



Welcome, friends and associates, to our October 2014 edition of the Orofacial Myology News. I am pleased to share my photo space with Becky Ellsworth, my co-instructor and newest member of our team. In August, 2011, we introduced our first edition and could only have dreamed that it would be welcomed worldwide, as is the case. Thank you for your interest, suggestions and article contributions over the past three years.

This edition includes important information on how to assess the freeway space, something that many of you have been asking for.

Updates on speakers and activities for the incredible October 2015 Orlando IAOM convention are inside to get you thinking about preparations for that event, perhaps including family members.... time is allotted for Disney exploration!

Feel free to challenge yourself with the Crossword in this edition and you have permission to make copies to use them as you please.

I'll share my pathway to "Certification and Beyond" in one of the articles inside to give you just one person's journey within the world of Orofacial Myology. As you continue along your own "orofacial myology" pathways, always remember to integrate both the science and the art, since one without the other just won't work!

Thank you for letting us share the Orofacial Myology News with YOU!



## Does Piercing Increase the Risk for Airway Obstruction?

In an earlier edition of Orofacial Myology News, we had an article regarding tongue piercing and the effect on treatment. Since that time, I've received emails with questions about the effect of "uvula piercing," "lip piercing," and nose piercing in addition to tongue piercings.

Dr. Stephanie McGann, DMD, FAGD, discusses this topic in an article of the February 12, 2014, Unionville Times (2014 Times Community News Group, a Division of Brandywine New Media, LLC).



She asks the question, "Oral Piercing – Is it worth the risk?"

Dr. McGann begins by stressing the importance of knowing what the risks are before deciding to pierce. Whereas ear piercing carries only a small risk of infection, millions of bacteria reside within the oral cavity. Of particular concern to us as orofacial myologists is her warning that "A tongue piercing or tongue splitting may look cool or seem like a good idea at the time, but if swelling occurs the airway can be obstructed. This adds a serious level of risk to oral piercings."

She notes that "Some piercings can interfere with speech, chewing or swal-

lowing. The practice of uvula piercing is extremely dangerous. A piece of jewelry could be aspirated and cause a blocked airway or a damaged lung."

She advises caution regarding possible hypersensitivity to the materials used in the "jewelry," warning that an allergic reaction could be life threatening from lip, tongue, and throat area oral piercing.

She explains a nerve might be damaged during the process of piercing, leading to tongue numbness that may continue even if the jewelry is removed. Of utmost concern to orofacial myologists: "A damaged nerve may affect the movement of your tongue, sense of taste, ability to speak normally and can affect normal eating. Some individuals experience excessive drooling after a piercing."



As a dentist she sometimes has to have a patient remove the oral jewelry in order to perform normal dental procedures, such as cleanings and x-rays. To minimize risk, she advises patients to use an antiseptic mouth rinse regularly; avoid the kind of jewelry that clicks against the dentition or rubs on the inner mouth tissue; avoid aspiration or swallowing by assuring that jewelry is attached tightly; and report any pain or swelling to the dentist or physician.

Editor's note: Although several sources cited airway obstruction as a risk, there did not appear to be any studies or detailed explanations regarding this possible connection. We will try to obtain more detailed information about this serious concern and we welcome your input.



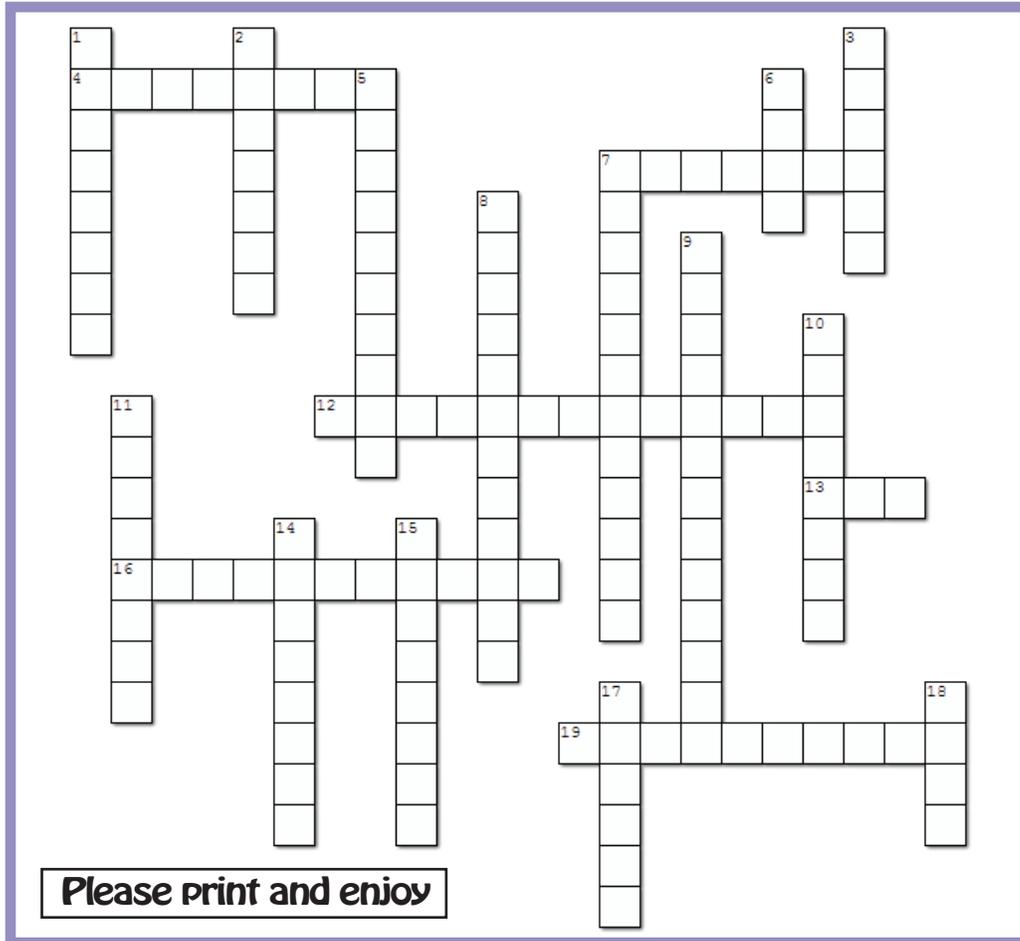
# Tongue-Tie definitions we should know...

1. Action of baby's attaching to the breast to nurse.
2. Angular or V-shaped
3. Roof of the mouth, separating the cavities of the nose and the mouth
5. Process that makes something move from the mouth, to the pharynx, and into the esophagus
6. Layman's term for lingual frenum release
7. Major muscle responsible for protruding the tongue.
8. Procedure to remove a lingual frenulum
9. Infant nursing on mother's milk
10. Gap between the teeth
11. Thin pliable sheet of skin of acting as a boundary, lining, or partition
14. Membrane connecting underside of the tongue to the floor of the mouth
15. Joined or fastened to something
17. Group of muscles on the floor mouth which manipulates food for mastication and creates placement
18. Long, narrow cut or opening

↓ Across

Down →

4. Socket in the jaws in which the roots of teeth are held
7. Mucosal tissue that lies over the mandible and maxilla
12. Congenital oral anomaly which may impede mobility of the tongue tip
13. Pointed or rounded end or extremity of something
16. Limitation of free movement
19. Particular trait from birth



The IATP presented its second World Summit, Tongue-tie: Across the Lifeline, Across Disciplines. This year's conference was held in beautiful Montreal, Quebec, Canada this October. There were featured expert researchers and clinicians from across the globe. Speakers explored influences of



**IATP**  
International Affiliation of Tongue-tie Professionals [Join Group](#)

oral restrictions on oral function, posture, speech, airway and other issues throughout an individual's lifetime, with an emphasis on prevention and interdisciplinary treatment. You can find a review of the Tongue-Tie conference in Montreal at the following link:

<https://www.facebook.com/pages/IATP-International-Affiliation-of-Tongue-tie-Professionals/154327071396819>



## CLINICAL ASSESSMENT OF THE FREEWAY SPACE

A clinical procedure for evaluating the dental freeway space is needed. This need presents an opportunity for interdisciplinary collaboration and cooperation.

### Background:

Kinematic recordings have been made of freeway space dimensions in a variety of dental patient categories (Rugh & Drago, 1981; Konchak, Thomas, Lanigan, & Devon, 1987; Martin, Alarcon, & Palma, 2000).

These and other studies have involved kinesiographic recordings of the rest position of the mandible and during dynamic excursions and other mandibular movements. In the research of Martin, Alarcon, and Palma (2000), for example, using a kinesiograph (K6, Myo-Tronics, Seattle, WA), 3-dimensional (vertical, anteroposterior, and lateral) jaw movements were made without interfering with the motion of the jaw. Their system used a sensor array strapped to the patient's head that tracks the spatial location of a magnet fixed on the mandibular incisors. Mandibular position was recorded at rest and during jaw movements in maximum excursions, during swallowing and chewing.

Martin, Alarcon, and Palma (2000) found that the freeway space ranged from 2.63 mm to 2.7 mm. These dimensions fall within the normal range of variability defined in previous studies by Nielsen, Marcel, Chun, and Miller (1990); and Ferrario, Sforza, Miani, D'addona, and Tartaglia (1992).

While our primary clinical interest in the freeway space is at the posterior dentition, it is impractical to obtain direct measures of the posterior freeway space in the typical clinical situation.

Borrowing principles gleaned from kinesiographic studies of mandibular position and functions obtained anteriorly and with external reference points, a simple clinical assessment of freeway dimensions can be proposed.

**Clinical Assessment:** A procedure for assessing the dental freeway space can be accomplished under three conditions: (1) The patient's mandibular rest position. Ask the patient to moisten his/her lips, swallow, breathe deeply, and relax his/her jaws with eyes closed (Martin, Alarcon, & Palma, 2000). For most patients with a myofunctional disorder, the lips will be parted for this task. Use a millimeter ruler to obtain a measure of the vertical distance between the base of the nose and the bottom of the chin. This dimension is referred to as the lower face height in facial esthetic evaluations. (2) The patient's mandibular rest position with lips gently approximated. Follow the patient instructions given for condition (1), with the added instruction to gently approximate the lips. (3) The patient's habitual occlusion position. Ask the patient to bite on his/her back teeth, and record the lower face height distance from base of nose to bottom of chin. For this measure, patients with a myofunctional disorder may exhibit a lips-apart posture. Comparison of the millimeter differences in lower face height between conditions (1) and (3), and (2) and (3) will yield two separate measures of freeway space. For patients with a myofunctional problem, these measurement comparisons may differ at initial examination. At the completion of treatment, a decrease or equalization of initial differing freeway space dimensions can be considered a therapy success. Comparisons of measures between conditions (1) and (2), with occlusion (3) would be expected to range from 2 to 5 millimeters. The freeway space values obtained in initial exami-

nation provide a baseline for evaluating progress during treatment and at completion, as well as in follow-up evaluations of stability. Such data should be included in clinical reports to referral sources.

Prior to examination, it is suggested that young patients be asked to blow their nose. This suggestion is based on aerodynamic studies of the airway showing that many children have poor nasal hygiene. Nasal debris can increase nasal resistance during quiet respiration by up to 50% (Riski, 1983; Mason & Riski, 1983, Hanson & Mason, 2003). An inability to properly manage nasal debris encourages a mouth open posture and mouth breathing. Teaching a patient to monitor and clear nasal debris is an appropriate component of a myofunctional treatment plan.

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

Speech-Language Pathology Continuing  
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Orofacial Myology "Tongue Thrust" Level 1 Course

R: From Basics to Habituation

Tongue Tie 101: What is Our Role?



The Presenters and Featured Keynote speakers for the Orlando 2015 IAOM convention have been selected. The program promises to be enticing to therapists, dentists, lactation consultants, and other related professionals. Here is the fantastic lineup:

**Kevin Boyd, DDS, MS**

Pediatric Dentist and presenter on Airway Interference in Pediatrics

**Alison Hazelbaker, Ph.D, IBCLC, FILCA, CST RCST**

Reknowned presenter on Ankyloglossia and author of Tongue-Tie (Morphogenesis, Impact, Assessment and Treatment)

**Rosanna Ramiers M.SLP,OMTS,PHS**

will be offering useful Therapy Techniques to attendees

**Naurine Shah, RDH, BDS, COM**

will be presenting on Clinical Photography and offering a hands on Lunch & Learn

**Howard, M. Green, B.M., MSIS**

Music Director, will be providing a unique presentation on the skills involved playing various musical instruments based on orthodontic classifications, therapeutic value or contraindication

**Dr. Fumi Tamura Ph.D. (D.Sc.)**

will discuss Dentistry in Japan and how it is similar or different from elsewhere

**Mable Sharp, PT, MS, CST, LMT** is presenting on The Effects of Posture on Occlusion and Speech

**Shari Green AAS, BA RDH COM** will be enlightening attendees on Oral Habits - Including Research Update, Thumb sucking Elimination and Treatment of Complex Oral Habit Cases

**Kathy Winslow, RDH, COM and Paula Fabbie, RDH, COM** will present Complex Orofacial Myology Case Studies

## Annual Convention



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Since instituting the new objective IAOM examination in January of this year, the number of requests for the exam and those completing the certification process have increased substantially. Currently there are 37 candidates in the certification process. They are given support via the mentoring committee and other experienced members. Congratulations IAOM on initiating your new system!



## MYO CAKES

### Tips to Frost Cakes



## “Myo-Recipes... Time to Lick your Lips”

1. Create a feathered pattern. Use a contrasting color of icing to pipe stripes across the top of your cake in even rows. Then, take a long toothpick and make even lines perpendicular to the ones you just piped. Make every-other line in the opposite direction. This will create a lovely marbled or feathered appearance to the top of your cake.
2. Try piping on designs. Use your traditional cake piping bag with different tips to add pretty designs to the top of your cake. You can create a repetitive pattern, writing, or small shapes with a piping bag. If you don't have a piping bag, try using a traditional ziploc bag with the tip cut off.
3. Use colored fondant. Purchase or make your own colored fondant - a sugar based dough-like frosting that can be shaped and spread for seamless application. Coat your entire cake in a layer of fondant, or use it to form small figures and details to place on top of your cake.
4. Add a ribbon border. You can choose to use real ribbons for a satiny look or create strips of ribbon out of fondant to add to the border. Ribbons are especially effective on a cake with several tiers, such as a wedding cake.

If you want to find more tips to frost a cake go to <http://www.wikihow.com/Frost-a-Cake>



by Becky Ellsworth,  
AAS, RDH, BS, COM

# Outside of the “mouthbox”

## The Palatogram/Orofacial Myology Connection

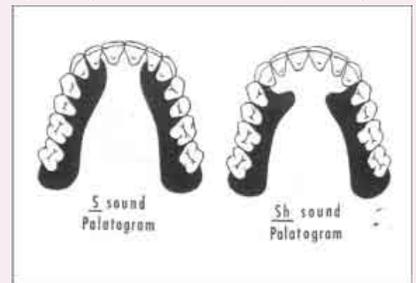
Many years ago when I attended an IAOM convention, I won a prize during a raffle drawing. As I perused the table of goodies to choose from, I saw a book by Pamela Marshalla dealing with articulation. Being an RDH, I thought, why not? I might learn something new.... I glanced through it, not really understanding it all, but I was fascinated by the palatograms she included in the book. For those who do not know what they are, they are a record of the placement of the tongue against the palate in the articulation of sounds. Not being a speech therapist, I had no idea of their connection to the field of Orofacial Myology until recently.

Fast forward to the present. Working with Sandra Holtzman, an SLP, has opened my eyes to many new ways to “connect the dots” in what we are trying to accomplish in therapy. How do palatograms fit in the picture?

When viewing the tongue placement for correct articulation of consonants on a palatogram, I asked myself, “What is consistent with that and with what we do in Orofacial Myology?” Good lateral border tongue position not only creates the proper speech sounds but also produces mandibular stability. Mandibular stability is needed for correct chewing and swallowing as well for achieving lingual mandibular differentiation. If the tongue moves in the patterns that the palatograms exhibit for speech, guess what? There is also going to be correct tongue rest posture...

Being an RDH, I would never state that I can correct speech issues with Orofacial Myology, but by helping patients attain the tongue position needed for rest posture, chewing and swallowing, I have seen speech improvements! It only makes sense as their new found tongue skills are mimicking the palatograms. Don't we have an amazing field!

Till next time,  
Becky



## History of how one SLP became a certified Orofacial Myologist: me!

My first recollection of “tongue exercises” was in undergraduate school at Kent State University. Back “then” we “speech and hearing therapists” saw patients throughout our junior and senior years. In our student workroom, there was a small shelf with papers. Among them, I had noticed a few that said “tongue exercises.” I know of no one who ever even looked at them during our four years there, including me. They were never mentioned in class and supervisors never suggested implementing them with our patients.

Next memory: I was working with a young client at the university school who was not able to use the “L” correctly. I told him to watch where I placed my tongue tip and to imitate me; it just made sense! Along came my crotchety supervisor and tapped her hand on the table in a disciplinary manner. “Sandra,” she commanded, “Do it THIS way.” She then proceeded to cover her mouth with a piece of paper and told the child to “Say this! La La La.” Needless to say, the child said “Wa Wa Wa.” In spite of his response, she implored me to focus only on the sound and not waste time demonstrating what the tongue does.

An early job: I got a job as the county school speech therapist in a rural area of Ohio. I was working with a group of fifth graders. One of them had a noticeable frontal (interdental) lip. He had an adorable round face, was quite intelligent, and tried really hard to comply with

my requests. He had been in therapy for years and probably is still in therapy 40 years later because of my own ignorance as well as that of others. You see, even though I was now ignoring my former crotchety supervisor's suggestions, I didn't realize that telling him to look where my tongue was and copy my actions....was not enough!

Time passes on: A few years later, I started seeing some people privately in a home office. One day, a father said to his daughter, “Sheryl, show Sandra what we noticed yesterday.” Sheryl proceeded to stick out her tongue and demonstrate how “fat” and “lazy” it was, to use her father's words. THAT was my AH HA moment! I was humiliated and determined that I would never be so ignorant again.

Beyond that: Took courses by Garliner, short ones and long ones. Kept 100's of notes in a drawer for 15 years on “discoveries” I made while working with patients and recording the exercises I created during that time. The notes were the foundation of the Myo Manual which ended up having no resemblance to the earlier simplistic program I began using .... but I give credit to Garliner and others who did what they



could, based on the information they had during their own times.

I took every oral motor course available; heard about a convention of an organization called IAOM; joined IAOM and worked hard to become certified, all the time juggling the certification process while overseeing my multi-disciplinary therapy center; became certified..... and never felt alone again in my newly discovered world of Orofacial Myology. Became involved on the Board of Directors, Board

of Examiners, and accepted requests to present at conferences. I was approached to teach the IAOM introductory course, in addition to the ASHA courses I was already offering across the U.S.A.

I, and many others who have taken similar pathways, have an important goal: Give newer Orofacial Myologists as much information gleaned through the years as possible so they can move forward faster and more efficiently. Please be comfortable availing yourself of experienced therapists to help you continue on your own Orofacial Myology pathway and so that you can use your own skills to influence the future of this incredible specialty area.



# Naurine Shah

**RDH, COM, BDS**

I am extremely fortunate to have worked with some great professionals who helped me envision the 'why' of some very prevalent conditions in dentistry. Having worked in various capacities and many years of orthodontics I began to wonder 'why' were

we not paying attention to the muscles at all? Why some patients relapsed and why some didn't? Why some open bites never actually closed and made the orthodontists try every trick up their sleeve?

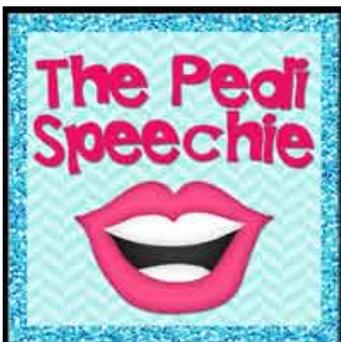
All those difficult patients had something in common. A history of thumb sucking, mouth breathing or tongue tie, all leading to tongue thrusting. Many had been treated for speech therapy in the past and many had been put in various appliances with very little success. Orofacial Myology dawned on me and then it all started to make sense!

My first step was to find more information about this exciting field. The IAOM website was a great resource for me from the start, and that's where I found my 'Guardian Angel' and forever loving Sandra Holtzman's course. From the day I signed up, till today she has been the light that has guided me at every step. I made some lifelong friends at her course, learnt excellent inside info on how to get started and hands on orofacial myology. I had officially begun my journey.

Being the first COM in Calgary AB and the privilege of working with some amazing dentists has added to my experience tremendously.

OMT is now a huge part of our diagnostic procedures and new patient exams. We have a customized program that's been integrated into most orthodontic treatments.

I regularly present to small communities and schools and try my level best to educate them about the benefits of therapy. My biggest achievements are reactions from parents that tell me that their children are sleeping better, are not noisy or messy eaters anymore and can now swallow pills!!! At some point in my life, I want to be a worldwide spokesperson for how immensely important Orofacial Myology can be for our future generations and how we as therapists can change the future of oral health.



**Our graduates stand out from the crowd and have the ability to make a difference in their communities. Karen Goske is no exception! She has created an interesting website that offers Therapy Ideas & Materials for the Pediatric SLP. You can visit it at**

**<http://pedispeechie.blogspot.com/2014/10/thumb-sucking-what-speech-language.html> or by clicking the picture at the left.**

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