Complete care
From Page 1

\[\text{Does your patient grind or clenches his/her teeth?}\]
\[\text{Does your patient have chronic stomachaches, burping, drooling, hiccup or acid reflux?}\]
\[\text{Does your patient have a forward head posture?}\]
\[\text{Does your patient have a short lingual frenum or a tight labial frenum?}\]
\[\text{When you check for oral cancer on the sides of the tongue, have you found lesions from tongue thrusting causing chronic irritation?}\]

These are all signs and symptoms of an orofacial muscle asymmetry that can be addressed by an orofacial myofunctional therapist.

History of orofacial myofunctional therapy (OMT)

OMT is an area of specialization arising out of orthodontics. The field of OMT is unique because the therapist helps the patient to make major life-enhancing changes, which affect the entire body.

Many dentists during the 1800s and early 1900s recognized that tongue rest posture, mouth breathing and oral habits influenced occlusion. Edward H. Angle — justly termed as one of the grandfather of orthodontics — wrote “Malocclusion of the Teeth,” appearing in Dental Cosmos in 1907, in which he recognized the influence of the facial muscles on dental occlusion. In his research he concluded that mouth breathing was the chief etiological factor in malocclusion.

The first program of OMT began in 1918 with an article written by an orthodontist, Dr. Alfred P. Rogers, titled “Living Orthodontic Appliances.” He was one of the first doctors in the United States who suggested that corrective exercises would develop tonicity and proper muscle function and thereby influence proper occlusion.

In the 1970s and ’80s there were two different organizations representing therapists. Daniel Garliner and Dr. Roy Langer founded the Myofunctional Therapy Association, and Dr. Marvin Hansson, Richard Barrett, William Zickefoose, and Galen Peachey founded the International Association of Orofacial Myology (IAOM). Currently the IAOM is the main professional organization in the world promoting and developing orofacial myofunctional therapy.

The team approach

Today the field is expanding to include many professions. Through a team approach the patient can experience the best of all worlds and achieve remarkable results. The interdisciplinary approach to patient wellness includes but is not limited to:

\[\text{orthodontics}\]
\[\text{general dentistry}\]
\[\text{speech-language pathology}\]
\[\text{dental hygiene}\]
\[\text{periodontics}\]
\[\text{oral surgery}\]
\[\text{ear, nose and throat specially}\]
\[\text{cranial osteopathy}\]
\[\text{allergology}\]
\[\text{pediatric dentistry}\]
\[\text{pediatrics}\]
\[\text{physical therapy}\]
\[\text{chiropractics}\]
\[\text{gastroenterology}\]
\[\text{plastic surgery}\]

Failure to help many patients

Through 30 years of practicing orofacial myofunctional therapy, some questions patients or their parents asked me include:

\[\text{Why didn’t someone tell me about this earlier?}\]
\[\text{I knew I had a tongue thrust, I didn’t know there was a special person to help me.}\]

\[\text{Why didn’t someone tell me my habit of tongue thrusting, thumb sucking or nail biting could be easily eliminated in therapy?}\]

\[\text{I have tried multiple splints, functional appliances, medications and occlusal adjustments for my TMD problem. I was even referred to a psychologist for counseling because they told me it was stress related. Why didn’t someone recognize my facial muscle dysfunction and refer me for orofacial muscle therapy sooner?}\]

\[\text{This is the third time my orthodontic surgical result has relapsed. Why hasn’t anyone referred me to an orofacial myofunctional therapist?}\]

My child was traumatized by wearing a “rake” in his mouth to stop his tongue thrust. His speech has gotten worse and he has withdrawn. After the rake was removed, the tongue thrust returned. Why wasn’t I given the option of seeing a therapist who specialized in treating this disorder with exercises?

My child wore a palatal expander for a high narrow palate. After the expander was removed, the palate collapsed because the tongue was resting down. Why wasn’t I referred to an orofacial myofunctional therapist immediately following the expander being removed?

I was told I was tongue-tied and needed a lingual frenectomy. After surgery, my tongue reattached and needed the palate resected.

See Complete care, Page 4

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scar tissue formed and was worse than before we started! Why wasn’t I told to see a therapist immediately following surgery to prevent re-attachment?

Patients can learn to develop healthy muscle patterns. Healthy muscle patterns, when permanently habituated, can be proactive in preventing or treating:
- orthodontic relapses,
- articulation disorders,
- breathing disorders due to allergies or mouth breathing habits,
- TMD when it is a muscle or habit-related issue,
- digestive disorders from not chewing properly or swallowing air,
- postural problems,
- faster normalization of the facial muscles and neuro-muscular facilitation post orthognathic surgery.

How can orofacial myofunctional therapy help the general dentist?

Orofacial myologists can assist the dentist in many aspects of his or her practice to:
- Re-educate muscle patterns that promote a stable orthodontic result.
- Reduce the time spent in fixed appliances.
- Normalize the inter-dental arch vertical rest posture dimension, the freeway space, also called the oral volume.
- Identify and eliminate orofacial noxious habits that interfere with stable occlusal results.
- Teach nasal breathing and remodel the airway through nasal cleansing and behavior modification.
- Reinforce compliance with wearing rubber bands, functional appliances and retainers.
- Develop a healthy muscle matrix and eliminate habits that contribute to TMD.
- Correct head and neck posture problems.
- Stabilize the periodontal condition by reducing tongue thrusting pressures and mouth breathing habits.

Since most of our patients are in need of orthodontic treatment or treatment by a functional dentist, if the patient was referred by a source outside of dentistry, we are certainly a great potential referral.

Study OMT!

Joy Moeller will teach a five-day IOM-approved course on orofacial myofunctional therapy Oct. 19–23, 2008, and a seven-day course (which includes two days of internship) on February 11–17 and June 24–30, 2009 in Los Angeles with Barbara J. Greene, COM, and Licia Cocceani-Paskay, MS, CCC-SLP, COM. For more information contact Greene at bgreene@tonguethrust.com or call (805) 985-6779.
source for dentists.

The best time for the dentist to refer the patient to an orofacial myofunctional therapist is before intervention by appliance therapy. It is always best to do the least invasive treatment first and elimi-
nate habits that are interfering with treatment. This will ensure that the muscles are working with the forc-
es of the appliances. Also, another good time to refer would be before the braces come off, depending on the patient’s facial structure and motivation. We can work together to help the motivated patient achieve amazing results.

To elaborate on the importance of the working relationship between OMTs and the dental community, I have reached out to some of my esteemed colleagues for commen-
tary.

According to Dr. John Kishibay, an orthodontist from Santa Monica, Calif., who is a professor at USC School of Dentistry, “Orofacial myo-

functional therapy must be part of the treatment plan from the begin-
ing. This way the patient under-
stands from day one that the muscle adaptation is important for long-
term stability. Especially important would be the orthognathic patient.

The patient must learn to use the new space in an ergonomic man-
ner, in both a functional patterning and habit elimination awareness.”

Dr. William Hang, an orthodontist practicing in Westlake Village, Calif., believes that OMT problems are one cause of poor facial develop-
oment. He says, “Stability will con-
tinue to be an elusive, unachievable goal with poor facial balance fre-
quently being the norm of the post orthodontic result. Myofunctional therapy must become the first line of defense in the quest for proper facial development rather than the rescue squad when the orthodontic result is going up in flames. When orthodontists embrace myofunc-
tional therapy, they stop treating symptoms and begin to focus on treating the cause of poor facial development [altered oral rest pos-
ture].”

Dr. Jerry Zimring, a practicing orthodontist for 44 years in Los Angeles, believes that attaining proper occlusion is a state of bal-
ance between the teeth, the muscles and the bones. He states, “Both my daughter and my grandson were treated with myofunctional therapy with excellent results that would not have been possible without this valu-
able treatment. I feel strongly that myofunctional therapy should be part of every orthodontic practice.”

Dr. Richard L. Jacobson, a Dip-

lomate of the American Board of Orthodontists who has been in the exclusive practice of orthodontics in Pacific Palisades, Calif., for the past 28 years, stated, “We know that form follows function and func-
tion can follow form. Therefore, it is vital to identify those patients that need myofunctional therapy. In these patients myofunctional ther-
apy by a specialist is essential. Treat-
ment is effective and orthodontic stability is enhanced.”

The author would like to thank Karen Macedonio, a Certified Life Coach (and patient), Barbara J. Greene, COM, and Licia Cocceani-
Paskay, MS, CCC-SLP, COM for their assistance with writing this article. A complete list of references is available from the publisher.

To find a therapist near you, go to www.iaom.com and look at the directory.

Joy Moeller, BS, RDH, COM, is a certified orofacial myofunc-
tional therapist and a licensed registered dental hygienist. She is in the exclu-
sive private practice of OMT in Pacific Palisades and Beverly Hills, Calif. She is currently an elected member of the Board of Directors of the IAOM and is the hygiene liaison. Joy is also a former associate pro-
fessor at Indiana University School of Dentistry and an on-going guest lecturer at USC and UCLA to ortho-
perio and pedo dental residents, and at Cerritos College to hygiene students.

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