Orofacial Myology News

Orlando, FL March 31, 2012

Its Time to have lots of Myo Fun!!!

Although I am one who strongly believes that superior therapy is an "art" form, we cannot move forward quickly until we have more information and studies to back up our treatment methods.

Since the release of our last Orofacial Myology News, we've had more class participants who are associated with universities. These "grads "are in a unique position in two ways. They are working in an environment where research is encouraged and they are in a direct position to teach orofacial myology concepts to the next generation of SLPs and dental professionals.

Questions and requests for assistance stream into our emails daily. Because 24 hours just isn't enough time to respond as well as we'd like to the many questions we receive nationally and internationally, we're doing our best to refer some questions to our past grads via holtzmansgraduates Yahoo group and to

Is the SLEEP APNEA a myofunctional concern?

Being that Orofacial Myology is still trying to gain recognition as a field of its own, there are still no set rules for claims and no codes specific to orofacial myology. The ICD revises and updates codes yearly, further complicating the process for the new Orofacial Myologist as well as seasoned practitioners.

When you file for medical claims, it is imperative that you are careful to remain within the scope of practice that is clearly determined by the IAOM, and that you use codes accordingly. Members will find relevant information on the following page:

www.iaom.com/_memberArea/memDocuments.html

According to feedback from our graduates and others, there is no one code for claim acceptance among the States. Insurance companies are in the process of being educated by orofacial myologists, and we are exploring how IAOM members from other countries such as Canada are working towards recognition and the development of specific codes. Here are 5 tips:

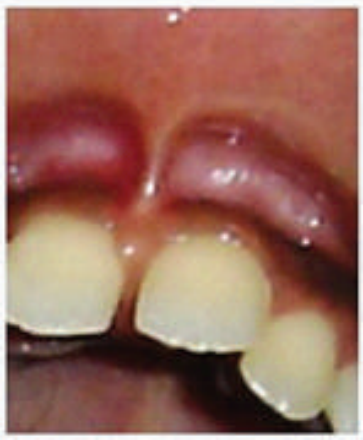
First, be cautious in determining the primary diagnosis because it tells the carrier what the most significant condition is. Secondary codes should represent a coexistent condition, something that relates to the primary condition, derives from it, or is a consequence of the main one.

Second, be as conscientious as possible to take and keep detailed records of all of your sessions. Sometimes insurance companies ask for written records until they better understand what your treatment involves. Once the diagnostic codes have been used and accepted on a consistent basis, the insurance companies seem more willing to approve treatments of patients with similar diagnoses. Because your initial evaluation report is of primary importance, knowing how to conduct a thorough orofacial myology exam and how to write it up is a big plus!

Third, find advisors. Past graduates and people that already work in the field will be your best advisors. Be aware of asking professionals in your same field who do not treat or understand what orofacial myology is or what we do.

Fourth, use family members as allies. Through the years we have found that parents are our best allies. They often manage to find time to fight for their rights, your rights and to get approval for therapy techniques that you might never have imagined.

SLEEP APNEA



Labial frena have come under more scrutiny lately. Besides the interest expressed by many members of the IAOM (International Association of Orofacial Myology), it is being examined by the IATP (International Affiliation of Tongue Tie Professionals), especially with regard to a relationship to restricted lingual frena. The actual appearance of the frena is being reviewed to see if any deviations might be related to various disorders. Some labial frena have niches, others are bifid, some sport an appendix and occasionally there is a complete absence of the labial frenum. This latter condition might be an indicator of serious conditions such as Holoprosencephaly, where the forebrain fails to develop into two hemispheres and Ehler's Danlos Syndrome, a life threatening genetic tissue disorder.

Persistent Tectolabial frenum is of particular interest to orofacial myologists: After eruption of the incisors and development of alveolar bone, the attachment progressively moves to the buccal surface of the alveolar ridge, assuming an upper position. In some cases, the attachment remains in the incisive papilla, allowing the fibers to be established between the incisors.

P. Kakodkar, T. Patel, S. Patel & S. Patel: Clinical assessment of diverse frenum morphology in Permanent dentition. The Internet Journal of Dental Science. 2009 Volume 7 Number 2

Orofacial Myology Exercises

Oops, the **wrong** way to follow directions!

Perhaps an exception to stopping the pacifier?

We've often heard that pacifiers may serve a purpose for some premature babies, helping to fortify the sucking reflex. But could there be other reasons to actually "introduce" the pacifier to a baby? Some studies have suggested that a pacifier be used for babies at risk for SIDS, sudden infant death syndrome. It may help prevent a fatal episode.

A study from New Zealand compared 485 deaths due to SIDS with 1800 control infants. They report that pacifier use was significantly less in cases than in controls. **Mitchell EA, Taylor BJ, Ford RPK, et al. Dummies and the sudden infant death syndrome. Arch Dis Child 1993;68:501-4.**

Arnestad et al from Norway reviewed 121 SIDS deaths and found only 10% 'always used' a pacifier, compared with 24% of controls. They conclude that the use of a pacifier could be a favourable factor in preventing SIDS. **Arnestad M, Andersen M, Rognum TO. Is the use of dummy or carry-cot of importance for sudden infant death? Eur J Pediatr 1997;156:968-70.**

The Chicago Infant Mortality Study examined the sleep environment in 260 SIDS deaths within a primarily black, urban population to help reduce the incidence in this high-risk group. They found the use of a pacifier substantially lowered the risk of SIDS in their sample population. **Hauck FR, Herman SM, Donovan M, et al. Sleep environment and the risk of sudden infant death syndrome in an urban population: The Chicago Infant Mortality study. Pediatrics 2003;111:1207-14.**

Here is a list of reasons why the usually negative habit could be a lifesaver:

- The bulkiness of the external handle may help keep the baby's nose and mouth clear of covers and bedding
- The sucking action may help improve the way your baby controls the upper airway
- Use of a pacifier may affect the sleeping position of your baby in a positive way that helps to prevent SIDS
- Using a pacifier may keep the baby in a state of greater arousal, reducing the likelihood of an episode

A tongue-tie quiz for you.

Answers to these are found at the end of this edition but don't PEEK until you bravely take this quiz!!

1. The incidence of tongue-tie is approximately which of the following?
a)1% b)4% c)8% d)15%

2. Studies on the incidence of tongue-tie and gender show which of the following?
a)More males
b)More females
c)No difference
d)No data exist

3. A positive family history for an infant with tongue tie has been found in what percentage?
a)10% b) 21% c)40% d)No data exist on this issue

4. Which of the following is most indicative of an appropriate infant latch for breastfeeding?
a) Gumming at the nipple,
b) Narrow angle evident at corner of infant's mouth,
c) Latch is slightly off-center of areola with a wide angle at corner of mouth,
d) Mother is complaining of pain at 8/10 level

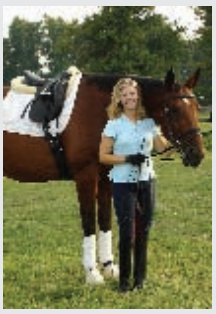
5. Indication for "clipping" tongue tie is which of the following?
a) Parental request,
b) Ineffective latch,
c) Excessive weight loss,
d) Maternal pain
e) All of these

6. "Clipping" tongue tie is so simple that no informed consent is needed:
True or False?

Source: www.tonguetieclipit.com/STEP_3_Test_Your_Knowledge.html

IAOM RELATED NEWS

Welcome to Our New Executive Coordinator Jenn Asher



Originally from Washington State, Jenn Asher moved to Lexington, KY, six years ago to pursue her Bachelor's Degree from the University of Kentucky (UK) in Community Communications and Leadership Development (CCLD). While at UK, Jenn implemented her Leadership skills while being President of the Dressage Team (Equestrian events) and serving as Chair for her CCLD degree . From there, Jenn has worked in the non-profit industry ranging from National Dressage Events to the local baseball associations before joining the IAOM. Her background is business minded for non-profit organizations in addition to being customer-service oriented while focusing on membership needs.

Jenn's goals for the IAOM include helping it to become more streamlined and efficient in the membership and continuing education processes, expansion through outreach to new and potential IAOM members, in addition to providing more course offerings to existing members.

In her spare time Jenn enjoys riding her Spanish Mustang, Fresa, going to parks with her two beagles Bayo and Maybelle, traveling, cooking and doing events for her wickless candles-Scentsy.

Jenn is excited to be part of the IAOM and looks forward to meeting everyone in Albuquerque!

Jenn Asher
IAOM Executive Coordinator
P.O. Box 278
Georgetown, KY USA 40324
Phone: 1 (502) 370-4071
Fax: (503) 345-6858
Email: iaomec@msn.com

Best Answer to our Question: Our Role in Nail Biting

Should Nail Biting be within our scope of practice?

In response to a questionnaire in the December 2011 Orofacial Myology News regarding whether or not nail biting should be treated by orofacial myologists, Karla Doherty, M.A., CCC-SLP, COM, President of Solutions In Speech, responded:

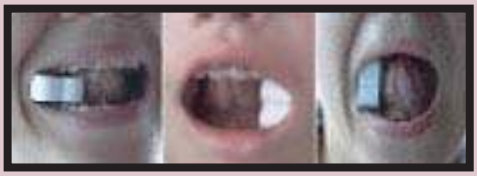
Hi Sandra! I had some time to read through the entire newsletter you put out and wanted to send you a few initial thoughts I had regarding nail biting.

Although there may not be any specific research to suggest that nail biting affects orofacial myology patients or orthodontic treatment, I believe that allowing a patient to have anything in the mouth other than an orthodontic appliance would impact their progress in therapy. If a patient is a chronic nail biter, then they for sure are not maintaining a normal rest posture that they have been taught or focusing their attention and energy on the skills learned in therapy while they are biting.

I also believe that the forward position that the tongue has to maintain while nail biting would also affect not only the rest posture but also the new swallow pattern, yet I have no research to support this. It just makes complete sense in my mind!

I also believe that a patient who is a nail biter is at a much higher risk of catching all sorts of illnesses, many of which could block their airway and preclude a nasal breathing pattern, again affecting the therapeutic process. I see our role in eliminating a nail biting habit as being just as important as eliminating any other noxious oral habit.

3 Way or 2 Way Mouth Props?

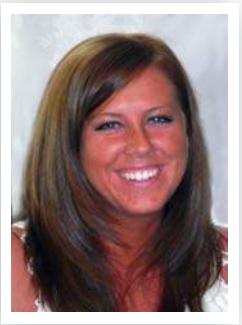


To view Mouth Prop demonstration go to:
http://orofacialmyology.com/blog/products
Both of these products are used to stabilize the mandible while the tongue "learns" new movements. In other words, they assist with the separation of tongue and jaw movements, something necessary right at the beginning of an orofacial myology treatment program. Most therapists use both, depending upon the patient's needs. Here are the advantages of each one:

2-Way Mouth Props
- Can be flipped to prevent tongue from interfering during exercises
- Durable and reusable
- One per patient is all that is needed during the entire program of treatment
- Is self contained, with a small edge to hold as it is inserted into the mouth.

3-Way Mouth Props
- Have 3 levels for maintaining mouth open position. Good for very small and very large mouth openings required for some exercises and some mouth sizes.
- Shaped so that their use can be varied, depending upon specific need for exercises
- Light and disposable
- Come 10 to a package

"Nobody can go back and start a new beginning, but anyone can start today and make a new ending."
M.R.



Sarah Hornsby

Having a passion for learning as well as a strong conviction to provide only the highest level of care for her patients, Sarah Hornsby seized the opportunity to expand her training into the field of Orofacial Myology, which she is now eagerly pursuing.

Sarah received her Bachelor of Science degree through a five year program of study at the Eastern Washington University School of Dental Hygiene. After completing her training, she moved back to the Seattle area to practice. Sarah completed a class in orofacial myofunctional therapy in Los Angeles and took an internship. She began to see patients after her regular working hours and during the weekends. She started a small business named FACEOLOGY, with the hope of developing it into a successful orofacial myology practice. In March of 2011, Sarah further pursued her dream of becoming a full time orofacial myologist by completing the Orofacial Myology: From Basics to Habituation course in the Orlando training center, under Sandra R. Holtzman.

In January of 2012, Sarah gave her first lecture, designed to introduce hygienists to orofacial myology. In the lecture, Sarah provided an overview of the field and explained what is involved in the pursuit of orofacial myology. She gave them her personal insight into what it is like to provide this treatment to patients as a dental hygienist:

"I would like to share my experiences in this field with other hygienists so that treating patients with myofunctional disorders can become the standard of care. I believe that Orofacial Myology is an emerging field in dentistry that will change the future of the hygiene profession in very positive ways.

It is a treatment that uses the skills we already possess as hygienists to help our patients. By learning to practice orofacial myology, hygienists can increase their personal marketability as well as their value as employees…"

Today, Sarah sees patients as a full time Orofacial Myologist. She collaborates with orthodontists, speech pathologists, and other professionals to provide the best care for her patients. She is an active member of the American Dental Hygiene Association as well as the International Association of Orofacial Myology (IAOM). She is in the process of forming the first study club in the Pacific Northwest for Orofacial Myology and hopes to greatly increase the awareness and understanding of the field in this region. She is working hard to complete all of the components for becoming a C.O.M., certified orofacial myologist.

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.

Answers to tongue-tie quiz for you:

1. b
2. a
3. b
4. c
5. e
6. False

Orofacial Myology:
From Basics to Habituation

Certification Track: Intensive Course

28 Hour Approved Course Presented by

Sandra R. Holtzman, MS,CCC/SLP,COM

offering you courses that provide you with a learning experience that participants have called "Life Changing."

2012 Offerings

May	03 – 06	Orlando, FL
Jun	27 – 30	Orlando, FL
Aug	02 – 05	Orlando, FL
Oct	04 – 07	Orlando, FL
Dec	27 – 30	Orlando, FL

Additional offerings, various dates at our

Orlando Training Center

Register online:
www.OrofacialMyology.com
and click Seminars button top of page

Or Call to register:
321-352-7411 or 954-461-1114

Email contact:
info@OrofacialMyology.info