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Commentary

Letter to the Editor: Relationship between myofunctional therapy and orthodontics

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IAOM INTERNATIONAL ASSOCIATION of OROFACIAL MYOLOGY

Letters to Editor

Dear Editor:

Regarding the current unrest in the field of "Oral Myofunctional Therapy", it appears that many practitioners in the area of orthodontics, speech pathology and other associated groups, who once were eager to jump onto the "bandwagon" of tongue thrust therapy as a panocea to the successful treatment of orthodontic problems, are now just as hasty to abandon the entire area of oral myology as if it were a total failure, not worthy of continued use as adjunctive treatment to various dental problems.

All major groups of the health field seem to be plagued by extremists both pro and con when a new treatment measure makes its appearance. Many times it is the same individual who flits from one end of the pendulum swing to the other . . . never coming to rest in a moderate position. As I stated in a recent letter to the editor of the American Dental Association Journal, "there have occurred excesses of various sorts by persons involved in so-called tongue thrust training". However, there is a core of hard working, well-meaning professionals earnestly at work trying to put this valuable asset to the orthodontist in its proper place and perspective.

My principal purpose with this letter is to assess the present thinking of the orthodontic community in general, (and one orthodontist in particular) as regards the relationship between myofunctional therapy and the field of orthodontics, and pass this on to IAOM members, along with some suggestions, for their consideration.

There seem to be three principal points of contention:

1. Do oral myofunctional abberrations affect the dental arches and associated structures in the first place? There is a puzzling and wide diversity of opinion within the orthodontic ranks on this point.
2. Is there any value or success from myofunctional therapy in correcting or aiding correction of dental problems?
3. Do these faulty habits correct themselves spontaneously with time, thereby obviating the need for therapy?

Regarding the first point, I for one cannot imagine how it is feasable to dissociate the oral dental and bony structures from the musculature and associated neuromuscular habits of the oral cavity.

As to the second issue, I don't see how one could logically assume that persons involved in the correction of speech pathology, with many years of experience and success in this area, would suddenly not be adept in changing and/or retraining other closely associated myofunctional habits that affect the dental structures of the oral cavity and structures surrounding the mouth.

The third question reminds me of the ostrich who puts his head in the sand so his attacker can kick his rump. I have long been an opponent to the attitude of some major groups of orthodontists who insist on waiting until a developing malocclusion has run its full course before intercepting the etiological factors involved, thereby mitigating the severity of the problem as well as the treatment of same. No other health profession lets

a pathology run its full course before attempting to stop its progress. I have personally devoted my time in orthodontics to intervention, and prevention if possible, of severe malocclusions. I know of no etiological factors causing malocclusions that surpass myofunctional causes in producing severe malocclusions.

As to suggestions for the IAOM members:

It has become quite apparent that tongue "thrusting" is not the major problem related to tooth movement, it is the tongue "resting" habit that appears to cause malalignment. I think it would be expedient to drop the former term in favor of the latter when dealing with orthodontic problems related to the tongue.

Also, I think it would be very wise for the oral myofunctional community to realize that therapy in this area is definitely not a panocea for successful orthodontic treatment, and avoid extravagant claims about concurrant tooth movement. The field of orthodontics is a vast and complicated one and this problem is tantamount to seeing just the tip of a huge iceberg. Similarly the field of speech pathology is large and complicated and happens to associate with the orthodontic field at this particular point.

Another suggestion would be, that any oral myofunctional therapy related to dental problems be done at the request of a member of the dental profession, preferably an orthodontist, since this is the area in which he is better qualified than any other professional to judge the need of such therapy.

I think it is the speech pathologists prerogative to decide whether he should treat just the tongue rest position habit, and leave the associated speech, deglution, and circum-oral musculature deviations to chance for correction (as has been suggested by some). That would seem foolish. It would seem far more sensible to me (with my limited experience) to attempt correction of the whole "ball of wax" at the same time even though some of the habits are not directly affecting tooth movement.

There is no doubt that, if a university oriented program is developed requiring strict and comprehensive training for future myologists, the profession will eventually be accepted in its proper roll by the dental and speech pathology professions. For, as I have said before, "tongue thrust" and/or "rest" problems are here to stay and are not going to go away just because some people say "I don't see any tongue problem and if I did, it wouldn't affect the teeth."

It will be the responsibility of the dental and oral myology groups to provide evidence that interference with these habits does in fact alter tooth position, or aid in the altering of same. This obviously must be done with sound research programs and irrefutable clinical results. I, for one, think there is much to be learned for the good of our patients by the association of the two professions. Thank you for your time.

Sincerely,

Robert E. Day, D.D.S.

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