

QUESTIONABLE CLINICAL PRACTICES IN OROFACIAL MYOLOGY: AN EDITORIAL

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ABSTRACT: Some selected questionable clinical practices in orofacial myology will be discussed. These include: intervention in sleep-related problems; nasal irrigation (lavage); the evaluation and treatment of temporomandibular disorders (TMJ/TMD); and facial rejuvenation.

KEY WORDS: sleep apnea; medical sleep labs; irrigation of the nasal cavity; TMJ; TMD; temporomandibular joint disorders; wrinkle removal.

INTRODUCTION

Current concerns and questions about the future of the field of orofacial myology relate in part to selected clinical practices and advocacies of a few clinicians who perceive orofacial myofunctional therapy to be a magic pill for almost everything, including selling pillows intended to maintain a particular posture during sleeping, claiming to be sleep apnea specialists, TMJ specialists, specialists for special needs patients, diaphragmatic breathing specialists, posture professionals, cosmetic face reshaping experts, and nasal irrigators of unwanted bacteria. Although those clinicians involved with such practices are few in numbers, their impact can potentially harm the entire field by advocacy of such practices.

PURPOSE

The purpose of this communication is to identify and discuss questionable clinical pursuits currently advocated and practiced by a few orofacial myologists and to offer guidelines for appropriate clinical practice or orofacial myofunctional therapy. Such guidelines can serve to clarify the scope of practice for orofacial myologists.

Rather than become all-inclusive, this communication will focus on selected clinical procedures that are considered to be not in keeping with the goals of the field of orofacial myology. If all orofacial myologists can embrace and adhere to a clear set of clinical standards, the reputation and the future of the field should be enhanced, strengthened, and insured.

SUPPORTING DOCUMENTS

Since many orofacial myologists are speech-language pathologists certified by the American Speech-Language Hearing Association (ASHA), and since many procedures and principles of conduct are derived from the ASHA scope of practice and ethical guidelines, two ASHA documents are specifically applicable to clinical activities in orofacial myology as provided by ASHA certified clinicians. One document is: **Orofacial Myofunctional Disorders: Knowledge and Skills**, (ASHA, 1993). It will be referred to in the dialogue to follow. The second reference document is: **Preferred Practice Patterns for the profession of Speech-Language Pathology**, (ASHA, 2004). Subsets # 38 and 39 are specific to the work of ASHA members who provide diagnostic and therapeutic services with orofacial myological disorders.

CLINICAL PURSUITS OF CONCERN:

INTERVENTION IN THE SLEEP PROCESS. It is not well documented how some orofacial myologists have become involved in evaluating and participating in the treatment of sleep disorders. There is a history of some orofacial myologists recommending and using lip taping as a reminder for patients to maintain a closed-lips posture during the day, and especially during sleep. A document available on this website details the assumptions and issues related to the use of lip taping. This intervention has apparently expanded into some clinicians recommending a particular type of pillow or particular sleep position. Some have also contended that sleeping on one's side can account for the development of a unilateral dental crossbite. The association of sleeping position and dental problem has no solid basis in research in dentistry and, therefore, this unfounded contention by some orofacial myologists should not continue.

The key perspective for the orofacial myologist regarding sleep disorders is that any **sleep issues are medical problems that should be evaluated and treated by physicians, preferably, those physicians associated with sleep labs or clinics.** Further, it should be recognized that **orofacial myologists, by virtue of education or experience, cannot claim any expertise in the evaluation or treatment of sleep disorders.** These perspectives are in keeping with the ASHA Knowledge and Skills document that specifically states: ...**“the practice of orofacial myology does not include: Practices related to the reduction of medical conditions, such as sleep apnea”** (page 23). For the non-speech pathologist orofacial myologist, this same exclusion should apply due to a lack of appropriate medical credentialing.

At the present time, no recommendations or procedures related to sleep are appropriate clinical activities for orofacial myologists, including any counseling or recommendations regarding the type of pillow or sleep posture that a person should use. Nighttime lip taping is not an appropriate clinical technique to use under any circumstance. The potential for harm from any restriction of breathing is applicable to lip taping. If a patient is ever identified as having a previously undisclosed cardiac condition where there is a history of lip taping, the orofacial myologist involved would have no defensible way to show that the lip taping had not contributed to or caused the cardiac problem. ***For the protection of the orofacial myologist and patients, lip taping is not appropriate as a therapy technique, whether as implemented in the daytime or during nighttime sleep.***

In the future, there may be a role for the orofacial myologist to participate in an exercise program that may be developed to help remedy problems of sleep apnea. At present, however, orofacial myologists can claim no expertise in muscle exercises related to the palates and pharynx, except for those speech-language pathologists working in the area of dysphagia who have had extensive background with palatal and pharyngeal muscle functions and exercises. At present, any therapy to “tone” or otherwise influence the rest posture of the tongue in relation to sleep should be determined and prescribed by a physician associated with a sleep lab. There is no current justification for an orofacial myologist to diagnose or undertake any muscle exercise program designed to remedy any sleep related disorder.

In summary, **orofacial myologists cannot claim expertise with sleep related problems and should only participate in experimental therapy procedure as prescribed by a physician associated with a sleep lab. Such therapy interventions should be clearly stated to patients as being experimental.**

NASAL LAVAGE (WASHING/IRRIGATING). While self-cleansing and self-medication of the nasal cavity is practiced routinely among the general public, there is a difference between the self-administration of nasal sprays and cleansing agents, and the administration of such agents to a patient by an orofacial myologist. ***Orofacial myologists cannot claim expertise in the area of the health and maintenance of the nasal cavity.*** The reason for this is that the health of the nasal cavity represents a **medical** issue that is not part of orofacial myology. Furthermore, the insertion of any fluid or spray into the nasal cavity is considered to be an **invasive procedure**, and as such, is not an appropriate role for the orofacial myologist.

The nature of the bacteria in the nasal cavity, the size and shape of turbinates, and the presence of swelling of the mucous membranes of the nasal cavity, are not appropriate diagnostic or therapy concerns or activities of the orofacial myologist. Any intrusion/insertion of any substance into the nasal cavity is not appropriate to the clinical pursuits of the orofacial myologist.

TEMPOROMANDIBULAR DISORDERS. Many orofacial myologists participate in the treatment of temporomandibular joint and associated disorders. Any therapists who are members of the American Speech-Language Hearing Association (ASHA) are subject to following the ASHA guideline in the Knowledge and Skills document: **“...the practice of orofacial myology does not include: Treatment of parafunctional problems related to temporomandibular joint disorders and myofascial pain dysfunction”** (page 23). Those orofacial myologists who are dental hygienists should not evaluate and provide therapy services without the approval and supervision by the dentists involved in the care of such patients. For orofacial myologists who are neither speech-language pathologists nor dental hygienists, there should be no participation in the therapy of any TMJ-related problem.

Dental hygienists who provide therapy for TMJ problems should not physically manipulate the mandible during therapy. Any procedure to reposition the mandible or guide the mandible to a centric relation should be accomplished by a dentist. The following ASHA guideline for speech-language pathologists should also apply to dental hygienists: ...**“the practice of orofacial myology does not include: Craniosacral manipulation or practices within the scope of physical therapy”** (page 23). The risks to a dental hygienist of further exacerbating the TMJ problem, rupturing the meniscus (disc in the temporomandibular joint apparatus), or contributing to the worsening of pain and functions by manual manipulations of the mandible, should remind hygienists that they are legally obliged to work on TMJ problems only under the direction and supervision of a dentist. **TMJ treatment is not physical therapy**, so the role of the dental hygienist, and others within orofacial myology, should be restricted to the elimination of noxious habits that are involved, such as bruxism, while also normalizing an excessive freeway space resting dimension of the mandible at rest.

FACIAL REJUVENATION. Some orofacial myologists who engage in facial rejuvenation procedures contend that sagging skin is related to toxins in the skin. Research to support this view is scant.

Nutritional or trophic changes form an important part of the symptomology in many neurologic disorders. They may appear in the skin, nails, subcutaneous tissues, muscles, bones, and joints. Although a neurologic basis has usually been stressed as a prime factor in the causation of trophic changes, other factors also play a role. These include physical activity, blood supply, nutritional elements (vitamins), lymph drainage, and endocrine activities. **Orofacial myologists have no credentials or expertise to make the decision as to why skin sags, or what procedures should be undertaken to treat such conditions.** Orofacial myologists who participate in facial rejuvenation can only harm the reputation of the field of orofacial myology, as this area of public concern has nothing to do with orofacial myology.

The procedures involved in facial rejuvenation by some orofacial myologists involve facial muscle exercises. There is no solid research support for a cause and effect relationship between facial exercises and skin tone, or that facial exercises increase muscle “tone”. In the primary areas of the face and neck where skin sagging occurs, there is no direct connection of muscles with skin, making the claim of a therapeutic link between exercise and skin toning highly questionable. Physicians who are experts in the skin and its problems (dermatologists) do not endorse facial muscle exercises as a means of alleviating sagging skin. The reason is that there is no evidence that they work.

Orofacial myologists cannot claim any expertise in the area of skin, its disorders and the aging process. None of the therapies designed to firm skin or “tone” muscles for purposes of improving cosmesis are a part of orofacial myology.

SUMMARY

Fortunately, the questionable clinical practices discussed above are being implemented by only a few orofacial myologists. The majority of orofacial myologists continue to provide traditional procedures of orofacial myofunctional therapy that have a long and well-established history of successful use and outcome. The discussion here of peripheral therapies which are outside of the boundaries of orofacial myology serves to alert the public to procedures and claims that merit concern.

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