



Hi Readers, there are so many activities related to orofacial myology that it is hard to know where to begin! This issue brings the information about upcoming events such as the Texas Dental Association meeting

in Dallas, Texas; the superb Las Vegas event RDH Under One Roof, where my own organization will have an exhibit booth; the AAPPSPA conference for private practice Speech Pathologists; and the exciting IAOM convention in Orlando in October, featuring a list of exceptional presenters in many different and interesting areas related to orofacial myology. I hope you will all come to say "hi" personally to me at that event!

I look forward to going to Toronto, Boston, and New York in the next few months to give training courses. The request for training has increased tremendously and classes are either filled or close to becoming so. That is a sign that orofacial myology is now well known in the dental, speech and medical worlds. Because of the increased interest, more professionals are seeking certification in orofacial myology. I direct you to an article in this edition titled *The Orofacial Myologist: Who Should be Eligible to Become One?* Also don't miss reading Dr. Robert Mason's article on Tonsils and Adenoids, one that has been requested by many of you. There is something of interest to just about all of our readers in this issue so please enjoy it as much as we enjoy bringing it to you!

The Orofacial Myologist: Who should be eligible to become one?

Should we limit training and certification to certain professionals? Or should we increase the professions that are eligible?

What are the considerations? What are the risks? What are the benefits?

This is a short article and as such, there is only space to discuss generalities. The goal is for our readers to think about this important and very timely matter. Timely...yes! Because there are lactation consultants, physical therapists, occupational therapists, and others who are waiting in the wings hoping to have the opportunity to join the ranks. Here are some of the comments and questions you will hear that merit our serious consideration:

1. Oro refers to the oral cavity; *facial* refers to the face; *myo* refers to muscles.

Virtually ALL speech pathologists, dental hygienists, dentists and orthodontists deal with all of the above and are highly qualified to do so.

Are physical therapists, occupational therapists, lactation consultants and others equally prepared in these areas? If yes, then shouldn't we include them?

If not, are they trained in some of the above? Is a 4 day training course enough to provide for the areas they missed during their formal professional training? Are they interested in offering all aspects of orofacial myology treatment or do they have only certain areas of interest and skill, such as ankyloglossia, pediatric feeding, or oral habit elimination? Should short courses be offered to permit them to specialize in specific treatments, but

not the entire array? I doubt that any of us know the answers, but since orofacial myology is literally becoming well known worldwide, we cannot avoid these questions much longer.

2. Treatment/therapy is the attempted *remediation* of a health problem following an *evaluation* and *diagnosis*. Who is able to perform these three aspects of orofacial myology? That has a bearing on who can or cannot become an orofacial myologist. Perhaps all of the above-mentioned practitioners can answer "yes" to this, perhaps one or two, or maybe none of above.

3. What peripheral areas should be considered as part of orofacial myology and who is equipped to provide such treatments as sleep apnea? TMD? Butekyo breathing techniques?

Some current orofacial myologists are not permitted to offer any type of treatments such as these; others are permitted to do so. How do we define our specialty area with such differences from professional to professional? And how can we create a solid Scope of Practice that all orofacial myologists must follow?

4. If our goal is to see Orofacial Myology as a field in itself, what university training should be the minimum required?

These questions and others will not go away. We have to face them with as open a mind as possible; yet, we have to be prudent as well as far sighted, or we risk becoming a factor in the meltdown of a specialty area that helps thousands around the world.

We will See You at Booth # 116
Look for www.OrofacialMyology.com

RDH • Under One Roof

JULY 15 - 17, 2015

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Tonsils and Adenoids

Adenoids can be seen on a lateral head x-ray shortly after birth. The adenoid mass grows rapidly, is (normally) large by age 3, and reaches peak growth by around age 6 and then remain large until around age 12 (sooner, or starting by age 9 in some individuals) when they begin to spontaneously regress (involute away) on their own. For individuals without a history of upper respiratory infections (URI), the involution process for tonsils and adenoids continues until they are small or sparse by around age 20. Although the growth cycles of the adenoid mass and faucial tonsils are similar, one cannot accurately evaluate the size of the tonsils and presume that adenoid size follows the same pattern of growth and involution for that individual.

From birth to around age 6, tonsils and adenoids contribute to the development of the body's immunologic system, but after age 6, these contributions decrease. Accordingly, while a tonsillectomy and adenoidectomy (T&A) was common practice years ago at an early age, physicians are now much more reluctant to remove tonsils and adenoids just because they are large since their role in the development of the immunological system has been recognized and is now appreciated.

Enlarged faucial tonsils can and will compete for space with the tongue when the faucial tonsils fill in and constrict the oral isthmus area. When this occurs, the tongue, as the most adaptable organ of respiration, gets out of the way by reposi-

tioning itself forward either at rest or by protruding forward as food approaches a very small oral isthmus.

The only way for food to pass through a constricted oral isthmus in some children is for the tongue to move forward and thus increase the vertical dimension of the oral isthmus. In such instances, a forward rest position for the tongue or a "tongue thrust" during swallowing in the presence of a constricted oral isthmus, is an appropriate adaptation by the tongue that should not be changed in therapy - at least until the oral isthmus has enlarged either from tonsillar removal or the normal process of involution that tonsils go through along with the adenoid mass. By the way, the term "tongue thrust" is a poor one since it implies inaccurately that the tongue is pushed forward with an increased amount of force. This is not the case. The important clinical point here is that when tongue thrusting or a forward rest posture is seen in children, the dimensions of the oral isthmus should be carefully evaluated to determine whether the tongue is adapting to a need to enlarge the oral isthmus during swallowing or at rest so that food can successfully pass through the oral isthmus into the oropharynx. Accordingly, not all tongue thrusting is a bad thing and in some instances, tongue thrusting and a forward rest posture is a logical and appropriate adaptation. Likewise, many adults with TMJ pain use a tongue thrust as a way of protecting the joints from pain and further damage. Not all thrusting in TMJ patients should be changed or eliminated.

I appreciate any physician and surgeon who is reluctant to remove tonsils and adenoids. Tonsil and adenoid size can often decrease or enlarge according to

the weather or if there are underlying allergic conditions. There are, however, indications for an adenoidectomy such as if the Eustachian tubes are closed over by adenoids, thus creating middle ear effusions and conductive hearing loss. Likewise for enlarged tonsils, if the tongue is obliged to rest in a forward position, with mouth hinged open, dental changes can be expected to follow.

In some cases, a total adenoidectomy may result in persistent hypernasality that may require additional surgery to correct. Such individuals usually have presenting intraoral signs that would contraindicate a recommendation for a total adenoidectomy. Such signs include bifid uvula (which is a microform of a cleft of the soft palate), submucous cleft of hard and/or soft palate, a velar dimple (or buckling area of an elevated velum) displaced forward as seen during velar elevation, or poor elevation of the velum. An alternate surgical procedure for such cases where adenoids encroach around the Eustachian tubes is a lateral (or partial) adenoidectomy whereby only the adenoid tissue encroaching around the Eustachian tubes is removed while the median strip of adenoids is retained to maintain normal velopharyngeal closure. Lateral adenoidectomies are now often done with the laser.

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Speech-Language Pathologist, ASHA Fellow
Former Chief of Orthodontics
Emeritus Professor of Surgery
Division of Plastic and Reconstructive Surgery
Department of Surgery
Duke University Medical Center
Private Practice in Orthodontics
Durham, NC
(now residing in North Myrtle Beach, SC)

Find more articles by Dr. Mason at
<http://orofacialmyology.com/Mason.html>

Speech-Language Pathology Continuing Education and Treatment Resources



Earn Orofacial Myology and Speech Pathology CEU's at Home

Orofacial Myology "Tongue Thrust" Level 1 Course

R: From Basics to Habituation

Tongue Tie 101: What is Our Role?

facebook 

Myo Mentors

I created a Myo page on Facebook called Myo Mentors. It began as a way for all of us who met at our course to stay in touch and ask each other any myo questions. It is a private group so you can only be added by me since I am the administrator. I am not sure if it will pop up if you do a search on Facebook. Please pass on my e-mail address to any of your graduates who want to be added.

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*Karen Galway Fedoruk,
M.S.CCC-SLP
Certified and Licensed
Speech-Language Pathologist*

IAOM President Shari Green To Host a Thumb Workshop at RDH Under One Roof



In the past, many professionals have felt that it is "OK" to wait in regards to a digit sucking habit. Families are often told that the child will simply "grow out of the habit". But has this advice stood the test of time? That is what we must continue to explore. Many of my clients often present in their second decade of life, stating that they wish they would have had help to stop sooner...often for a myriad of reasons. What IF a child waits? What are the physical and emotional risks? And, what are the benefits of quitting early? New research is now emerging that points to significant impacts on the overall health of a child and more. This is related to oral structural concerns that research shows may often develop as a result of sustained oral habits.

Of course, the strain in family from the frustration of seeing a child suck beyond an "acceptable point", and observing the physical and emotional ramifications that can result often puts a strain on relationships and family dynamics. It IS so much more than a thumb!

If you are planning to attend the RDH Under One Roof in Las Vegas, you can't miss IAOM President Shari Green. She dispels the myths surrounding oral habits. Find out how...This interactive two hour workshop entitled "Thumb Class is in Session", is a *must* for any therapist working with kids.

To register for this Workshop, visit: <http://www.rdhunderoneroof.com/register.html>

**CAESAR'S PALACE,
LAS VEGAS**

Shari Green

AAS, RDH, COM, BA
President IAOM

Wednesday - July 15 2015

8:00AM - 10:00AM

Room: Milano IV

Workshop - "Thumb Class"

Session Number:WK2

Session Type:Workshop

/ CEU Credits:2

Tracks: Oral Myology Speaker

www.ThumbLady.com

Many of our graduates are members of AAPPSPA, an organization that might interest our SLP readers.



AAPPSPA

American Academy of Private Practice in Speech Pathology and Audiology



**2015 AAPPSPA Business Institute and Conference
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for more information and registration!**



IAOM Orlando CONVENTION 2015

International Association of Orofacial Myology Related News

The IAOM wants to let you know of its "Cert-Support" listserv which provides support for those members who are seeking help with the certification process. Contact Dana Mattson at dsmslp@aol.com to send you an e-mail invitation to begin your preparation.

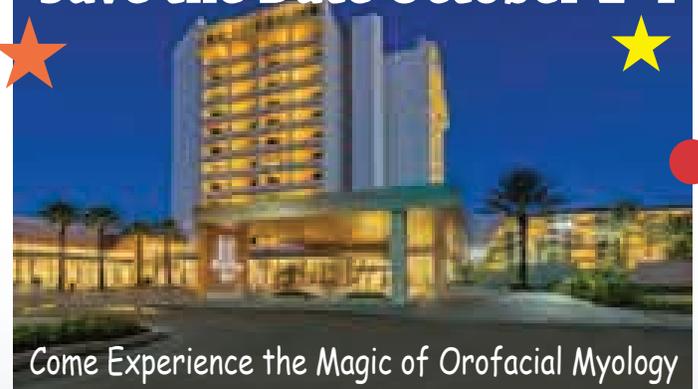
The Schedule for the Annual Convention is ready. You can find it to better plan your visit at: <http://www.iaom.com/pdf/2015Schedule.pdf> Remember that it may be altered due to last minute changes.

You might want to check the price of airline tickets from your home airport to Orlando. At the moment, they are somewhat reduced. For example, prices to Orlando just went down almost \$90 from Chicago to Orlando. So if you plan to attend the Convention, check your flight price soon.

Join us as we "Find The Magic of Orofacial Myology" on October 2-4, 2015, at the Holiday Inn Lake Buena Vista near beautiful Walt Disney World® Resort, Florida.

Whether you are an Orofacial Myologist looking for the latest research and therapy techniques, a Speech or Dental Professional seeking more information about sucking habits and tongue thrusting, a Lactation specialist wanting more education on Tethered Oral Tissues (TOT's), or a Physician who seeks to understand the connection between the airway and craniofacial growth and development, our conference is the place to be.

Save the Date October 2-4



Come Experience the Magic of Orofacial Myology

The 2015 IAOM Convention is focused on providing a variety of courses, both clinical and didactic to improve assessment, diagnosis, treatment planning, treatment implementation and evaluation practiced by orofacial myologists on a global basis.

Get special ticket prices only for IAOM convention attendees by clicking here



<http://www.mydisneymeetings.com/iaom15/>

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



TONGUE TIED



From: www.delish.com

We were amazed when we discovered that one of the most popular drink nowadays is called "Tongue Tied".

This drink is served in a champagne coupe, a glass that has made a big comeback in the cocktail world. Ironically, we don't put champagne in this glass, or it would go flat pretty quickly. But, it easily takes the place of a martini glass for those beverages served straight up.

DIRECTIONS

Muddle all ingredients except lavender tincture. Shake with ice vigorously, and double-strain into a chilled coupe or martini glass. Spray with lavender tincture and garnish with a slice of strawberry.

Lavender tincture: In a small canning jar, cover lavender and vanilla bean with 100-proof vodka. Let sit for at least four days, shaking daily. After four days, strain off lavender and vanilla bean. Add bottled water and bottle tincture.

- 1 oz. Sombra Mezcal
- 1 oz. Luxardo Amaro Abano
- 0.75 oz. lime juice
- 0.75 oz. simple syrup
- 2 sprays lavender tincture
- 1 slice strawberry
- Lavender Tincture
- 2 oz. lavender
- 1 vanilla bean
- 100-proof vodka
- 0.50 oz. bottled water



by Becky Ellsworth, AAS, RDH, BS, COM

Outside of the “mouthbox”

Why do we keep “tongue thrust???”

There is a saying that old habits die hard. This is so true and it is alive and well in the dental, speech and medical community as it relates to orofacial myology! I believe now is the time to make a change – out with tongue thrust being the issue and in with incorrect lip and tongue rest postures! There is no denying that tongue thrusting is an issue with which we must deal but it is an ancillary issue, so why does it get center stage in our referrals? I cannot think of a time when a patient who is coming to see me has not said, “I was told to see you because my son, my daughter, etc. has a tongue thrust, whatever that is”.

A tongue thrust swallow is certainly a visual but so are open lips and a low tongue rest posture (if the lips are far enough apart). I put it to you that if you observe open lip rest posture and the tongue is visible at rest, you don’t even need to check for a tongue thrust swallow; it will be there!

In our course, Sandra has created a definition of Orofacial Myology that attempts to cover the wide range of concerns inherent within this field. The definition states, “Orofacial Myology is the study and treatment of oral and facial muscles as they relate to speech, dentition, chewing/bolus collection, swallowing and overall mental and physical health.” Swallowing is only one aspect of many. As we have learned more about this fascinating field, we are moving toward revamping our orofacial myology verbiage such as the use of the following: “muscle imbalances,” “weakness” and “tone”. Even the topic at hand, tongue thrusting, has been shown to be incorrect. We used to believe that a thrust caused malocclusions and that we swallowed 2,000 times a day, but we now know that the thrust itself isn’t the problem. Children swallow approximately 800 to 1,000 times per day and adults much less than that.1

My point in this article is we have come far thanks to those who have gone before and paved our way; however, the need is to change the rhetoric by embracing what we now know is true. I submit that we should all begin stating that Tongue and Lip Rest Postures, not tongue thrusting, should be the primary referral terminology. There is also an old saying that “a rolling stone gathers no moss” so let’s start rolling!!

Till we meet again,
Becky

1 International Journal of Orofacial Myology, Volume 37, November, 2011, pages 27-38
MYTHS THAT PERSIST ABOUT OROFACIAL MYOLOGY Robert M. Mason, D.M.D., PhD
This article can be found on our website.



TDA 2015 May 7-10, San Antonio

The Texas Meeting Education 7-9 • Exhibition 7-8 • House of Delegates 7-10

One of the largest nationwide conventions for dental professionals will be held in TEXAS this May, 2015. You can find more information at the Meeting website:<http://www.texasmeeting.com/>.

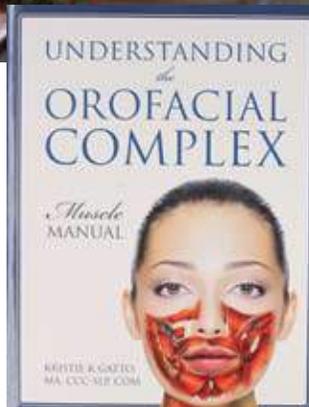
Here you will find what you need to know about speakers, continuing education, exhibits, governance, travel and so much more.

They are anticipating an attendance in excess of 11,500!

IAOM will be present as well as some of our graduates.

They will be thrilled to answer all your myo-functional questions.

Come to say hello and to meet Kristie Gatto, author of *Understanding The Orofacial Complex*, one of our most popular books in 2015.



Cheryl Thoms Metcalfe

MA, Reg. CASLPO



I have been a Speech-Language Pathologist for over 25 years, and a graduate of Sandra's "bootcamp" since 2007.

I worked in various settings as an SLP, including school boards, hospitals and community health care both as a staff SLP, Discipline Manager and am now the Director of a very busy community practice that is located in Windsor, Ontario, Canada but provides home care therapies across Canada.

While I enjoy all aspects of being an SLP and a Manager, my love has always been providing SLP services to children and young adults. For this reason, I have always maintained a clinical role in whichever setting or capacity I was working.

Early in my career I really began to notice that traditional therapies were not addressing some of the lingual issues I was seeing in clients. I was aware of "tongue thrust" therapy so I began to research it in greater depth and became very intrigued with Orofacial Myology. In 2007 I decided to take a leave of absence from my managerial role and focus solely on client care and I decided to take the leap and study under Sandra, taking her boot camp with 3 other SLP's.

Sandra was an exceptional teacher and mentor. She shared her immense knowledge, taught us how to treat myofunctional disorders and has remained an important contact for me as I have practiced as an OM.

When I returned to clinical practice, what I had learned had immediately changed the way in which I assessed my clients with speech and oral motor issues, and impacted my approach to therapy. I started working with several orthodontists in the city and was invited to give a talk to the local dental society. I was certainly grateful to Dr. Robert Mason for the information he provided to OM's when talking to dental professionals regarding lingual resting posture. I remained very connected with Janice Thomas, an SLP and fellow classmate of the "boot-camp" and we have worked together developing tools to help us with client care.

In 2015, 8 years after I started working as an OM, I have finally decided to become certified and have just started the certification process. One of the key factors was the impetus it is giving me to ensure I am aware of all that is current in terms of research and knowledge in the field, and the more I work with dental professionals, the more aware I am of the need to communicate with them using the appropriate dental terminology and other concepts pertinent to that discipline.

I am grateful to Sandra for starting me down a path that has changed my therapy focus, enhanced my clinical practice and allowed me to broaden my knowledge- all of which have made me a better clinician with all clients with whom I work.

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Eligibility is Limited to DDS, SLP & RDH

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Or Fax to 321-352-7411

Email contact:
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