



The Orofacial Myology News is growing bigger and better each quarter. We are proud to have interesting article contributions from many of our professionals in the field. Inside this issue you will learn more about trichotillomania, nasal polyps, and more.

Like many of you, we are preparing our suitcases for the IAOM convention to be held in Canada. Our Canadian friends have put all their efforts together to be sure that we have a full Canadian experience by choosing Calgary, a major cosmopolitan city that is full of activity. Please come say "Hello" to me at our vendor table or at breaks during the presentations. We'll have hard copies of this edition for you to take with you.



Our goal is to provide you with pointers about what is happening in our field right now, including differing opinions about the newest hot topics in Orofacial Myology. If you have some suggestions or ideas for future editions, please share them with us at Info@orofacialmyology.info

Macroglossia and Decisions we have to Make

The term, macroglossia, is sometimes overused among those of us in the medical and dental fields. It is usually erroneous to refer to our clients' tongues as macroglossic. Most often with clients seen for orofacial myology treatment, it is a matter of the tongue position and the ability of the palate to accommodate the tongue that underlies our challenges in therapy rather than the size of the tongue itself. If we misdiagnose, we are more likely to put our efforts in the wrong direction. For true macroglossia, our goals should be to select from among our program of exercises with the goal of maximizing the ability to shape the tongue and to manage it as well as possible, depending upon the patient's specific complaints and concomitant conditions.

If we practice long enough and see enough patients, we might come across true macroglossia in a patient. My personal "first" was a lovely 32 year old woman referred to me by an orthodontist. She had acromegaly that had been misdiagnosed for several years. By the time I saw her, her facial structure had dramati-

cally changed based on earlier photos she shared with me. Her bite had opened considerably and a Class 3 malocclusion had developed. Her lateral dentition, however, could occlude and often did so at the expense of painful lacerations on the lateral borders of her tongue. Knowing that this was true macroglossia, my goals were to maximize her abilities as described above. Thankfully, this resulted in a significant reduction in the number of painful bites she endured daily.

We have to be judicious in labeling someone's tongue as being macroglossic so as to be realistic about what we can or cannot expect to accomplish in therapy. If, indeed,



the tongue is macroglossic, we cannot reasonably expect our standard program of treatment to be fully effective in eliminating whatever symptoms accompany the macroglossia. If, on the other hand, we are too easily labeling someone's tongue as macroglossic, we might fail to treat them completely.

"Evidence Based" Is that enough?

As we enter into a world demanding ever more "evidence base" for what we do as therapists, we have to take care not to lose sight of the advantages of hands-on experiences. In the book, "Play" by Stuart Brown, MD, (Avery Publisher, NY, 2009), he describes a Jet Propulsion Lab company (JPL) that had had success as a top aerospace research facility for over 70 years. In the late 90's many became of age to retire, so several new young staff members were hired to replace the retiring employees. In a short period of time, things stopped running smoothly, and it was found that the newer employees were having difficulty moving from theory to practice. They showed weakness in finding major flaws in the systems, breaking down or pulling apart difficult areas, and in using their abilities to rearrange problems in innovative ways in order to find solutions.

What had changed from the older employees to the younger ones?

JPL discovered that the older workers, who had not had the availability of our modern technology in their youth, had had opportunities to take apart objects such as clocks, radios, hi-fi stereos... to see how they worked. They made soapbox derby cars, repaired appliances and engaged in a lot of hands on activities. JPL decided to look more closely at their new start ups, and found that the younger ones who had done similar activities when they were kids were the employees who could see solutions as compared to the new hires who had not had the same opportunities. They concluded that those who had not worked with their hands as youngsters were the ones who experienced difficulty seeing solutions. Based on these findings, JPL devised an interview method to separate the two groups of young applicants. By asking questions about youthful projects, they were able to find the young replacements with the insight and creativity to problem solve. Once again, we are reminded that pure science in and of itself, is not as effective as the blend of science and hands-on experience.

Jet Propulsion Laboratory is a federally funded research center, staffed and managed by the California Institute of Technology. Most of their work has been in support of NASA's robotic exploration of the solar system and universe.

Nasal Polyps: A short tutorial

Nasal polyps are greyish masses of tissue that resemble a bunch of grapes. They are generally multiple, nearly always bilateral (anteriorly only), and produce nasal blockage by restricting the nasal airway. Anterior nasal polyps are easily seen with anterior rhinoscopy and may even be seen at the nostril. Less frequently, and more related to OMDs, they may occupy the posterior choanae (the posterior entrance to the nasal cavity). In this location, they are more commonly large, single and unilateral.

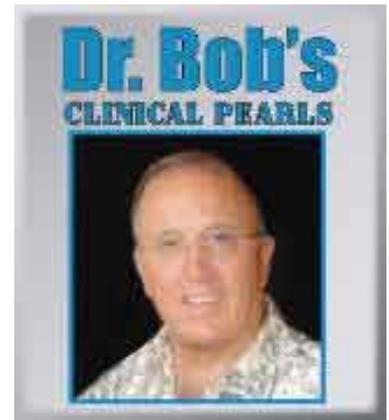
This posterior variety generally arise from the maxillary sinuses and are known as antro-choanal polyps (the maxillary sinus is also known as the Antrum of Highmore, the entrance of which is in the posterior part of the nasal cavity). Antro-choanal polyps can cause a valvular obstruction, most often in adolescents and young adults. While inspiration is relatively free-breathing, the impaction of the polyp in the posterior choanae on expiration can produce almost total blockage. Anteriorly, the nose can look entirely normal while posteriorly, the nasopharynx can be almost totally filled by a single smooth polyp. The condition at the posterior choanae can occasionally be bilateral.

The etiology of polyps is usually the end-product of prolonged swelling (edema) in the mucous of the nose and sinuses. The submucosa around the middle meatus is especially lax and easily water-logged, leading to swelling of tissues. The swelling is aggravated by the traction of the tissues such as from efforts to clear the nose and also also from interference with lymphatic flow.

It has been claimed that for at least 75% of nasal polyps, the initial cause of the edema is allergy and related vasomotor disorders. The main evidence for this is the histo-pathology and the close association with other allergic diseases, notably asthma. In spite of this, once the polyps have developed, the allergic state of the patient seems to have little if any relation to it, and the recurrence of polyps are often high in spite of anti-allergic treatment. Of special interest to orofacial myologists, there is, generally, no associated evidence of active allergy or infection, so the polyp can be the sole source of the airway issue.

Repeated nasal and sinus infection in which resolution and re-aeration are delayed by an anatomical deformity, such as a deviated septum, can also initiate a vicious circle in which polyps become a pronounced feature. Sometimes suppuration (the formation and discharge of pus) precedes polyps, and sometimes the suppuration follows. When polyps become obstructive, the resultant stagnation of secretion in the sinuses can lead to infection, and sinusitis will follow.

The formation of polyps can follow from poor nasal breathing. Whatever can account for prolonged swelling of the mucous membranes in the nasal cavity, can lead to the development of polyps. It would appear that mouth breathing, allergies, and anything else that can interfere with normal nasal respiration and cause nasal edema can lead to the formation of polyps.



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Myofascial Release Not Part of Orofacial Myology!

Labial Frenulae Important Orthodontic Considerations

Treatment Options For Jaw Growth Variations

Suggested Clinical Research Projects in Orofacial Myology

Facial Osteotomies

Down Syndrome

The Buccal Corridor

Lip Incompetence

Concerns About Lip Taping

Evaluating Cephalometric x-ray Films

Gathering Clinical Research Data in Orofacial Myology

Speech-Language Pathology Continuing Education and Treatment Resources



Orofacial Myology "Tongue Thrust" Level 1 Course

R: From Basics to Habituation

Tongue Tie 101: What is Our Role?

Earn Orofacial Myology CEU's at Home



Related News

In our past edition we informed you about the Orofacial Myology Yahoo group and the intense activities among the members. This is a friendly reminder for you to sign into that group to take advantage of its continuous interchange of knowledge. In their recent blogs they have discussed such important practical topics as changes in insurance codes, syndromes found in patients, and clients needing therapy in various geographical locations. If you are an IAOM member who has not joined the blog, please request an invitation so you can help others with your questions, and perhaps receive answers to yours.

IAOM is becoming a nonprofit organization. The committee is working extremely hard to expedite the process. Although there are many advantages, there are numerous time consuming tasks to complete. Tons of paperwork and endless discussions are underway in order to comply with all the nonprofit regulations.

Some of you will be reading this edition during or close to our Calgary 2014 convention. If that is the case be sure to pick up a hard copy at our vendor table and ask for a sample of the updated QTT, Quick Tongue Tie assessment tool.

And speaking of conventions, if you can guess the following answers you will know where the next convention will be held:

The headquarter of our Orofacial Myology News is:
Sunny South Beach
Magical Orlando
Historical St. Augustine
Pleasant Panama City



Are you ready?

CONNECTING THE THOUGHTS...

Linking Prevention, Treatment & You!
**43rd Annual 2014 International Association
of Orofacial Myology (IAOM) Convention**
May 30, May 31 and June 1, 2014
In Calgary, Alberta, Canada

Register via the website: www.iaom.com





by Becky Ellsworth,
AAS, RDH, BS, COM

Outside the Mouth Box:” A New Perspective

Having been a Dental Hygienist for over 35 years, I can look back and see how many new and unexpected things I have learned. After working solely in private practice for awhile, I was fortunate enough to find employment in a local community college’s hygiene program as a Clinical Instructor. There I was exposed to new and innovative “tools of the trade” from instruments to classroom technology. I was also exposed to something I had only heard about in a short lecture during one of my hygiene classes as a student: Orofacial Myology. A pioneer in the field, Marge Snow, was teaching a course in the program and she asked me if I would like to sit in on her classes to see what it was all about. Not only did I sit in, I became one of her students! I was fascinated by it – she had gotten me hooked!

Many years later, after her retirement, I took over the course, became a Certified Orofacial Myologist and have been teaching it ever since. What I love about the field is that there is always something new to learn. The patients and their issues are so varied and it requires deductive skills to figure out what is going on in many cases.

As hygienists, we are trained in observation so this takes us a step further to looking not just at the teeth and the intraoral structures, but also external features as well. Checking facial symmetry, the lips, chin, eyes... all of these can tell a tale even before the patients open their mouths! You owe it to yourself and your patients to be as “in the know” as you can be. Open up a new vista for yourself to learn about something that can, and will, change how you look at every patient you will see in the future! First you will need to check with your own state’s Dental Hygiene Scope of Practice to make sure it is legal for you to work in orofacial myology. After you find that it is permissible, come and join Sandra and me for an eye-opening adventure... One I know you will never regret!

If it is permissible for you per your state, you can bring this field into your private practice dental setting. Working in a Pedodontist’s or Orthodontist’s office, you can offer evaluations and therapy. In a General Dentist’s office, you can work out an arrangement with him/her to do the same. Maybe you can work with private practice speech therapists, helping the orofacial myology patients they have coming in. How about starting your own practice? All of these are possible ways to use the added and invaluable knowledge you will gain by becoming involved in this incredible field. There is no time like the present to step out and take on a new perspective. Who knows? That something new, that change you want, or growing need could be as close as giving a call or email.



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

MYO CAKE

Directions; Preheat oven to 350 degrees F (175 degrees C). Grease and flour a 9x9 inch pan or line a muffin pan with paper liners. In a medium bowl, cream together the sugar and butter. Beat in the eggs, one at a time, then stir in the vanilla. Combine flour and baking powder, add to the creamed mixture and mix well. Finally stir in the milk until batter is smooth. Pour or spoon batter into the prepared pan. Bake for 30 to 40 minutes in the preheated oven.

Covering Cakes with Rolled Fondant

Prepare cake by lightly covering with buttercream icing.

Before rolling out fondant, knead it until it is a workable consistency. If fondant is sticky, knead in a little confectioners' sugar. Lightly dust your smooth work surface or the Roll & Cut Mat and your rolling pin with confectioners' sugar to prevent sticking. Roll out fondant sized to your cake. To keep fondant from sticking, lift and move as you roll. Add more confectioners' sugar if needed.

Gently lift fondant over rolling pin or slip cake circle under fondant to move; position on cake.

Shape fondant to sides of cake. We recommend using a Smoother because the pressure of your hands may leave impressions on the fondant. Beginning in the middle of the cake top, move the Smoother outward and down the sides to smooth and shape fondant to the cake and remove air bubbles. If an air bubble appears, insert a pin on an angle, release air and smooth the area again. Use the straight edge of the Smoother to mark fondant at the base of cake. Trim off excess fondant using a spatula or sharp knife.

Your cake is now ready to decorate.



Ingredients:

- 1 cup white sugar
- 1/2 cup butter
- 2 eggs
- 2 tspns vanilla extract
- 1 1/2 cups all-purpose flour
- 1 3/4 tspns baking powder
- 1/2 cup milk
- Rolled Fondant 24 Oz.

You can find these directions at:

<http://allrecipes.com/recipe/simple-white-cake/>

<http://www.wilton.com/decorating/fondant/rolled-fondant.cfm>

What is Trichotillomania (Hair-Pulling) and Can Orofacial Myology Really Help?

By: Sandra R. Coulson
MS, S.T., Ed., COM



Sandra R Coulson has been practicing OM therapy for over 40 years and has a full time practice in Denver Colorado. She currently is teaching approved LAOM OM Courses as well as lecturing about OM throughout the world at various conferences and seminars. To find out more about Sandra, see her practice website at www.sandracoulson.com or her teaching institute website at www.coulsoninstitute.com. She can also be reached by email at sandra@sandracoulson.com.

Trichotillomania, also known as trichotillosis or “trich” for ‘short,’ is a hair pulling disorder. It is described as the compulsive urge to pull out and sometimes eat one’s own hair. It has been treated mainly by psychiatrists and physicians by prescribing psycho-tropic drug therapy and at the present time, it is classified as an impulse control disorder.

This disorder can be present in infants, but it usually begins between the ages of nine and thirteen. Often parents do not report it to their doctors and the vacant patches are sometimes not visible, so accurate statistics are not available. It is estimated that about 1.5% of males and 3.4% of females pull hair from their scalps, eyebrows, eyelashes, arms, legs and any other area of hair on their body.

The name TRICHOTILLOMANIA was coined by a famous French dermatologist, Francois Henri Hallopeau, who treated many of these cases. He felt that it was a ‘coping mechanism’ where people learned to self-soothe in response to high anxiety. Like nail biting and skin-picking, “trich” is often considered to be a compulsive behavior. I feel that it is related to tongue posture since I see a quick ‘turn-around’ as we establish where the tongue should rest and how easy it is to find the “SPOT” when they feel the urge to pull.

In one study, the Trichotillomania Impact Project for Adults, (16 and older [TIP-A]), 1697 people reported mild to moderate impact on their lives. Of those who participated and responded from that group, 20% said that they avoided vacations, 23% said that it interfered with their jobs and 24% said that they had missed school because of their pulling. In addition, most had experienced teasing and some sort of bullying which definitely affected their social interaction, but we still are not clear if it is an inherited trait. Much more research is still needed in this area.

Treatment approaches in my practice are similar for all age groups. It does depend on whether the “trich” is “automatic” or “focused.” Children are more in the “automatic” mode where it is simply an unconscious habit. However, teens and adults tend to be more in the “focused” mode as they often have rituals associated with their hair pulling which might include selecting specific hairs or types of hairs to pull or the times that they pull. My youngest case was two and my oldest, who is an attractive, bright attorney, whom I am presently seeing, is forty-six.

You are probably asking yourself, what makes my OM program a success for “trich?” For both children and adults, I begin with a behavior modification program using a basic myofunctional therapy structure. I discovered that when the tongue rests in the proper position (up), that the hair pulling just stops. I focus strictly on tongue posture (which is what we, as Orofacial Myologists, work so hard on) because research shows that when the tongue rests up, the pressure during a swallow can release the ‘happy chemicals’... endorphins, serotonin and dopamine. This is the same result I see for those people who suck thumbs, fingers and pacifiers. I have noted that most hair pullers have a low tongue posture and often an open mouth rest posture as well. The usual treatment time is eight to twelve visits and in addition to the usual benefits of orofacial myology therapy, the result is that always, always the pulling is stopped and the result is a higher self-esteem.



Let me share with you a few patient stories of those whom I have seen in my office:

Some people choose only one section of hair to pull, like Andy. He stated that he had extreme difficulty with relationships at school. He also fought with his brother constantly and was really grouchy much of the time. He was twelve when I saw him. His father, who is a doctor, had tried everything possible to help him to stop his hair pulling. He had been on every psycho-tropic drug imaginable and nothing had worked until he was referred to my office. He stopped pulling on day ONE and was amazed at the ease of the program which I outlined and he followed.

Kari began to pull her eye lashes and eyebrows at age four. Her parents attempted to get her to stop pulling by using punishment which did not work; and then rewards, which also did not work. She was reclusive and had very few friends. She was referred by her pediatrician who had tried everything he could think of. She stopped pulling on the first day of therapy. Everyone was aware of her positive personality change!

Angela, the girl in the photos above, had worn a hat full-time since age seven. She was sixteen when she

came to my office and was not referred to me for “trich”. Like many others she was referred by her orthodontist for a severe tongue thrust. She was grossly underweight (anorexic) and again had few friends. She also had been treated with many of the same drugs and psychotherapies as the other patients; all with no results. That was until I started OM therapy with her. She stopped pulling her hair and eyelashes on the first day and also corrected her tongue thrust! The final photo is on her recent high school graduation announcement which she just sent to me!



My referral sources are psychiatrists, psychologists, pediatricians, dentists and parents who have heard about OM therapy and the proven success rate I have with my patients.

My understanding is that there have been many proposals for a name change for this disorder from trichotillomania to hair pulling disorder which will cause it to be listed as an obsessive-compulsive disorder. This may change the way insurance companies can justify to pay for this type of therapy, but only time will tell if that is true.

While the medical profession and others work toward drugs at many of these issues, we treat the same symptoms with non-invasive therapy and with no drugs, working through known successful exercises, accomplishing remarkable success in many types of patients. As we work together to see that more and more patients are treated for this and other disorders, we can truly see how OM therapy can change lives.

Sandra R Coulson has been practicing OM therapy for over 40 years and has a full time practice in Denver Colorado. She currently is teaching approved IAOM OM Courses as well as lecturing about OM throughout the world at various conferences and seminars. To find out more about Sandra, see her practice website at www.sandracoulson.com or her teaching institute website at www.coulsoninstitute.com. She can also be reached by email at sandra@sandracoulson.com.

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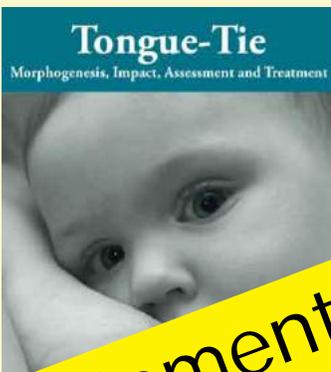
Amy Garren

I studied Speech Pathology at Northwestern University and moved to Hawaii, where I worked in a nursing home for 6 years. I truly loved that environment but eventually got burned out. So when I moved to Yuma, AZ, I took a position at a private clinic that also provided therapy at the local hospital. I worked with a wonderful SLP and noticed she had an Orofacial Myology Certificate on her wall. When I asked her about it, she told me how helpful it was with the patients she saw. Since I only worked in the hospital, I didn't feel Orofacial Myology would benefit me at that time.

Fast forward 6 years and I own a private clinic, where we treat patients from birth to geriatric. While working with my patients, I would become frustrated because they were not making progress. I would think, "Why, oh why can't I get this child to make a /s/? There has to be something else I can do!" For some reason I always remembered my friend and the fact that she had studied Orofacial Myology, so I Googled it. Luckily Sandra Holtzman was holding a conference in San Diego in just a few months. I felt like it was meant to be.

I attended the conference and my life has never been the same. I learned so much information in those 3 days. Sandra made it easy for me to relate everything back to my Speech Pathology knowledge and practices. Furthermore, I now look at patients in a totally different way and am able to treat them more thoroughly. It has made such a difference in my ability to be an effective therapist.

We want to say thank you to all of you who have bought the Hazelbaker Tongue Tie Book: Morphogenesis, Impact, Assessment. It was written to cover the lack of information and common mistakes regarding tongue tie. We knew that it would be of great interest, but your demand surpassed our expectation! The book is out of stock now, but for you who have not been able to get a copy, the author, Dr. Hazelbaker, has notified us that our new shipment will arrive the second week in June. We are able to take your orders now through email (info@orofacialmyology.info) and after mid June, via our www.OrofacialMyology.com website. We want to give a special thanks to Dr. Alison Hazelbaker for using Neo-Health Services, Inc. as a distributor.



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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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