposition) of teeth is the likely result. However, not all individuals with a tongue thrust habit will need treatment since the thrusting alone is not linked as a cause of changes in dental position. But still, a tongue thrust most often presents a cosmetic or an eating problem and, when accompanied by a forward tongue rest posture, dental changes will likely result. Some patients show a rest position of the tongue between the side(back) teeth. In such cases, dental alignment problems can develop in these areas of the dental arches.

Where there is a tongue thrust, clinicians will look closely for an accompanying abnormal rest position of the tongue. In either case, treatment may be indicated. A primary goal of orofacial myofunctional therapy in children is to re-establish a normal oral environment in which normal processes of dental eruption can be achieved. In adults, the goal is to normalize oral postures and functions to create stability in the dental arches. Working on the elimination of a tongue thrust as a cosmetic concern is also an appropriate reason for therapy in some individuals. This is done by repositioning the tongue at rest, or eliminating a tongue thrust during the function of swallowing.

When the house in which the tongue resides becomes normal with regard to where the tongue rests and how it functions during eating, swallowing and speech functions, the dental structures can then be placed in a normal position that should remain stable, with no future problems anticipated. However, follow-up appointments will be needed after the completion of therapy to monitor success and to identify any possible recurrence of problems.

One final thought: what is seen at the front of the mouth can often serve as a clue that something is not normal at the back of the throat. A tongue thrust, a forward rest position of the tongue, or the mouth resting in an open position are diagnostic observations that raise suspicions of a problem at the back of the throat that interferes with normal breathing. Examples of such problems are enlarged tonsils, adenoids, or allergies that can affect the nasal cavity or reduce the size of the throat cavity. Such problems can result in a need for the tongue to adapt by positioning forward at rest or thrusting forward during the first part of a swallow to maintain an open airway for breathing.

By Robert M. Mason, DMD, PhD
Speech-Language Pathologist (ASHA Fellow)
Emeritus Professor of Surgery and Chief of Orthodontics
Division of Plastic and Reconstructive Surgery
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Durham, NC 27710

NJ Bill 2318 : Infant Screening for Tongue-tie

This bill requires that all infants born in New Jersey be screened for tongue tie/ankyloglossia. We are delighted by this legislation and await other states to follow suit.

SENATE, No. 2318, STATE OF NEW JERSEY, District 19 (Middlesex) 215th LEGISLATURE INTRODUCED NOVEMBER 19, 2012
Sponsored by: Senator JOSEPH F. VITALE

SYNOPSIS
Requires newborn infant screening for tongue tie.

CURRENT VERSION OF TEXT As introduced.
AN ACT concerning screening for tongue tie in newborn infants and supplementing Title 26 of the Revised Statutes.
BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. a. All infants born in this State shall be tested for tongue tie.
b. The Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to carry out the purposes of this section.
2. This act shall take effect on the first day of the fourth month next following the date of enactment, but the Commissioner of Health may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act.

STATEMENT
This bill requires that all infants born in this State be screened for tongue tie, also known as "ankyloglossia" or "anchored tongue."

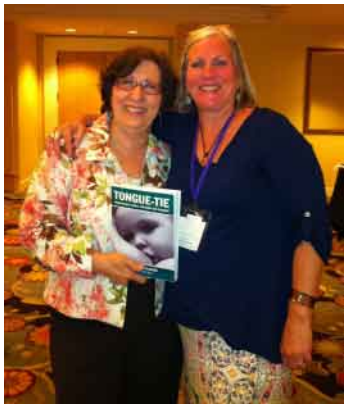
Tongue tie is a common but often overlooked condition. It is seen at birth and causes a wide range of difficulties that affect the sufferer in different ways. Diagnosis and assessment are essential before taking any remedial action. The consequences of untreated tongue tie are wide ranging and can affect the structure and appearance of the face and teeth, as well as oral function. Breastfeeding, eating, digestion, teeth, speech, kissing, and social skills can be adversely affected. Some consequences, such as breastfeeding difficulties, can be experienced early, but others, such as speaking and kissing, only become apparent in later life.

The impact of a significant tongue tie on the ability of a baby to be breastfed is very often severe. As a consequence, many mothers who plan to breastfeed their babies are compelled to wean them to the bottle much earlier than expected.

There are several options available when a tongue tie has been assessed and found to be restricting movement, that is, when the frenum (the string that connects the tongue to the floor of the mouth) is recognized to be abnormal. This situation requires surgical correction by an appropriate professional, which can be performed as early as seven days after an infant's birth.

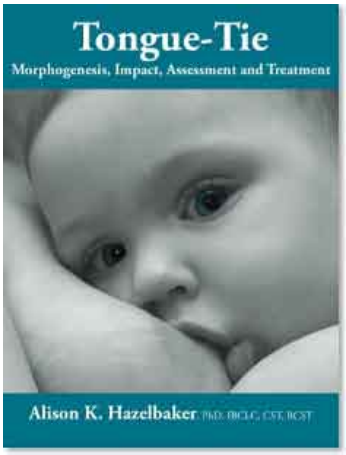
This bill takes effect on the first day of the fourth month after the date of enactment, but authorizes the Commissioner of Health to take prior administrative action as necessary for its implementation.

Tongue Tie: Morphogenesis, Impact, Assessment and Treatment



The best source I have ever seen for thorough information about ankyloglossia is Dr. Alison Hazelbaker's, recently released.....Tongue-Tie: Morphogenesis, Impact, Assessment, and Treatment. I had just grabbed the remaining copies at the recent Global Tongue Tie Conference (IATP, International Affiliation of Tongue tie Professionals) to make them available to my course attendees and others when I received a question from a past graduate of my course: Do you have any good research articles on the impact tongue-tie has on articulation and the impact oral rest postures have on articulation?

I was relieved to be able to direct her to Hazelbaker's book which contains several pages related to speech and tongue tie. She cites several specific studies and articles that back up our treatment in all areas related to ankyloglossia, not only the speech aspects.



Dr. Hazelbaker provides both the old and new evidence that enables clinicians to properly assess, diagnose and treat this genetic condition that creates so many problems with feeding, speech and orofacial development.

She also presents the embryological and physiological underpinnings of tongue-tie, discusses tongue-tie's impact, provides information on assessment and classification and then rounds out her book with research-based treatment options and guidelines. She weaves in her personal story, having been tongue-tied and being the mother of two formerly tongue-tied children, as well as the stories of many other families, creating both a readable and credible book. Tongue-tie: Morphogenesis, Impact, Assessment and Treatment is the definitive book on tongue-tie that will serve us as health professionals as we endeavor to enlighten medical and dental professionals worldwide about this common but serious problem.

2013 Tongue-tie Summit

The International Affiliation of Tongue-tie Professionals

This year the IATP (International Affiliation of Tongue tie Professionals) held their 2013 Tongue-tie Summit in Orlando, Florida, the same location where the original founders met to establish the organization in 2009, under the leadership of Dr. Alison K. Hazelbaker. It was the first conference to be open to the public. Attendees came from all around the globe, including Australia, New Zealand, Canada, Chile, Israel, France, India, across the United States, and more. Among the many expert speakers were Dr. Alison Hazelbaker, Dr. Larry Kotlow, Sandra Holtzman, Dr. Ben Lynch, Dr. Julie Doherty, Ms. Erica Anstey, Dr. Sharon Vallone, Cathy Watson Genna, Holly Puckering, Dr. Greg Notestine, Jennifer Tow, Dr. James G. Murphy, and Rachel Lamb. The timely topics included: Assessment Tools; Ankyloglossia in relation to nursing infants and lactating mothers; implications of not providing labial and lingual frenum release; recent studies, including those with ultrasound documentation; and many other related topics.

Sandra R. Holtzman was warmly received as she connected the dots between Orofacial Myology and Ankyloglossia. Sandra's graduates were also represented by Barbara Carter from Ft. Walton Beach, FL, and Kaye Baumgardner from Minnesota. Sandra Holtzman was named as one of the six peer reviewers for the upcoming Online International Journal of Tongue-tie and Lip-tie.

"Myo-Recipes... Time to Lick your Lips"

LICK YOUR LIPS CHILI

Ingredients

- *1 tablespoon(s) olive oil*
- *1/2 pound(s) lean ground turkey*
- *1 medium onion, chopped*
- *1 teaspoon(s) ground cumin*
- *1 teaspoon(s) ground coriander*
- *1 4-oz can(s) chopped green chiles*
- *Kosher salt and pepper*
- *Sour cream, shredded Asiago and cornbread (recipe, opposite), for serving*
- *2 tablespoon(s) chili powder*
- *1 15-oz can(s) chickpeas, rinsed*
- *1 poblano pepper, cut into ¼-in. pieces*
- *1 clove(s) garlic, finely chopped*
- *2 teaspoon(s) ground cinnamon, plus more for serving*
- *1 medium red bell pepper, cut into ¼-in. pieces*
- *5 thin slice(s) prosciutto (optional)*
- *6 cup(s) low-sodium tomato juice*
- *1 28-oz can(s) diced fire-roasted tomatoes*
- *3 ounce(s) semisweet chocolate, chopped (½ cup)*
- *1 15-oz can(s) kidney beans, rinsed*
- *1 15-oz can(s) black beans, rinsed*

Directions

1.Heat the oil in a large saucepan over medium heat. Add the turkey and cook, breaking it up with a spoon, until no longer pink, 4 to 5 minutes.

2.Add the onion, peppers, garlic, chili powder, cinnamon, cumin, coriander, green chiles, and ½ tsp each salt and pepper. Cook, stirring occasionally, until the vegetables are just tender, 6 to 8 minutes.

3.Meanwhile, if using the prosciutto, cook it in a large nonstick skillet over medium heat until crisp, 3 to 4 minutes. Transfer to a plate to cool, then chop into pieces and add to the saucepan.

4.Add the tomato juice, tomatoes and chocolate and bring to a simmer. Add the chickpeas and beans and gently simmer, covered, stirring occasionally, for 1 hour. Uncover and cook, stirring occasionally, until slightly thickened, 1 to 1½ hours more. Serve with sour cream, Asiago, additional cinnamon and cornbread, if desired.

From Woman's Day
www.womansday.com

Judy Halpren

Each edition we highlight a past graduate who is using the techniques and spreading the important concepts of Orofacial Myology. Judy Halpren provides us with feedback about her Orofacial Myology experiences which she wants to share with our readers. We hope you enjoy it and can relate to some of the same experiences yourself!

I studied Speech-Language Pathology in Boston and have always practiced in Toronto, Ontario. My first area of practice was in the area of adult neurorehabilitation, which I found extremely interesting, but also a little depressing. After taking a few years off when my children were young, I decided to return to a "new career" in articulation, fluency, and voice therapy with children in the schools. A few years ago, it frequently happened that the government-funded agency that paid for therapy in the schools "held back" new referrals (for budgetary reasons), leaving those of us who worked on a pay-per-visit basis lacking clients. An orthodontist that I knew told me about the field of Orofacial Myology (OM) and suggested that I investigate it via the IAOM website. After making a couple of calls to the very few people who practice OM in Ontario, I followed their guidance and decided to take a course taught by an SLP, since we "speak the same language". That led me to Sandra Holtzman's "boot camp" in June 2010 in Asheville, North Carolina.

The study of OM has opened up a whole new world that I didn't learn about in graduate school! I am much better able to understand what is happening (or not happening) with my articulation clients and why. I use exercises that I learned with Sandra with these clients and feel much better prepared to make referrals to other professionals and provide a rationale to both parents and professionals for these referrals.

I have started my own small private practice for OM clients and love to see how rapid their progress can be. What a great feeling when clients say "it feels funny" to hold their tongue "the old way". Unfortunately, the practice of OM is still relatively unknown in this area, and most orthodontists seem content with the status quo. I have recently met with a couple of orthodontists who just moved here from Western Canada, where OM is apparently more prevalent. I have enjoyed discussing the field with them and am looking forward to joining their practice a few times per month. Together, maybe we can expand the field of OM in this part of the country. I am also looking forward to broadening my knowledge and connecting with others at the IAOM Convention in Washington this fall.

Orofacial Myology Newsletter is brought to you by Neo Health services, Inc. in order to keep you posted on conventions, policy, noteworthy therapist, IAOM happenings, products, interesting questions we receive, and other topics related to Orofacial Myology.

This newsletter is meant to provide a connection among all of us who practice or have strong interest in this wonderful specialty area of Orofacial Myology. Since there are only a small number of us worldwide, it is important for us to maintain as strong link as possible from state to state and from nation to nation, so that we can grow as individuals and as a respected profession.