



I am writing this editorial as I prepare to take the big bird in the sky once more to Calgary, this time to teach a course.

Requests to give courses all over Canada are coming faster than the calendar can supply dates. Orofacial Myology is truly booming worldwide. All conscientious therapists are doing their best to be sure that it grows in a healthy manner that will benefit patients for the years to come. Sometimes we do this by relying on studies, often taking them from other fields that relate to orofacial myology. Sometimes we do this by attending study groups that focus on subject matter that keeps us on the straight and narrow. Sometimes we have brainstorming sessions and let our minds go free to dream about possibilities. This is truly an exciting time, perhaps the most exciting years since I began as a young "myo-functional therapist" in the 70's. We went through difficult times when some practitioners made claims that were unfounded; we went through challenging times when some of the foundational concepts we had been taught were turned upside down. We remained strong and revised our way of treating, teaching, and thinking. We have to maintain a solid scope of practice, do our best to offer an evidenced based practice to our clients, and yet never forget that the "art" is as important to treatment success as is the "science." Thank you, loyal readers and contributors of the Orofacial Myology News... enjoy the rest of the summer and I hope that I get to see all of you in Orlando for the 2015 IAOM convention!!!

RPM – A New Acronym for Us

This acronym has become my byword when evaluating and treating patients and when teaching or presenting to other professionals. RPM can mean "rotations per minute" when referring to how fast an engine is running. Coincidentally, this acronym will also help with the speed we need... the speed of getting a patient from basics to habituation. Rule out – Probe – Maximize

RULE OUT: Save yourself and the patient a lot of valuable time by attending to certain findings right from the start. To name a few: enlarged tonsils, restricted lingual or labial frenum, chronic allergies that are not under control, or the presence of a "habit" appliance that precludes treatment. Addressing these and other issues that inhibit the success of therapy is necessary before moving forward.

PROBE: We have to find any underlying etiologies or attitudes that might impede therapy. We do this by physical means during a thorough orofacial examination. And we do this by asking the right questions during the case history and consultation meetings. Digging deeper enhances our chances and the client's chances of catching anything that may have been missed earlier by the client and his family or by other practitioners.

MAXIMIZE: Once the patient is entered into a program of treatment, our goal is to maximize them in all areas. Some patients will not be able to "pass" the assessments along the way, depending upon their age, cognitive skills, and physical limitations. If we keep the goal in mind to Maximize them in all areas, we can rest assured that we have done the best that can be done, regardless if it meets the "ideal" or "perfection" that we strive to achieve with every client.

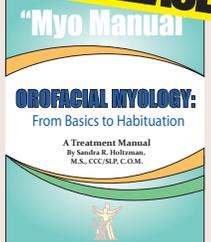
The New Edition of the Myo Manual is Here!

We have received many calls and emails from you wanting more information. We are going into greater detail in our next Orofacial Myology News. In brief, it is even more **Sensible, Sequential, and Systematic.** Criteria is given for exercises and typical assignments are provided.

Click Here to Purchase

If you own a previous version of the Myo Manual and wish to upgrade to the new edition, we are offering excellent discounts for a limited time. Please contact us directly regarding the discount.

PRESS RELEASE



What to Demo for Lunch and Learn at Dental Offices

The question comes up on occasion, "What exercises or assessments can I demonstrate when I go to a dental office for a Lunch and Learn or for a short presentation?" I'll give my choices and then tell you how to submit your favorites at the end of this article. Because of the particular tools and assessments I use with my program, I demo the Lip Strength Meter and then explain that it measures much more than simply "strength." I use the Quick Tongue Tie (QTT) assessment tool since that is of interest to virtually every dental professional. I demo and describe the advantages of the Battle Button exercises and let them "battle it out" between two of their staff members for fun and training. Then I select one or two of the most

interesting exercises and explain how they fit into the sequence of treatment overall and why they are offered to particular patients. The Orofacial Myology News would like to devote some more time and space to this important topic in the next issue...we are opening the subject to all of you readers. This includes the orthodontists and dentists among you who are likely to have some suggestions of what you would like to have presented at your offices. To give your input, write to Sholtzman@OrofacialMyology.com and put Lunch and Learn in the subject line. I hope you will share your ideas so we can pass them on to others in the next edition of the Orofacial Myology News.





Can a posterior crossbite in children be the result of airway issues?

The question posed is an excellent one and yes, a crossbite can develop from an airway issue in both children and adults – but only if there is a postural change of 6 or more hours per day that impacts the dentition.

Clinicians are reminded that the two primary reasons for the development of OMDs are unresolved airway issues, and unresolved allergies involving the upper airway.

Details: If the airway interference causes the child to rest with lips apart and the freeway space is habitually opened beyond the normal range (that is, if the mandible hinges open to maintain the airway), a posterior crossbite – usually bilateral – could result over time. For this to happen, the mandible would have had to drop down, and the tongue along with it, to the extent that the lateral surfaces of the posterior tongue no longer provide resistance to the normal pressures of the cheeks against the maxillary posterior dentition. When the competing slight pressure of the cheeks against the posterior maxillary teeth is unopposed by the tongue, this could result in narrowing of the maxillary dental arch, and the development of a bilateral crossbite. There is no concomitant crossbite in the mandibular arch since the lateral surfaces of the tongue continue to provide resistance to the cheek muscles.

But how can a unilateral crossbite occur according to the scenario explained here? The answer to this again relates to the tongue. The rest position of the tongue, with mandible hinged open, can be asymmetric vertically, with the posterior surface on one side resting higher than its companion side.

Not only is swallowing an asymmetric activity, with one side of the tongue typically rising higher than the other side, the same is true for the rest posture when the freeway space is open beyond the normal range. Thus, if the higher lateral surface of one side of the tongue provides opposing pressure to the cheek muscles while the other side does not, a unilateral crossbite can develop.

The scenarios described reinforces once again why an abnormal resting tongue posture is the link with dental changes, rather than from any intermittent thrusting actions of the tongue tip at the anterior dentition, as in swallowing and speaking. The duration of pressure applications of the tongue at the teeth is the link between the tongue with developing malocclusions rather than the amount of pressure, which plays no discernible role (that is, the amount of tongue pressure does not impact the dentition in actions that lack adequate duration of hours per day, such as with tongue thrusting). Also, one cannot add up the pressures of swallows, as has been inappropriately done by some. The reason is that the periodontium is very resilient and rebounds well from brief applications of tongue pressure – at any magnitude level of pressure. Thus, intermittent pressure applications against the teeth do not add up over time.

A different scenario: With the mandible hinged open, but this time with the tongue positioned forward between the anterior dentition, but remaining elevated enough posteriorly so that the lateral margins of the tongue continue to provide resistance to the opposing natural pressures of the cheeks, can lead to a different kind of malocclusion – an anterior open bite. That is, with the mandible hinged open and tongue protruded, for 6 or more hours per day (a habitual rest posture), additional posterior dental eruption is

triggered, while the interposed tongue at the anterior dentition inhibits the anterior teeth from also continuing to erupt. The result is an anterior open bite.

In this scenario, the posterior teeth have supra-erupted and will meet a bit earlier during biting following the additional eruption, while there is a lack of concomitant eruption of anterior teeth. This results in an anterior open bite. The process involved is termed “differential eruption” characterized by additional posterior eruption but no anterior eruption. Thus, a difference (differential) in eruption occurs between anterior and posterior teeth. Also, as maxillary posterior teeth erupt downward, the supporting alveolar bone follows along. This is called “vertical drift” of alveolar bone and is why the additional eruption does not result in more root structure showing.

It is important for clinicians to remember that dental eruption can occur throughout life. Opening the mandible beyond the normal freeway space (2-3 mm at the molars and 5-6 mm at the incisors) for hours per day as a habitual rest posture can trigger the brain to initiate more eruption, and an open bite is the result.

Again, the reason for the change in resting posture of the tongue and mandible for 6 or more hours per day is usually an unresolved airway issue, or allergic rhinitis. By comparison, tongue thrusting alone related to an airway issue, with no habitual opening of the mandible at rest, will not affect dental alignment due to the brief moments of pressure applications against the dentition involved with tongue thrusting.

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[Click here to find more articles of Dr. Mason](#)

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Related News



Our IAOM Canadian committee delighted attendees with one of the most amazing conventions ever. It was worth traveling thousands of miles to experience the unforgettable memories that awaited us in Calgary. The hotel, food and hospitality were superb. The participants hardly had time to become hungry before another table was spread out with excellent food to enjoy. The social event was very memorable as some of our most talented members took to the floor at Ranchman's well known cowboy/ cowgirl hangout! After enjoying a big meal, all the good sports among us got right out on the floor and line danced to our heart's content. A highlight of the evening was the White Hat Ceremony where we each received our own white cowboy hats and became true "Calgarians!"

Speakers were interesting and stimulating. Diane Bahr, a speech-language pathologist, discussed how to prevent feeding, speech and oral development problems in 0 to 2 year olds. Gill Rapley, a family public health nurse, presented on the importance of a baby-led approach for the first year of a baby's life. Rochelle McPherson, a very active Dental Hygienist and Orofacial Myologist from Sydney, Australia, spoke on the inter connections of orofacial myology and other etiologies and how to co-manage patients with concomitant conditions. Dr. Honor Franklin, a speech-language pathologist and longtime IAOM member from Dallas, Texas, provided pearls of wisdom for those who want to have a successful private practice in Orofacial Myology. She left no topic untouched and provided much food for thought for everyone. Dr. Ganz Ferrance rounded out the convention with a knockout presentation that left some members ready to make drastic and positive changes in their own lives. Those who had early flights the last day really missed out on his great topic and presentation skills.

In brief, nearly every minute of this convention was filled with learning, entertainment, good food and a warm feeling among members that was just about as uplifting as "the good old days when IAOM was but a small close group of friends and associates.

The Orlando committee for the IAOM 2015 convention has a big challenge ahead of them, but my bets are on them to do just as fine and as exciting a job as this year's committee accomplished! We hope that all of you readers will be in Orlando to make the 2015 convention truly "Magical".....





Ranchman's Calgary



With Kim Benkert and Rochelle MacPherson



Nancy Magar



Naurine Shah and Becky



Always a pleasure to speak with Deb

THANK YOU  CALGARY



What a party!



Our future Dental Rep Karen



Honor and Robert



Orlando CONVENTION 2015

Let's continue with the magic...



by Becky Ellsworth,
AAS, RDH, BS, COM

Outside of the “mouthbox” Who Needs Us?

One of my most memorable patients was a tall, gangly young girl who was just starting eighth grade. You could see the potential beauty but she had to grow into her body and definitely correct her “mouth open, tongue visible” rest posture! She was full of energy and eager to please; in other words, a perfect patient...

She wanted her braces removed but was told this would not happen until she had completed Orofacial Myology. Oh yes, she was eager...

I was amazed at how hard she worked at her lip closure exercises, worked to break her low forward tongue posture, worked to slowly but surely differentiate her tongue movements from, not only her jaw, but her whole upper body! The mirror became her friend as she saw the changes that began to occur week after week.

I will never forget the day, my, by then 14 year old “star”, excitedly came into my office exclaiming she had swallowed a pill for the first time in her life!

Who needs us? People like my eventual “graduate” sporting beautiful teeth (that stayed together post orthodontics), a winning smile and confidence in herself that was lacking when we first met.

It isn't all about the habit, or the swallow or the rest postures but when put altogether, it is about helping children and adults lead more normal lives.

What we do *can* and *does* change folks. What fun it is to be along for the ride!

Want to make an even bigger difference than you already do? Join us and find out how....



When I was asked to write an article about my experience as a mentor, I think that request was for me to explain what I did as a mentor for IAOM. But in truth, my life as a mentor started many, many years ago.

My first remembered experience as a mentor was when I taught my doll how to behave properly at a tea party. My growth as a mentor took place over the years as I coached my younger sister with her multiplication tables, and continued as I encouraged my Brownie troop members to extend friendship to one another. As the growth in my mentoring skills continued, I offered my own children knowledge from my life experiences. When I joined IAOM, it was then that I began to share my knowledge about myofunctional therapy/orofacial myology with anyone who was interested in listening to me.

The dictionary defines a mentor as:

a: trusted counselor or guide

b: tutor, coach

c. an experienced and trusted adviser

In re-reading my résumé, I seem, over the years, to have earned the title of Mentor. Does mentoring happen naturally? I think it does for some of us. Informal mentoring occurs all the time and is a powerful experience.

My personal rule, when I am functioning as a mentor is to reflect an open and sharing attitude. My feeling is that “Whatever I know, someone shared with me.” Whenever we think an exercise is “our own,” it is more than likely that it has also been developed by another therapist somewhere else in the world. At one of my first conventions I was lucky to share a room with Roberta Pierce. She was from Alabama and I was from Illinois. After the last session of the day we were sitting cross legged on our beds exchanging exercises, and I very proudly introduced my “pickle tongue/pancake tongue” exercise when she said, “Oh no, that’s Fat Tongue/ Skinny Tongue.” There we were, from two different parts of the country doing the same exercise, just with a different name. Sharing is growing and learning.

My person philosophy is one that I hope other mentors share: If I am going to guide, advise or counsel someone, I share with them my experience and knowledge; that includes forms, sources and friendship. I trust them to not abuse our relationship.

If you a thinking of serving as a mentor, please be sure you are willing to share your knowledge (all of it). Nothing is more discouraging to a new member looking to improve their skills than to hear from a mentor, “Oh, I can’t share that with you”.

I’ve received great pleasure in the lasting relationships that have evolved over my years as a mentor. and I encourage others to enriching your life by

My Life as a Mentor

By Anita Weinfeld, MA.COM

Member IAOM 1974
Certified 1976
Past President, IAOM
Member of IAOM
Board of Examiners
Life Member, IAOM
Private practice 1973
through present





Karen Wuertz

Why Orofacial Myology? Why Now?

We normally highlight our graduates who have been in the field for awhile, but Dr. Karen has done so much in such a short period of time that we wanted to share her accomplishments in this edition. She attended our course in March and since that time she has been involved in developing ideas for new research studies, advancing her techniques for tongue tie release, and

has been elected as the new Dental Representative on the Board of Directors of the IAOM. She will assume her new position in 2015. She writes:

Earlier this year, I discovered Orofacial Myology. I was at a crossroads in my professional career that I'm sure many of you can relate to. What was I going to do in the next 20 years in dentistry that would continue to challenge me, provide excellent quality services to my patients....and how could I make a significant impact to help change their lives?

As a General Dentist, I have been privileged to practice in a very diverse way. In 1993, I completed a General practice Residency that was hospital based. That immediately helped me to understand the Oral-Systemic connection. Fast forward twenty years---in 2012/2013, I advanced my professional education by completing Tufts University Dental Sleep Medicine and the American Academy of Craniofacial Pain Mini Residency programs with an emphasis on TMD. I have become Board Certified in Dental Sleep Medicine and a Diplomate in Craniofacial Pain. While on this journey, it was like a lightbulb went off!

The more I studied, the more I discovered layers of the proverbial onion! What I discovered was that Orofacial Myology is another important layer....one that is not much known in the Dentistry profession.

It was by no coincidence that when I ordered the book, Tongue Tie by Alison Hazelbaker, that I received the Orofacial Myology News from Sandra Holtzman...and after researching orofacial myology, I signed up to take her 28 hour certification track course. I further explored the membership of the IAOM and more and more unfolded each and every day with each and every patient.

So how did I take what I learned in those jammed packed 4 days, and immediately implement it into my private practice?

- 1) I looked at my intraoral exams with a fresh set of eyes.
- 2) I expanded my exams to include evaluations for tongue and lip ties in both children and adults.
- 3) I more critically evaluated the source and etiology of areas of decay.
- 4) I listened to speech and articulation with critical ears.
- 5) I observed the facial expressions and movements of the lips and tongue.
- 6) Placing emphasis on medical and developmental histories in children has allowed me to correlate oral habits such as tongue thrust, incorrect swallowing, lip and tongue postures, and craniofacial development. By studying orofacial myology, it has brought me back to a true emphasis on evaluating and treating the body as a whole....connecting the dots on the Oral-Systemic Health Connection.



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Sandra R. Holtzman MS, CCC/SLP, COM **Becky Ellsworth RDH, BS, COM**

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Orofacial Myology Newsletter is brought to you by Neo Health Services, Inc. in order to keep you posted on conventions, policy, noteworthy therapists, 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 a link as possible from state to state and from nation to nation, so that we can grow as individuals and as a respected profession.

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