



We are excited to begin this Fall 2013 season by adding a new team member, Becky Ellsworth.

Becky, who is the Chair of the IAOM Board of Examiners, joined our Orofacial Myology team a few short months ago and we feel very fortunate to have her with us! Being an RDH instructor, she is a great addition to our classes.

When she is not teaching or working on IAOM projects, you will find her spending time with her husband, her cats, or researching a new topic to stimulate the avid minds of our attendees. She is soon to become a first time grandmother and cannot wait to hold that little new one in her arms. We welcome you, Becky, and look forward to many enjoyable times together.....

Our Orofacial Myology News now boasts a column by Dr. Robert Mason. Check it out on page three and use it to help educate your patients and their parents.

We added a section for international orofacial myologists to tell what approaches and programs are used in their own countries. This edition contains an article by Ana Lia Garretto. Many of our readers already know Ana Lia as an active enthusiastic therapist from Argentina.

Our 2014 schedule is set and we will be busy giving classes more often and in more locations including Orlando, Raleigh, Michigan, Calgary, and California. We hope to see some of you during our travels.

Enjoy this crisp and delightful season and as always, we appreciate your emails and input and ideas for future editions.

Pursuing Perfection Through Technology

We have to exercise caution when incorporating technology in trying to resolve real life problems with "real life" patients.

Software developers and other information management specialists offer guidelines as to what technology should be able to do for us. Among them are the following:

- To help us do our jobs better by clearly displaying the critical information that we rely on to do our jobs.
- To filter out irrelevant data so that we aren't drowned in meaningless messages.

But are these guidelines achievable? In well-ordered situations with clear goals and standards, with stable conditions, it makes perfect sense to seek such performance. With complex conditions and the need for constantly evolving goals, (yes, the ones we deal with in each and every therapy session!), it doesn't make sense to pursue those same goals. We have to exercise caution when incorporating technology in trying to resolve real life problems with "real life" patients.

Some books are addressing these issues. In "Seeing What Others Don't" by Gary Klein, the author explains why we need insights to avoid faulty beliefs that may come about by "failing to filter out irrelevant data." He explains how we are often drowning in meaningless messages along with the relevant ones.

Google can be TOO helpful. In

fact, Facebook, Google and other programs and search engines "learn" our preferences and try to limit our choices based on what they have "learned" about our prior selections. They screen out what they "think" we don't want or need, thus limiting our exposure to new and differing input that can lead to possibilities of new insights and professional growth. So when we put our request for information into a search engine, we can expect the first several results to reflect what we already know or have already seen in the past.

We need to see challenging articles and encounter other points of view. We need exposure to ideas that are NOT all similar to what we currently believe to be true.

We are taught throughout life to stay a course in order to reach our original goals. Unfortunately, doing so often interferes and stops us from discovering new and better goals that lead to insights about our patients and their immediate needs.

So how do we use technology effectively in the always variable environment of therapy settings?

- When using Search Engines, dig deeper, perhaps even starting on a later page and working backwards.
- Learn how to use objective measurements as a guide to "general" expected behaviors without downplaying our own instincts and without ignoring what is honestly occurring in our treatment sessions.
- When we discover something new or different or unexpected in the way a patient is responding to our treatment "plan," we have to be able to use that momentary insight to change direction. We must remember that striving to meet predetermined goals might sometimes actually obstruct progress and keep the patient and us stuck on an irrelevant pathway.

Suggested books: "Play" by Stuart Brown, MD (Avery Publishing, NY, 2009 and "Seeing What Others Don't" by Gary Klein (PublicAffairs Publishing, 2013)

IATP World Summit 2014

Oct 8-12, 2014 in Montreal featuring world class researchers and clinicians from around the world. Specific information about slate of speakers coming soon.

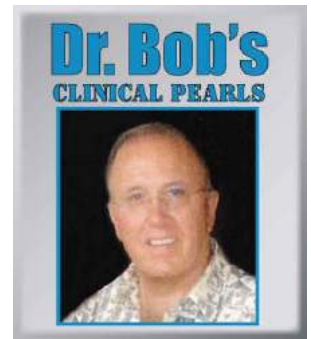
International Affiliation of Tongue-tie Professionals

LABIAL FRENULAE – IMPORTANT ORTHODONTIC CONSIDERATIONS



Robert M. Mason, DMD, PhD

While much appropriate attention has been directed toward the evaluation and treatment of tongue-tie, the labial frenum can also become problematic and may need to be released. Although there are normally several labial-lingival frenulae around the upper and lower labial and buccal vestibules, the midline maxillary and mandibular frenulae are the ones that can become problematic.



A short, constricted maxillary midline frenum can interfere with sucking and feeding and later, speech misarticulations and may be indicated for release of the connective tissues involved. A simple “clipping” may be appropriate in early infancy or beyond.

A concern that needs to be addressed, however, is the status of a maxillary or mandibular midline frenum attachment that extends over the alveolar ridge. In the **maxillary arch**, it is critical to avoid cutting and removing the extra connective tissue at an early age. Such procedures often result in leaving a “window” at the gingival area when the central incisor teeth are fully erupted. The prudent perspective about a maxillary labial frenum that extends over the dental arch is to not remove this extra tissue until the central incisors edges are in contact at the midline. In instances where a diastema develops with dental eruption as a result of the maxillary frenum extending across the alveolus, orthodontic treatment should first be undertaken to close the diastema before surgery to correct the frenum is achieved. Such surgery should involve **contouring** the connective tissue excess rather than a simple removal of extra tissue. In this way, a “window” at the gum level is avoided, and the contouring provides an acceptable and more ideal cosmetic result.

The **mandibular** labial midline frenum can also negatively impact sucking, feeding and later speech productions. As well, a frenum that extends across the anterior alveolus can have a negative impact on dental eruption, even causing ectopic eruptions of the central incisors, either lingually or labially. As with a maxillary midline frenum, correction can be accomplished early by clipping the frenum, or releasing it with the laser. Although there is less of a chance that a window will develop following eruption of incisors if the extra frenum tissue is surgically excised, the prudent choice is to wait for eruption of the lower central incisors to undertake a definitive contouring of the area where the connective tissues of the frenum cross the alveolus. However, there seems to be a lesser risk of creating a gingival-located window from surgical removal of the extra frenum tissue. The laser has been used effectively and successfully from infancy onward to contour the gingival area between the central incisors.

For sucking, feeding, and to prevent later speech problems in infancy and childhood, when a short, restricted labial frenum is released by whatever method that is used, the mid-portion of the frenum should be the focus of tissue release. In this way, the tissue mass that extends across the alveolar ridge is preserved for definitive contouring later on following closure of whatever diastema may appear from eruptions of central incisors.

Speech-Language Pathology Continuing Education and Treatment Resources



Earn Orofacial Myology CEU's at Home

Orofacial Myology “Tongue Thrust” Level 1 Course

R: From Basics to Habituation

Tongue Tie 101: What is Our Role?



Orofacial Myologists Around the World

When we asked Ana Lia Garretto to tell us about her activities as an orofacial myologist in Argentina, she created a nice timeline that introduces us to the life of a person who has devoted herself to learning and lecturing about Orofacial Myology topics. Thank you, Ana Lia. We are sure our readers will enjoy reading about your evolution as an orofacial myologist as much as we have.



Enjoying a little free time with Susemarie Swenson and our dearly beloved Marge Snow



During my first 25 years as a professional, I worked at the Department of Pediatric Dentistry at Buenos Aires University, where I taught dental students, saw patients, performed evaluations and conducted research. I always worked in a close relationship with an interdisciplinary team of ENTs, dentists, pediatricians, neurologists, and other specialists. I decided to get my PhD and realized that as an SLP, the doctoral thesis included a mandatory original research project. I decided to do my research in Orofacial Myology. I traveled to Orlando, Florida, in 1986 where I met Daniel Garliner and heard about the IAOM. I attended courses with Dr. Marvin Hanson, Joe Zimmerman, Bill Zickefoose, Gloria Kellum and Dr. Robert Mason with whom I visited Duke University. I collaborated with Dr. Hanson and Dr. Mason for their book, Orofacial Myology: International Perspectives, writing about "Orofacial Myology in Argentina", Chapter 15. Irene Queiroz Marchesan invited me several times to Brazil, where I spoke about Orofacial Myology in different cities. I also presented Chapter 2 of the book "Tratamiento de la Degluticao" organized by Irene. We still keep in touch.

Currently, I see patients in private practice at the Argentine Orthodontics Society (Sociedad Argentina de Ortodoncia-SAO), where I teach graduate students specializing in orthodontics and orthopedics. I also conduct patient evaluations and diagnoses associated with Oral Myofunctional Disorders. I work every day with patients that have negative habits such as thumb sucking, lip biting, nail biting, bruxism, functional respiratory habits, and more. I also see patients regarding restricted lingual frenula and temporomandibular joint disorder and general body posture. Most of the patients present with mouth breathing, dysfunctional swallowing, and speech disorders. I continue presenting papers and

courses to dentists, ENTs, pediatricians, and speech pathologists specializing in orofacial myology. I organize intensive courses and training for SLPs in Spanish and English.

I would like professionals to expand their knowledge all over the world, paying attention to the importance of Orofacial Myology in our overall health. I want professionals to understand that orofacial myology cannot be applied the same way in every location because there are different cultures and restrictions. I wish the best for Orofacial Myology now and in the future and I especially thank Sandra Holtzman for inviting me to write these lines.

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"Winter Conference, Orlando"



Here I am with Co-Chairs Marvin Hanson and Sandra Holtzman, also present Sandy Coulson.



One of many wonderful moments

Outside of the “mouthbox”



by Becky Ellsworth,
AAS, RDH, BS, COM

I am delighted to be part of a new career adventure with Neo-Health Services, Inc. and to be able to share some of my thoughts with you in my column in the Orofacial Myology News. I look forward to meeting many of our readers as I travel with Sandra Holtzman, giving courses throughout the U.S. (and perhaps elsewhere!). I wanted to use this opportunity to delve a little bit deeper for those readers who may not yet fully grasp the possibilities of orofacial myology and the advantages of treatment.

Assess – to appraise, determine **Evaluate – to examine, to get the measure of**

These are two terms with which all dental hygienists are aware as they are the crux of our profession. We are trained to work intraorally and observe all aspects of the soft tissue and periodontium, noting any abnormalities, but what about the whole person, not just the inside of the mouth? What about the head, mouth and tongue postures? Each one of these is important in ascertaining an orofacial myofunctional disorder (OMD).

There are very simple ways to screen for and detect an OMD, and they are literally staring us in the face!

Observe:

Are the patient's lips apart at rest? Are they chronic mouth breathers? Is there a large “freeway space” at rest? Is the tongue visible? If so, where is it resting? Does the mentalis tighten when they close their lips? Is there low tongue posture or interdental position during speech? Are there anterior or posterior crossbites or openbites? Is there an ankylosed lingual frenum or a diastema between the maxillary central incisors related to the labial frenum?

These are just some of the many ways we can screen for an OMD. We can also ask questions to determine if there is a current or former oral habit that is a contributing factor.

We need to move our perspective outside of the “mouthbox” and if we do, we will be able to help our patients in ways that they, and you, can only imagine! What an exciting and vitally important way to expand our knowledge and grow our profession. If you have not yet done so, consider taking an IAOM approved course and jump on board for a new way to add to your skill set!



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

LICK-THE-BOWL-CLEAN HUMMUS

TOTAL TIME: Prep: 10 min. Cook: 35 min.

Ingredients

2 large sweet onions, thinly sliced

1/4 cup plus 1/3 cup olive oil, divided

1 can (15 ounces) garbanzo beans or chick-peas, rinsed and drained

1/4 cup plus 2 tablespoons lemon juice

1/4 cup tahini

4 garlic cloves, minced

1/8 teaspoon salt

1/8 teaspoon pepper

Baked pita chips or assorted fresh vegetables

Nutritional Facts

1/4 cup (calculated without chips and vegetables) equals 218 calories, 17 g fat (2 g saturated fat), 0 cholesterol, 91 mg sodium, 14 g carbohydrate, 3 g fiber, 3 g protein.

Directions

1. In a large skillet, saute onions in 1/4 cup oil until softened. Reduce heat to medium-low; cook, stirring occasionally, for 30 minutes or until deep golden brown.

2. Transfer to a food processor; add the beans, lemon juice, tahini, garlic, salt, pepper and remaining oil. Cover and process for 30 seconds or until smooth. Serve with chips. Yield: 2-1/2 cups.



Originally published as Lick-the-Bowl-Clean Hummus i Taste of Home February/March 2011, p69

by Taste of Home



Dawn Moore

"I have been an SLP for 15 years practicing in the schools and in private practice.. After diagnosing my own daughter at 2 years old with an OMD and struggling to find treatment for her tongue thrust and associated myofunctional difficulties, I sought out training to be able to help others with similar conditions."

When I was asked about orofacial myology on a recent list serv for Speech Pathologists at Large, I responded as follows:

I took Sandra Holtzman's course when she offered it in Raleigh this past spring. She usually gives it in Orlando. It is an eye opening, amazing training that will show you why you couldn't "fix" kids you had in the past. Their issues were not really articulation, they were orofacial. The kids I saw at school had issues ranging from "tongue thrust" to tongue tie to low tone to weak masseters, to mouth breathing and on and on and on. These issues cannot be fixed with articulation therapy and in the schools we can do nothing else. I am not talking about oral motor therapy. Orofacial myology deals with correction of the muscle function that may cause inappropriate habits (i.e., tongue thrust) which create articulation problems and dental problems. You have to work with patients and then pass the test and onsite visit observations to become certified. After being in this field for 15 years, I have finally seen what we should have been doing all along and what we should have been taught in graduate school when it comes to speech/articulation therapy. I have always said our field is way too broad and should be broken up into specialized areas, but since ASHA doesn't do it, we have to do it ourselves. I agree with Susan Arnold that there need to be more orofacial myologists in this country! If you are looking for a niche area in speech, this is a good one to consider. Working with orthodontists in your area will help you build up a practice. Just being a member of the IAOM has allowed me to receive referrals. I now have a way to assess and recommend lingual frenum release for those that truly need it and will benefit from it instead of just saying "It might help." That is just ONE of the areas I learned about in the training.

Orofacial Myology: From Basics to Habituation Certification Track: Intensive Course



28 Hour Approved Course presented by

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

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- Mar 06 – 09** Raleigh, NC
- Jun 26 – 29** Raleigh, NC
- Jul 24 – 27** Grand Rapids, MI
- Aug 18 – 21** Calgary, Alberta, CA
- Oct 10 – 13** Raleigh, NC
- Nov 06 – 09** Orlando, FL
- Dec 27 – 30** Orlando, FL



Welcome to Our
New Instructor:
Becky Ellsworth,
AAS, 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 an 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.