Are Assessments Of Orofacial Myofunctional Disorders Meeting Patients Needs?

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ABSTRACT

Oral healthcare professionals are increasingly seeking orofacial myofunctional therapy (OMT) treatment for their patients exhibiting problems caused by orofacial myofunctional disorders (OMD). Dental professionals have minimal training in assessing OMD. Many OMT patients' have expressed frustration and confusion regarding dental healthcare professionals' analysis and timing of referral. The purpose of this action research is to investigate the patients' point of view regarding the management of their OMD by dental healthcare professionals. Negative dentofacial growth can be attributed to OMD. Improper facial growth and development can contribute to a restricted upper airway and associated sleep disorders. Delay in addressing the primary etiology may lead to orthodontic re-treatment and the possible need for surgical realignment of the jaws and dental structures. A survey was completed by thirty seven, orofacial myofunctional therapy patients. Over thirty-five percent of the patients responded that they were aware that they had an OMD before the dental professional addressed it. More than
sixty seven percent confirmed that their referral doctor informed them that the OMD might have played a role in dental, facial and upper airway development. Thirty-three percent of the respondents reported that the dental professional did not correctly diagnose the problem initially. Over eighty-six percent expressed that an earlier diagnosis would have better addressed the issues, resulting in improved outcomes. One hundred percent of the participants responded that addressing OMD should be part of routine dental examinations. Early identification and interdisciplinary care produce the best results. The data collected reinforced the need for proper education of dental healthcare providers regarding identification and treatment of orofacial myofunctional disorders. Further research is needed to raise awareness and improve the healthcare of individuals with orofacial myofunctional disorders.
History of Orofacial Myology and Dentistry

Orofacial Myology is defined by Hanson and Mason as, “the study of the normal and abnormal patterns of use of the mouth and face and their relationships with dentition, speech and vegetative functions.” “The term orofacial myofunctional disorders refers to a collection of oral patterns that are variably related to psychological and physiological factors.” “The tongue thrust swallow is the most commonly identified orofacial myofunctional disorder (OMD) by dental and speech professionals.”

“Orofacial myofunctional therapy in orthodontics dates back to the early 1900’s and is attributed to Alfred Paul Rodgers, DDS. In the 1960’s Walter Straub, an orthodontist developed a method for reeducating atypical swallowing.” (Levrini, 2007) Hansen wrote that, “Orofacial myofunctional therapy came into existence because orthodontists found their work being thwarted and undone by improperly functioning oral musculature. Their efforts to produce improved teeth and faces were being blocked by hostile tongues and incompetent lips.” Hanson went on to explain that, “anything that promotes mouth breathing including hypertrophic adenoids, swollen nasal membranes are responsible for tongue thrusting in many children.” (Hanson & Mason, 2003)
Mouth breathing has a significant impact on dentofacial development and overall health. Studies on mouth breathing were done by Harvold in the 1970's. Researchers inserted latex plugs into the nasal openings of young rhesus monkeys to evaluate changes in the dental structure. Forcing the monkeys to switch from nasal breathing to mouth breathing. To compensate, the monkeys developed postural changes, which were then followed by soft tissue changes. Responding to the different functional demand of mouth breathing, the craniofacial muscles then caused various malocclusions, including retrognathia, prognathism and anterior open bites.

McNamara who was interested in Harvold's work, “presented four cases where alterations in respiratory function were associated with abnormal steep mandibular craniofacial growth.” (McNamara, 1981)

“Habits can influence facial growth, oral function, occlusal relationships and facial esthetics of the child patient.” (Josell, 1995)

“Prevalence of tongue thrusting during swallowing has been estimated to be higher than 40 % in adolescence.” (Eslamian L & AP, 2006)

Orthodontists are aware of the harm caused by myofunctional disorders. The text Contemporary Orthodontics states, “Because of rapid growth exhibited by children
during the primary dentition years, it would seem that treatment of jaw discrepancies by growth modification should be successful at a very early age. If treated from ages 4-6 when rapid growth occurs, significant improvements in skeletal discrepancies can be accomplished in a short period of time. It was concluded, stability of these results are dependent on eliminating OMD’s and establishing harmonious muscle function.” (Proffit, 2000).

Dental healthcare professional need to be evaluating OMDs in patients early during their development, and they need to be knowledgeable in recognizing the presence of OMDs. Indeed every pediatric patient deserves the same scrutiny, regardless of the reason for consultation, and regardless of the dental setting or specialty. In general dental practice, the patient should receive the appropriate referral when there is a problem that needs to be addressed. Not every dentist is comfortable with addressing malocclusion and improper facial growth. Most orthodontists prefer to see the patient for a consult at age 7, however, this may be too late to achieve effective results. Experts agree that 60-70% facial growth is complete at age 7.

The American Academy of Pediatric Dentistry in its 2013 revised guidelines on periodic examinations. These guidelines were designed to help practitioners make clinical decisions. “Anticipatory guidance is a way for practitioners to provide practical and developmentally-appropriate information about the child’s health. Non-nutritive oral habits that include digit and object sucking, bruxism, abnormal
tongue thrusting and nail biting should be addressed before the malocclusion or skeletal dysplasia occurs. Deficiencies and abnormal delays in speech can be recognized and care coordinated using dental appliances and professional speech and language intervention. From age two to adolescents it is advised to provide treatment or appropriate referral for treatment of non-nutritive habits. Treatment of developing malocclusion is an integral part of comprehensive pediatric dental care. Intervention to improve the dental structure will assist with achieving occlusal harmony, proper oral functions and dentofacial esthetics. Objectives for intervention and treatment include: reversing adverse growth, prevention of skeletal and dental disharmonies, improving esthetics, self-image, and improving the dental occlusion.” (The American Academy of Pediatric Dentistry, 2013)

In 2006, a study on tongue thrust stated, “By assessing the child’s habits and improper rest postures, a customized exercise program can be developed that addresses and retrains the dysfunctional muscle patterns at rest and during function. A team approach that includes the dentist, orthodontist, myofunctional therapist, a speech pathologist, and otolaryngologist along with other healthcare professionals as indicated will ensure the best outcomes. Treatment by the myofunctional therapist can begin as early as early as age 5. Tongue thrusting and other OMD have been associated with posterior cross-bites, anterior open bites, excessive over jet, retruded jaws as well as speech issue.” The researchers went on to say, “Orofacial myofunctional therapy has been shown to produce improved outcomes over orthodontic habit trainers.” (Eslamian L & AP, 2006)
Smithpeter and Covell in their study concluded, “Orofacial Myofunctional Therapy in conjunction with orthodontic treatment was highly effective in maintaining closure of anterior open bites compared with orthodontic treatment alone.” (Smithpeter & Covell, 2010)

Parents of patients in my practice have expressed concern. One parent said, “I was told that sucking my thumb until eight and mouth breathing may have contributed to my improper dental and facial development. I use a CPAP for obstructive sleep apnea and have TMD.” The parent went on to say, “I do not want my child who sucks his thumb, has been diagnosed with sleep disordered breathing, and has trouble focusing to grow up and have my problems.”

Like-minded dental healthcare professionals who screen for OMD refer over 95% of the patients I treat in my practice. Since my patients are referred by dentists who are aware of the need to screen for OMD, they serve as an ideal population to survey. What are my patients’ perceptions of how the OMDS are assessed and treated? I decided to investigate my concerns with action research.
BACKGROUND

During dental hygiene education, the twenty students in my class were introduced to expanded functions and concepts that were not typically taught in other programs. After graduation, students were encouraged to attend a myofunctional therapy course offered by Garliner in Florida. It was an exciting goal. Unfortunately, full-time clinical practice and starting a family forced me to put my myofunctional therapy career goals on hold.

Throughout my dental hygiene career, I observed and followed the lifelong problems associated with OMD in my patients. It became obvious to me that an orthodontic habit eliminator, parental nagging, cosmetic dental makeover, jaw repositioning surgery, or the tincture of time did not always eliminate these soft tissue dysfunctions. By contrast, I have experienced that early intervention with OMT in addition to orthodontic functional appliances can favorably offset any negative dentofacial growth. Throughout my career, I gained an understanding of the reciprocal relationship of form and function and how it impacted my patients’ oral health. Patients’ myofunctional disorders were entered into charts and discussed with the dentist to share with the orthodontist, periodontist, TMD specialist, prosthodontist, and oral surgeons. Nonetheless, I knew that merely documenting habits and myofunctional issues in clinical notes was not improving the habits or oral postures. All along, I assumed that the referral doctors would
address the OMD and find an OMT program that would address the habits, dysfunctional oral phase of swallow, tongue and lip tie. However, for the most part, I found that the referrals failed to address the myofunctional needs of patients.

I was reintroduced to OMT when attending a dental hygiene continuing education course in sleep disordered breathing (SBD). This program taught me that many of the problems I was seeing in my dental patients could have improved with early identification and OMT. The solution was clear; I had to pursue the educational process needed to have a practice in orofacial myofunctional therapy. I decided to focus my career on addressing and co-treating OMD with other healthcare professionals.

I questioned, how do these myofunctional issues relate to dental, upper airway and sleep problems? How am I addressing the needs of my patients?

When first introduced to OMT back in hygiene school, we focused on how these habits effect occlusion and appearance. In the late 1970’s, the focus was on the teeth, occlusion and periodontium. We look at mouth breathing, and the effect it has on teeth and gums. Ankylosed tongues and lips were revised for esthetics and speech and social reasons. On many occasions, I would be shocked to find out that the patient sitting in my chair had previous orthodontic treatment, because I often
observed that they still had crowded arches and open bites even following orthodontic treatment.

Sometimes the etiology was blurred. Often, I would have to look for bicuspid extractions, or other missing teeth. Treating the children of these patients with relapsed orthodontic cases was also challenging, because of the difficulty of persuading parents to follow a treatment regimen for their child that had failed for the parents themselves.

One parent reported, “Everyone in my family had braces, and eventually all the teeth went back. I am not putting my child through that!”

As an example, I would ask a patient age 10 to swallow and notice the tongue thrust along with the improper use of the facial muscles. I would make a mental note of the OMD and enter my findings in the chart. That was the limit of what I could do.

At recare visits I would often notice that bites were changing, dental work and teeth were fracturing, periodontal problems were existent, and restorative and cosmetic makeovers were sabotaged by OMD and parafunctional habits. Frequently mouth breathing, tongue thrusting and parafunctional habits were blamed, but never addressed. Kissing tonsils and swollen adenoids restricted their upper airway,
forcing children to mouth breathe, yet none of the issues were adequately addressed.

With enlarged tonsils and adenoids, children often gag easily. Gagging increases patient anxiety. Impressions, taking x-rays and providing prescribed dental treatment was an ongoing battle, because of the failure to perform andenotonsillectomies. Parents and healthcare practitioners would pray that the child would somehow grow out of this problem and the necessary care could begin at “a mutually agreeable time.” Certain cases did not improve as planned. Orthodontic treatment was deferred. Problems became more complex and expensive to treat.

Questions arose in my mind. As professionals are we truly working on eliminating the need for service? Are we maintaining our role as prevention specialists? I asked myself what was missing that may have made a difference in the oral healthcare of these patients? What do our patients want and deserve? Parents are speaking out about these issues and as oral health educators, dental professionals are relied on to detect deviations from normal that will impact our patients’ oral health and wellbeing.

How do I, in the role myofunctional therapist, communicate with dental professionals regarding OMD and orofacial myofunctional therapy? Are
assessments of orofacial myofunctional disorders meeting patients’ needs? My hypothesis: OMDS go undetected during dental visits. To answer this question, I needed to have a strong factual foundation.

INTRODUCTION

When reflecting on my practice for this research project it became clear that dental professionals had little education regarding OMD. This discovery has led me to look into published work that would shape the direction of my action research.

METHODOLOGY

The survey was sent out to thirty-seven patients in my practice to examine their opinions regarding how their OMD was addressed and treated. Patient ages range from 2.5 to 72 years of age. Parents answered the survey for their children. It was disclosed that the results would be used for a research project and that their identity would remain anonymous. All patients polled signed releases that allow me to use their information for research and educational purposes.
Over thirty-five percent of the patients responded that they were aware that they had an OMD before the dental professional addressed it. Earlier observations of OMD and appropriate questioning to discover etiology during recare visits are advised. Ten percent had other forms of treatment that were unsuccessful. Sixty-seven percent were informed by the dental professional that the OMD might have played a role in dental, facial and upper airway development. Thirty-three percent of the respondents reported that the dental professional did not correctly diagnose the problem initially.

Proper identification of OMD involves a thorough evaluation. Because dentists often are not adequately trained to detect OMD’s, a team approach may better serve the patient.

Eighty-six percent of patients expressed that an earlier diagnosis would have better addressed the issues, resulting in improved outcomes. Because multiple etiologies can exist; a multidisciplinary approach will provide better results. One hundred percent of the participants responded that addressing OMD should be part of routine dental examinations.

**Survey Results:**
1. Were you aware that you had a myofunctional disorder before your initial OMT visit?

Yes – No prior treatment 25.64%
Yes – Had prior treatment to address issues 10.26%
No – 64.10%

2. When your dental professional informed you of these issues, were you told that the OMD’s could (have) effect (ed) facial, dental, and airway development?

Yes
No
Yes- 67.57%

No- 32.43%

3. Was the problem diagnosed correctly by the dental professional?

Yes-66.67%

No-33.33%
4. Do you feel that an earlier diagnosis would have better addressed the issues resulting in a better outcome?

Yes - 86.49%

No - 13.5%

5. Do you feel routine dental examinations should address orofacial myofunctional disorders?
Yes- 100%

No- 0%

The data results from the survey were sent to six licensed dental hygienists and three licensed speech and language pathologists, all who have practices in OMT. Sharing the data allowed me to test my claim by achieving critical judgment from my peers. All of the therapists who reviewed my survey responded that it was an accurate representation of what was being expressed to them by their patients. They remarked that the questions were pertinent and that they would be interested in seeing further surveys of my patient population in the future.
An interesting observation was that the patients polled were referred by like-minded healthcare professionals who had some formal training in identifying and assessing OMD. This fact suggests that, among healthcare professionals who have no training in identification of OMD and little awareness of their impact of treatment to reduce their impact, there could be virtually no referrals and virtually no treatment of the conditions.

BUSINESS MODEL

Owning my own business in OMT has been rewarding and challenging. Increasing professional and public interest in myofunctional therapy has grown my business. Weekly assessments include, the effectiveness of treatment, implementation of newly learned techniques, investments in equipment, as well as additional educational courses required to enhance the quality of care that I provide. Traveling to different office locations to meet the needs of patients and referral sources is a demanding part of my practice.

Addressing the concerns voiced by the parents and patients is paramount. Many times parents are disappointed with the timeliness of the referral, in many cases, happens after dental and facial growth has slowed. Because of the delay of identification of OMD’s and referrals to OMT’s, comorbidities that require additional treatment and cost have often developed.
Communicating with the members of the treatment team is essential.

The need for educating dental and other healthcare professionals on OMD and OMT efficacy is needed. As a professional my goal is to limit the need for service.

Patients want easy, holistic solutions. Many of the exercises I teach empower the patients to achieve results in a relatively short time. Program length is usually a year-long in order to habituate the new postures. Orthodontic treatment can coincide with OMT. When OMD’s aren’t addressed, dental treatment options are often time consuming and costly. Patients’ become disgruntled when the prescribed numerous treatments have produced little improvement with their problems. OMD screenings in dental settings may provide an opportunity to address issues that can effect appearance, dental health, overall health, and school performance. Sleep dentistry is now looking at the tongue, facial and upper airway development and how it affects sleep, as well as the impact of sleep-disordered breathing on overall health and cognitive behavior and learning issues. Speaking about my practice and presenting case studies at professional study clubs has been an excellent way to introduce myofunctional therapy results. Physicians have also invited me to speak, and my lectures were well received. Many dentists are now referring their children for myofunctional therapy. Sleep physicians have referred their children to have the OMD’s treated. Speech and language pathologists have referred their children for myofunctional therapy. Chiropractors, physical therapists, otolaryngologists’ and
other healthcare professionals are referring their family members. All patients
deserve to have their OMDS addressed and treated.

In a Dental Economics article titled, “Creating Awareness of Sleep Apnea in the
Dental Office” in the April, 2014 issue, Gary Radz, DDS writes about how he
incorporated dental sleep medicine into his practice. “Sleep apnea therapy in a
dental practice is a hot topic.” He continues, “It is critical that the entire team has a
good working knowledge of sleep apnea and be able to carry on a conversation with
the patient...” “Every member of our team has completed a two-day course...so that
they can inform and educate patients who wish to learn more.” (Radz, 2014)
Screening can start with the dental hygienist taking the medical history, and asking
parents specific questions regarding their child’s sleep. Dental Hygienists as oral
health educators have a unique opportunity to assess the deviations from normal
that may alert the dentist that a sleep referral is indicated.

Using DENTRIX and EAGLESOFT software for notes, can help with gathering the
adequate data regarding myofunctional issues and patients’ habits. The user is
prompted to evaluate tongue habits, lip habits, speech, nail biting, thumb/finger
sucking, gum chewing, teeth grinding/clenching, cheek biting, tongue thrusting,
mouth breathing, and a place to write in other patient habits.
DENTISTRY AND MEDICINE

Oral health is being integrated into healthcare. Professional boundaries are being blurred by standard of care. People are seeking dental care once or twice per year and may only visit their medical provider when there is a medical problem. A relationship established between dental health care professionals and their patients can span many years. “The American Dental Association claims that medical screenings for hypertension, diabetes, and high cholesterol in a dental office at chair side could save $102 million a year.” (Goldie, 2014)

“Sleep disorders have been estimated to affect 50-70 million Americans have been linked to increased risk for hypertension, diabetes, obesity, depression, heart attack, and stroke.” (Commitee On Sleep Medicine and Research, 2006)

The emergence of dental sleep medicine brought to my attention the sleep apnea epidemic that exists today. “The cumulative effects of sleep disorders have been linked to an increased risk for hypertension, heart attack, stroke, diabetes, obesity, anxiety and depression. The risk of a serious car accident increases when the operator is sleepy. Teenager drivers who are sleep deprived are at an increased risk. Hundreds of billions of dollars are spent each year in medical costs related to sleep disorders.” (Commitee On Sleep Medicine and Research, 2006) “Dental Sleep medicine brings these medical issues into the dental office. Many dental offices have incorporated dental sleep medicine into their practice.” (Swecker & Schroder, 2014)
“Risk for heart disease, diabetes, difficult childhood behavior and attention issues, inadequate sleep, poor self-esteem can be increased when orofacial myofunctional disorders go undetected and are overlooked. “Many health care professionals are increasing their awareness and understanding of orofacial myofunctional disorders, TMD, respiration, and sleep apnea’s impact on the oral facial environment and total health.” (Benkert, 2012)

“Physicians are prescribing mandibular advancement devices and dentist are fabricating them for their patients to use in place of or in conjunction with CPAP. Compliance to these mandibular advancement devices is superior to CPAP due to portability, ease of use, and comfort.” (Ngiam & Balasurbramiam, 2013)

Many of these adults with sleep apnea will want their children’s sleep and airway issues assessed and addressed. Current programs offered by Henry Schein and other companies in airway orthodontics and dental sleep medicine has increased dentists’ interest in myofunctional therapy. Screening for OMD in children can easily be included during routine exams. This underserved population of patients can provide added income to dental practices.
FUTURE BUSINESS MODEL

Orofacial Myology, Dentistry and Sleep Medicine: a Team Approach

Helen Keller once said, “Alone we can do so little, together we can do so much.” Medical and dental professionals are co-treating patients successfully. We all have the same goal for our patients. Many of my patients are under the care of several different professionals. Excellent results have been achieved by working together as a team. A multidisciplinary approach is shaping the future of my practice.

CHILDREN and SLEEP

What impact does sleep disordered breathing have on children? In children, snoring and mouth breathing and obstructive sleep apnea can negatively affect behavior and ability to pay attention. In a large, multi-year cohort study, it was shown that in 6 months to 7 years, snoring, obstructive sleep apnea and mouth breathing contribute to neurobehavioral morbidity, including greatly increased risk of ADHD, peer to peer behavior problems, increased aggression, and anxiety.(Bonuck & Rao, 2012)

Researchers from Sanford University have published an article that addresses the relationship between OMD and sleep disordered breathing. “The importance of early recognition and treatment in children is paramount to maximizing resolution
of symptoms and potential avoidance of OSA syndrome during adulthood. Adenotonsillectomy, palatal expansion and the addition of myofascial reeducation may play a role in the treatment for sleep-disordered breathing. Tonsil and adenoid hypertrophy, maxillary or mandibular deficiency, orthodontic complications, craniofacial abnormalities contribute to these sleep issues.” (Guilleminault & Huang, 2013)

Many adults with Obstructive Sleep Apnea have long standing OMD and sometimes overlook these problems in their children. In 2003, a study was done by Jaghagen on snoring, sleep apnea and swallowing dysfunction. This study’s results were explained by Dr. Brian Palmer on his website. “Swallowing dysfunction has been found to be more than seven times as frequent among patients with snoring and sleep apnea as it was among controls.” (Palmer, 2013) It is frequently observed in my practice that patients with sleep disordered breathing have low forward postured tongues and exhibit tongue thrust swallows.

New evidence tells us that there is so much more involved with tongue thrust, non-nutritive sucking, and poor rest postures. Pediatric sleep experts are looking at improper facial and jaw growth that has an impact on the upper airway. “These improper rest postures and noxious habits may play a role in the development of sleep disordered breathing and obstructive sleep apnea. The presence of snoring in a child should be addressed according to Pediatric Clinical Guidelines. Family
history of OSA and disruptive snoring is commonly found among children who exhibit these symptoms. “ (Midell & Owens, 2010)

Ankyloglossia is a contributing factor to myofunctional disorders. Lactation consultants are assisting with identifying tongue and lip tie. It fosters a low forward tongue posture, is attributed to the difficulty with breast feeding and swallowing, doesn’t allow the palate to develop, effects the airway during sleep, and harnesses the tongue’s ability to properly function during eating and when cleaning teeth. Ideally, the best time to address these defects is shortly after birth.

DENTAL TREATMENT CONSIDERATIONS

Physicians, dentists, orthodontists, oral surgeons and periodontists are utilizing cone beam CT scans (CBCT 3D) studies to assist with proper treatment planning of complex cases. Incidental pathological findings cannot be overlooked. Programs that map airway are very useful tools. Some dentists are considering holding off on complex orthodontic, implant and prosthetic cases until they are assured that there is adequate room for the tongue, a patent nasal airway, healthy temporal mandibular joints and no orofacial myofunctional disorders. “These concerns must be addressed during the treatment-planning phase. The size of the tongue and parafunctional tongue habits must be evaluated. Lateral and frontal tongue thrusts can displace natural teeth as well as certain types of implants.” (Mills, 2002)
In many instances, an ankylosed low forward tongue and tongue thrust may be blamed for moving the natural teeth adjacent to implant restorations creating open contacts and unwanted food impaction. As a practicing dental hygienist in a prosthetic/implant practice, I am becoming increasingly aware of parafunctional habits that go undetected and therefore untreated. These harmful habits undermine the life, longevity, and appearance of dental restorations.

Adults with severe obstructive sleep apnea have elected mandibular and maxillary jaw surgery to improve their quality of life. Orthognathic surgical results can be undermined by a tongue habit and improper rest postures of the tongue and lips. These patients should be co-treated with OMT. Addressing the etiologies such as mouth breathing, tongue thrust and non-nutritive sucking is imperative for the long term success of the case. Post-surgical OMT goals are to restore proper rest postures and orofacial muscle function.

CONCLUSION

The experience of this action research project has pushed me beyond my personal and professional comfort zone. Information collected from my patients and validated by other myofunctional therapists empowered me to write this paper.
“The purpose of action research is to generate new knowledge which feeds into new theory.” (Mc Niff & Whitehead, 2011) This statement from McNiff and Whitehead inspired me to have a better understanding of myself, my goals, and future directions for my business. The personal growth that I experienced during the past few months, allowed me to open up and reach out to others. Input and feedback from my peers and dentists during the reflective process was extremely helpful and appreciated. Reflecting on my business, persuaded me to reach out to health care professionals and educate on OMD. I have accepted speaking engagements and designed presentations to share my work on OMD with other professionals in various areas of health. I am teaching continuing education courses on OMD to dentists and hygienists. My courses have been approved for continuing education credits by the Academy of Dental Hygiene. Free baby screenings for ankyloglossia and lip tie was started recently, with much positive feedback. I also give back by consulting and sharing information on OMD, ankyloglossia and myofunctional therapy with dentists and other healthcare professionals.

RECOMMENDATIONS

I recommend that you consider implementing screening for OMD in your practice. As experts of the oral cavity and its supporting structures, patients rely upon dental professionals to assess and educate on the lifelong deleterious effects of OMD.
Utilizing the clinical exam prompts in dental software programs such as DENTRIX and EAGLESOFT can assist every dental office in assessment of many myofunctional disorders. The public demand is great, and that influence will drive oral healthcare professionals to implement this standard of care into their scope of practice.

“These OMD’s, when identified early can give young patients a chance at eliminating noxious habits and allow for natural appropriate dentofacial growth. In older children, in mixed to permanent dentitions, a multidisciplinary team approach utilizing Orthodontists, Orofacial myofunctional therapists, ENT’s and other multidisciplinary health care providers is best for optimum outcomes.” (Paskay, 2012)

It is essential that all healthcare providers interested in OMT take continuing education courses... Non-profit organizations have educational programs that can help dental healthcare professionals get the proper training.

Dental hygienists currently trained in myofunctional therapy have an obligation to our fellow professionals to introduce them to our work. With knowledge and understanding, screening for these dysfunctions can be done periodically by dental health care professionals. Referral doctors can benefit from our knowledge insight and expertise when co-treating these complex cases.
My role as an oral health educator began in hygiene school, continued through clinical practice and now into myofunctional therapy. Patients and healthcare professionals reach out to orofacial myofunctional therapists as a source of information on assessment and treatment of OMD. Oral healthcare professionals are in a unique position to address, and treat these disorders.

There remains a great need for courses on OMD and OMT to be incorporated into dental and dental hygiene curriculum. More research needs to be done to provide evidence of the efficacy of this beneficial therapy.

REFERENCES


