Are you a ‘cutting edge dentist’?

By Robin Goodman
Group Editor

D r. Martha Cortes, current president of the American Academy of Cosmetic Dentistry New York Chapter and former co-chair of dentistry with the American Society for Laser Medicine and Surgery, took some time to talk about lasers with Dental Tribune.

What is the state of lasers in dentistry today?

Dental lasers are state-of-the-art technologies. Every dentist should own one and use it as an integral part of his or her practice, especially as they are much more affordable than they were 15 years ago when I got my first laser; I had the the Duopulse by Excel Quantronix, which has two separate lasers in one unit: a holmium and neodymium laser. I still have this unit in my office and use it as a backup laser to my newer ones. Lasers can be used by themselves or as an adjunct tool as they are versatile and precise. A simple diode laser can be used to disinfect tooth structure, in crown lengthening, frenectomy, biopsy, periodontal disease and gingival sculpting, etc.

There are lasers like the Perio-lase MVP-7, which are specifically built around a patented soft-tissue technique for periodontitis — laser assisted new attachment procedure [LANAP]. There are hard-tissue (modifies lasers) as well as soft-tissue (modifies lasers) and there are lasers available today that combine both a soft and hard tissue laser in one unit. It all depends on the practice one has, or the one that you want to develop. Bottom line is that you cannot consider yourself a dentist on the cutting edge if you do not have and use a laser as part of your daily regimen regardless of what type of dentistry you practice.

Illustrations contributed to anterior gingivitis or open-mouth rest posture.

Does your patient complain about chronic headaches?

Does your patient have an open-mouth rest posture?

Have your patient’s teeth moved after orthodontic treatment?

Does your patient exhibit an open bite?

Does your patient complain of temporal mandibular joint dysfunction (TMJ) or neck pain?

Is the patient’s tongue always “in the way” when you are drilling, scaling or examining the teeth?

Does your patient exhibit a scalloped tongue from pressing against the teeth?

Have you noticed oral habits such as thumb or finger sucking, nail biting, lip licking or hair twirling or chewing?

Does your patient grind or clench his/her teeth?

Does your patient have chronic stomachaches, burping, drooling, hiccups or acid reflux?

Does your patient have a forward head posture?

Does your patient have a short lingual frenum or a tight labial frenum?

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 contributing to anterior gingivitis or open-mouth rest posture.

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be used to pocket depths above 12 mm. Those interested in the Nd:YAG for gum disease should really look at the Periosteal MVP-7 by Millennium Dental Technologies as the laser is sold with instruction/training in the laser and LANAP technique.

And for lasers and hard tissue such as tooth and bone?

Erubium lasers are great for disinfection of teeth and for osseous surgery as they are specifically made for disinfecting and cutting hard tissue. They are also ideal for preparing class I and class V restorations and removal of defective composite materials; however, they cannot be used on metal or porcelains, as these cannot be cut by a laser.

Metals and porcelains must first be removed using the drill; however, once they are removed the laser can be used directly to remove any underlying carbies. If the carbies are very deep, the erbium laser can be used in a direct/indirect pulp-capping technique with the immediate placement of a CEREC 5-D porcelain restoration. An erbium laser like the Waterlase MD by Biolase can also be used in the direct treatment of root canals as it has laser endodontic tips that are used post instrumentation for cleaning and disinfecting the canal.

What are your thoughts on a connection between heart disease and periodontal disease?

I love it when patients tell me that they are fit and in good shape except, of course, for the severe gum disease they have. Unfortunately, we have grown up with faulty medical/dental health models that describe the body as distinct and disconnected units, and this shows up in how we view disease and the body. Severe infection in the body is dangerous as it can spread, especially to vulnerable organs.

Periodontitis is a bi-directional manifestation of disease. It can be seen as a manifestation of systemic disease such as diabetes, cutaneous disease, joint disease and osteoporosis. It can also be seen separately from systemic ones as its own complete disease with the great potential of releasing bacterial emboli into the blood system that can travel to the heart, lungs and other major organs. It has been linked to cardiovascular disease since the late 1990s and right-so, as oral bacteria are not contained but spread and are particularly dangerous for heart patients who are vulnerable to endocarditis, especially before open-heart surgery.

An Nd:YAG laser can reduce microbial colonies that inhabit periodontal pockets by 97 to 100 percent, as the laser is precise, site specific and does not rely on secondary or tertiary effects to kill microbes. It destroys microbes and their colonies on contact without any side effects.

Editor's Note: Please see Cosmetic Tribune in this edition for a clinical article by Dr. Cortez and her contact information.

Failure to help many patients

Through 50 years of practicing orofacial myofunctional therapy, some questions patients or their parents asked me include:

Why didn't someone tell me about this earlier?

I knew I had a tongue thrust, I didn't know there was a special person to help me.

Why didn't someone tell me my habit of tongue thrusting, thumb sucking or nail biting could be easily eliminated in therapy?

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?

This is the third time this year my orthognathic surgical result has relapsed. Why hasn't anyone referred me to an orthofacial 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 with-

Complete care

From Page 1

From Page 1

Are you

From Page 1

From Page 1

From Page 1

from the field. 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 by some as the grandfather of orthodontics — wrote “Malocclusion of the Teeth,” appearing in Dental Cosmos in 1907, in which he recognized the influence of the facial musculature 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 Appliance.” 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 Hanson, Richard Barrett, William Zickefoose, and Galen Keyes 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:

odontotics

general dentistry

speech-language pathology

dental hygiene

periodontics

oral surgery

cranial nerve and cranial pain

allergy

pediatric dentistry

pediatrics

physical therapy

chiropractics

gastroenterology

plastic surgery

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From Page 1

From Page 1

From Page 1

From Page 1

From Page 1
drawn. 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 surgery to prevent re-attachment?  

I was told I was tongue-tied and needed a lingual frenectomy. After surgery, my tongue reattached and scar tissue formed and was worse than before we started! Why wasn’t I referred to an orofacial myofunctional 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.

Because 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 source for dentists.  

The best time for the dentist to refer the patient to an orofacial myofunctional therapist is before inter-vention by appliance therapy. It is always best to do the least invasive treatment first and eliminate habits that are interfering with treatment. This will ensure that the muscles are working with the forces 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 commentary.

According to Dr. John Kishibay, an orthodontist from Santa Monica, this disorder with exercises?  

I have never looked forward to doing extractions in my practice. It can take just a few minutes or more than half an hour if I hear that dreaded ‘cracking’ sound indicating I have broken a crown or a root. Since using the Physics Forceps that sound is a thing of the past. These new forceps don’t rely on brute force, but rather, use the simple concept of leverage. Instead of grasping, pushing, twisting and pulling the clinical crown, this technique employs a slow, steady rotational force that literally rolls the tooth free from the PDL. Seldom do new innovations come along that truly revolutionize the way a dentist approaches a service – this is one!
Joy Moeller, BS, RDH, COM, is a certified orofacial myofunctional therapist and a licensed registered dental hygienist. She is in the exclusive 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 professor at Indiana University School of Dentistry and an ongoing guest lecturer at USC and UCLA to ortho, perio and pedo dental residents, and at Cerritos College to hygiene students.

Dr. William Hang, an orthodontist practicing in Westlake Village, Calif., believes that OMT problems are one cause of poor facial development. He says: “Stability will continue to be an elusive, unachievable goal with poor facial balance frequently 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 myofunctional therapy, they stop treating symptoms and begin to focus on treating the cause of poor facial development [altered oral rest posture].”

Dr. Jerry Zimring, a practicing orthodontist for 44 years in Los Angeles, believes that attaining proper occlusion is a state of balance 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 valuable treatment. I feel strongly that myofunctional therapy should be part of every orthodontic practice.”

Dr. Richard L. Jacobson, a Diplomate of the American Board of Orthodontics 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 function can follow form. Therefore, it is vital to identify those patients that need myofunctional therapy. In these patients myofunctional therapy by a specialist is essential. Treatment 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 Coceani-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.

Study OMT!

Joy Moeller will teach a five-day IAOM-approved course on orofacial myofunctional therapy Oct. 19–25 and a seven-day course (which includes two days of internship) on Feb. 11–17 and June 24–30, 2009 in Los Angeles with Barbara J. Greene, COM, and Licia Coceani-Paskay, MS, CCC-SLP, COM. For more information contact Greene at bgreene@tonguethrust.com or call (805) 985-6770.

Contact info

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