Orofacial Myology News

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Spring arrived in North Carolina as we were inaugurating our second location for Orofacial Myology training. Participants were thrilled with all the new techniques they could now implement, and I was delighted, as always, to work with our excited, inquisitive SLPs and RDHs who were entering the never boring specialty of Orofacial Myology. Outside, a new season was starting; inside, new orofacial myologists were blossoming. One of the reasons that training has been a consistent pleasure for me is the reality of a multiplier effect…. As I see those whom I trained open up their own offices and clinics, offer training in their communities, add to our overall knowledge and research, and become contributing members of the IAOM as well as officers and board members, I experience a peace within that is difficult to explain. I have high hopes for the future of our specialty area, knowing that enthusiastic graduates of my classes continue the momentum into the future. We are delighted to be providing training in North Carolina as well as Orlando and look forward to continuing to add to the numbers of quality professionals who bring so much to the world of orofacial myology.

Mandibular Tori: possible connection with sleep apnea?

Singh GD, Cress S, McGuire M, Chandrashekhar R.
Case Presentation: Effect of Mandibular Tori Removal on Obstructive Sleep Apnea
Parameters. Dialogue: AADSM. 2012; (1): 22-24.

Lately, the topic of obstructive sleep apnea (OSA) comes up wherever I turn. As of this point in time, we orofacial myologists are not prepared or equipped to make the determination of OSA nor claim to treat it. Worldwide, there are medical and dental professionals offering many solutions, but there is still a dearth of solid evidence that points to any particular remediation or "cure."

A case presentation came over my desk recently that caught my eye and I decided to share it with you. It discusses the effect of mandibular tori removal on obstructive sleep apnea parameters. Being a "sufferer" myself of large mandibular tori and exostoses, I found I could relate to much of what was being theorized. Based on this case study of a 47 year old male, removal of the tori and exostoses led to a subsequent increase of oral volume which is to be expected, thus permitting more space to accommodate the tongue. In comparing the pre and post operative sleep studies, there was a 15% reduction in the overall apnea-hypopnea index and a 31% improvement in the oxygen desaturation index. They concluded that further studies are warranted to try to explain the relationship between the tori and exostoses with regard to sleep apnea symptoms. Although there are likely many causes and contributing factors that come into play with regard to OSA, I hope that this particular possibility continues to be examined as one of those contributing factors.

The order of things.....the importance of a sensible, sequential treatment program

Do you ascertain that your clients are well prepared before you introduce "swallowing" exercises?

We used to consider the swallow as the "villain" behind all of our patients' woes. We used to "dig right in" on the first or second sessions, introducing the correct placement for the tongue tip and the initial processes for the swallow itself. In keeping up with current information and best practice, we now understand that the actual "swallow" is only one of many symptoms….mouth breathing, rest postures of tongue/lips/mandible, overall inability of the tongue to perform basic lingual skills required for habituation to occur, lip "strength" and compression capacity, difficulty with the suctioning process related to bolus collection, and much more.

Be sure to analyze whatever program you are currently using to rest assured that you are giving your patients every opportunity for success as they work toward the critical goal of lifetime habituation!

POSITION STATEMENT REGARDING APPLIANCE USE FOR ORAL HABIT PATTERNS

Prepared by: Robert M. Mason, DMD, PhD Honor Franklin, PhD

Dr. Bob's
CLINICAL PEARLS

BACKGROUND: Some orthodontists and others in dentistry continue to address oral habit patterns with appliances involving cribs, rakes, spikes, prongs or other tongue reminders. By contrast, procedures utilized by orofacial myologists are effective in modifying oral habit patterns without the need for appliances.

NEGATIVE ASPECTS OF HABIT APPLIANCES:

- Most habit appliances are designed to block a tongue thrust (swallow) rather than to modify the rest posture of the tongue and address the problem of inability to close the lips.
- Habit appliances attempt to prevent a tongue thrust swallow. They neither teach the tongue where it should rest, nor teach a correct nasal breathing rest posture.
- Habit appliances do not address the cause of the oral habit pattern. Unresolved airway issues or prolonged sucking habits are the usual reasons for a retained tongue thrust or forward, interdental rest posture of the tongue.
- Habit appliances, by virtue of cribs, rakes, spikes, prongs or other vertical components, serve to open the dental freeway space. This encourages a differential eruption of teeth in the mixed dentition by accelerating posterior dental eruption and vertical drift while impeding the normal eruption of anterior teeth. The consequence of this can worsen rather than correct the malocclusion and further exacerbate lip incompetence.
- Clinically observed patient adaptations to habit appliances include eating and speaking problems, the development of a lateral tongue thrust and even lateral open bites. Some patients are seen to adapt by positioning their tongue under the appliance, thus increasing the vertical freeway space dimension, leading to further posterior eruption and lip incompetence.
- When a habit appliance is removed and the cause of the tongue pattern is not addressed, the forward tongue posture and functions are expected to return.

PERSPECTIVES ABOUT ORAL HABIT PATTERNS AND THE ROLE OF OROFACIAL MYOLOGY

- In our view, and as well established in dental science, the rest posture of the tongue is linked to the development of malocclusions, especially anterior open bite, while tongue thrusting is viewed as an adaptation to, rather than a primary cause of a developing malocclusion.
- Orofacial myofunctional therapy is rest posture therapy: orofacial myofunctional therapy procedures are designed to normalize the rest posture of the tongue and lips. Working to eliminate a tongue thrust swallow is a secondary but important aspect of therapy.
- A primary goal of orofacial myofunctional therapy is to establish or recapture a normal freeway space dimension. In our view, a normal interocclu sal rest position is key to normal dental eruption and creating stability of the dentition. An excessive freeway space beyond the normal range of 2-3 mm posteriorly, is a characteristic of many patients with oral habit patterns.
- Other oral habit patterns, such as a mouth-open lips-apart posture, lip biting, clenching and grinding, and sucking habits, respond well to treatment without the use of appliances. Thumb and finger sucking habits respond well to behavioral modification. Appliances are never recommended by us for thumb and finger sucking habits.
- For patients with a tongue thrust and thumb sucking habit, the tongue thrust will remain as long as there is a sucking habit.
- Therapy to modify tongue rest posture or functions will not be successful until any associated airway issues are resolved.

SOME SELECTED REFERENCES/ BACKGROUND STUDIES/ CLASSIC ARTICLES RELATED TO OROFACIAL MYOFUNCTIONAL PERSPECTIVES: RECOMMENDED REFERENCE TEXTS

Enlow, D.H., and Hans, M.G.: Essentials of Facial Growth, W.B. Saunders, Philadelphia, 1996.
Hanson, M.L., and Mason, R.M.: Orofacial Myology: International Perspectives, C.C. Thomas, Springfield, IL, 2003.
Proffit, W.R., Sarver, D.M., and Fields, H. W.: Contemporary Orthodontics, 4th Edition, C.V. Mosby, St. Louis, 2006.
Sicher, H., and DuBrul, E.L.:Oral Anatomy, 5th Edition, C.V. Mosby, 1970. PRESSURE TRANSDUCER STUDIES. Mason, R.M., and Proffit, W.R.: The tongue thrust controversy: Background and recommendations. J. Speech Hearing Disorders, 39, 2, 1974, 115-132.
Proffit, W.R.: Lingual pressure patterns in the transition from tongue thrust to adult swallowing. Arch. Oral Biol., 17, 1972, 555-563.
Proffit, W.R., Chastain, B., and Norton, L.: Linguo-palatal pressures in children. Am. J. Orthodontics, 55, 1969, 154-166.
Proffit, W.R.: Muscle pressure and tooth position: A review of current research. Australian Orthodont., 3, 1973, 104-108.
Proffit, W.R., and Norton, L.: The tongue and oral morphology: Influences of tongue activity during speech and swallowing. In Speech and the Dentofacial Complex: The State of the Art, ASHA Reports 5. American Speech and Hearing Association, Washington D.C., 1970, 106-115.
Proffit, W.R., and Mason, R.M.: Myofunctional therapy for tongue-thrusting: background and recommendations. J. Am. Dental Assoc., 90, February, 1975, 403-411.
Proffit, W.R.: Equilibrium theory revisited: Factors influencing position of the teeth. Angle Orthod. 48, 3, 1978, 175-186. ORAL HABITS Norton, L.A., and Gellin, M.E.: Management of digital sucking and tongue thrusting in children. Dental Clinics of North America, July, 1968, 363-382.
Nowak, A.J., and Warren, J.J.: Infant oral health and oral habits. Pediatric Clinics of North America, 47, 2000, 1043-1065. GROWTH AND DEVELOPMENT/MOR-PHOLOGY Ingervall, B., and Eliasson, G.B.: Effect of lip training in children with short upper lip. Angle Orthod., 52, 3, 1982, 222-233.
Mason, R.M., and Serafin, D.: The tongue: Interdisciplinary considerations. Chapter 38, in Serafin, D., and Georgiade, N.G: Pediatric Plastic Surgery, volume 2, C.V. Mosby, St. Louis, 1984, 711-732.
Satomi, M.: The relationship of lip strength and lip sealing in MFT. Int. J. Orofacial Myology, 27, 2001, 1823.

"When should we be seeing patients post-frenectomy?"

This interesting topic came up on the IAOM list/serv: When I read the responses, I breathed a sigh of relief. We truly have come a long way in our speech/dental professions. When I first began providing post frenectomy treatment, I always deferred the answer to that question to the person performing the surgery. The problem, I soon discovered, was that sometimes it was literally weeks before I saw the patient to begin treatment. One of two situations occurred in such instances: The tissue reattached, depending upon what type of procedure had been performed….or the tongue and mandible continued to maintain the former rest postures and lingual excursions with the newly released tongue, further embedding the incorrect placement and posture in spite of the potentially new found freedom. We want to take advantage of this opportunity to "get in" as soon after the surgery as possible so that we can pair the newly released tongue to a newly learned manner of using it! So I was overjoyed to read response after response that demonstrated a full understanding of this important concept. One person stated that she typically schedules babies "for the same day if not immediately after the procedure is done," both for labial and lingual releases. For older clients, she sees them the same day or the day following the release. Another stated that she schedules within 3 days of the release to minimize the chance of reattachment. One respondent made an important comment that frenectomies are sometimes in conjunction with other surgeries such as tonsillectomies. It is important for parents of those children to realize that they cannot wait excessively long periods before seeing the orofacial myologist, in spite of the concomitant procedure.

One mentioned that she relies upon the professional who performed the surgery. My personal experience is that they would gladly defer to us and to our decision. The surgeons (or others) whom my patients have seen in the past often or always have felt that we orofacial myologists are in the best position to decide when to begin our own treatment. Therefore, I rarely ask for their opinion about initiating treatment unless there are underlying concerns or additional surgery that was performed.

RELATED NEWS
What events are coming?

IAOM is holding their 2013 convention in Washington, DC. We will have details in our next Orofacial Myology News, but you might want to "keep the date" for now: October 11 - 13.

These are our new members. We wish you great success as you enter this fascinating specialty area of Orofacial Myology. We look forward to your participation and future contributions to the IAOM: Katherine Fink, Karen Pollock, Andrew Christler, "Carol" Fetzik, Daniel Kinkela, LynneMathy, Allison Trujillo, Jane Loh, Amy Wetherill, Bernadette Rivera, Patricia Tracy, and Dawn Moore.

If you are a member or are interested in becoming one, these are the three Board of Director members who can answer questions about the organization, the certification process, and what it means to you as an SLP, RDH, or DDS:

Sandra Holtzman:	SLP Representative	Sholtzman@OrofacialMyology.com
Heidi Widoff:	RDH Representative	Smile@oralmyology.com
Gary Sigafoos:	Dental Representative	gsigafoos@san.rr.com

Leslie Whitaker

Each edition we highlight a past graduate who is using the techniques and spreading the important concepts of orofacial myology. Leslie Whitaker 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 have been a speech-language pathologist for 16 years and it has been quite a ride. I studied and practiced in North Carolina, Oregon, and California before settling down in Mill Valley, California (San Francisco Bay Area). I have been in private practice for 10 years serving children and adults with a wide range of communication issues. A while ago I realized that I always had a few patients on my caseload who were just not responding to my traditional methods of articulation and language therapy and I did not know why. I started to do some research and came across Sandra Holtzman's website, www.orofacialmyology.com . I remember reading it thoroughly and becoming so excited thinking that this might provide some clarity.

I was able to attend one of Sandra's 28-hour boot-camps in Ft. Lauderdale in December 2010. At the time I was 6 months pregnant and had a 2 year old-but I was determined to attend! Fortunately I had family in South Florida who was able to watch my daughter.

The course was just what I was looking for. It helped answer so many questions that I had as well as provide a new framework for viewing the oral structures as a system. Since taking the course I can honestly say that I use techniques from this course every single day at work with my clients. It has helped make treatment more efficient and more effective. My clients and their families are truly grateful for the precise information and techniques that I give them.

On a personal note, this course has helped me to better understand my own oral-facial imbalances to help correct them. It has also helped me better manage my own children's' thumb sucking habits.

I am so grateful to Sandra for sharing her knowledge and being my long distance mentor. She has always been quick to respond to my questions and provide feedback. I'm not sure when I will get to it with my full plate of running a busy private practice and having 2 young children but I plan to continue my OFM to complete my certification.

Orofacial Myology News 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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Dec	27 – 30	Orlando, FL

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