From the Editor

Editor's Corner: IAOM's 40th Anniversary, and Sleep Posture

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EDITOR'S CORNER: This 2011 issue of IJOM celebrates the 40th Anniversary of the International Association of Orofacial Myology (IAOM). This issue provides our many new members the opportunity to become more familiar with the foundations of our organization, while at the same time, provides an opportunity for our long-standing members to reflect on the principles and practices upon which our organization was established. Christine Mills' article on the origin and background of IAOM contains insightful information on our history, some of the pitfalls which were encountered, and most importantly, contributions from many of our 'Founding Fathers' and influential early members of IAOM.

One of the contributors to Mills' article, Dr. Marvin Hanson - a Founding Father - indicated the critical need for the IAOM to be a truly international organization. With that premise in mind, Dr. Fumiyo Tamaura's article on food refusal provides insight not only on specific techniques for treatment, but also helps us to understand that variations in the provision of orofacial myofunctional services do exist, and represents the continued international nature of the IAOM. Dr. Almiro Machado Junior's article on the influence of morphology on swallowing, and Dr. Silvia Fernandes Hitos' article on a standardized method for the analysis of chewing provide examples of the ongoing research on orofacial myofunctional disorders (OMDs) in Brazil. Pam Marshalla continues the reflection of historical perspectives in her article on the use of 'tools' in treatment. While writing from the stance of speech and oral motor difficulties, Marshalla describes many of the items we use in treatment, their origin, purpose, and implementation.

Many premises about OMDs are incorporated into our treatment methodologies. Dr. Robert Mason's article on 'Myths that Persist' challenges members to reassess long-standing ideas which may have historically been espoused within IAOM. Mason discusses nine myths in an insightful manner, which should provide members the opportunity for reflection and re-evaluation of time-honored beliefs.

However, another 'myth' related to sleep posture could be added to the nine which Mason mentions. There has been the notion among IAOM members that individuals who experience OMDs should be advised that the 'proper sleep position' is to sleep on their back. Sleeping in this supine position may be fine for some of our clients, however this sleep position may actually exacerbate medical conditions in others. For example, individuals who experience sleep apnea may be at an increased risk for apnea episodes while sleeping in the supine position. This is not a new idea. Sleeping in the supine position was recognized in 1966 by Gastaut as having the potential to aggravate sleep apnea. Sleeping on the back is thought to increase the possibility and frequency of upper airway collapse (Isono, Tanaka, Nishino, 2002; Cartwright, 1984). There is a higher pressure needed to maintain an open airway (Neill, Angus, Sajkov, McEvoy, 1997) and more depressed oxygen desaturation (Oksenberg, Khamaysi, Silverberg, Tarasiuk, 2000). In 1991 'positional dependency' was identified as a possible factor in patients with obstructive sleep apnea (OSA) and 'positional therapy' was introduced by having individuals sleep in a lateral position which reduced their apnea-hypopnea index (AHI) approximately by half (Cartwright, Ristanovic, Diaz, Caldarelli, Alder, 1991). The incidence of positional obstructive sleep apnea (POSA) reported in the literature ranges from 50% to 67% among individuals who have been diagnosed with OSA (Teerapraipruk, Chirakalwasan, Simon, Hirunwiwatkul, Jaimcharyatam, Desudchit, Charakon, Wanlapakorn, 2011; Richard, Kox, den Herder, Laman, van Tinteren, de Vries, 2006; Mador, Kufel, Magalang, Rajesh, Watwe, Grant, 2005; Oksenberg, Silverberg, Arons, Radwan, 1997; Cartwright, 1984.)

Teerapraipruk, et.al (2011) found that POSA was brought within normal limits in 47% of subjects when non-supine sleep positions were used. While Lee J, Park, Hong, Lee H, Jung, Kim, Yi, and Shin (2009) indicated that not only sleeping in a lateral position (side sleeping) with at least a 30 degree angle reduced the prevalence of sleep disorder symptoms in patients with mild or moderate apnea, but the addition of cervical vertebrae support with head tilting, and scapular support could reduce the apnea-hypopnea index (AHI) by 80 %. Kwon, Yong, Bong-Jae, and Yoo-Sam (2010) indicated that a change in sleep position is one of the non-surgical options in the treatment of OSA. Ozeke, Erturk, Gungor, Hizel, Aydin, Celenk, Dincer, Ilicin, Ozgen, and Ozer (2011) conducted a retrospective analysis on sleeping positions of OSA patients and their AHI. They determined that for patients with moderate and severe OSA the Right Side Sleep Position (RSSP) was associated with significantly less obstructive breathing occurrences than sleeping on the left side (LSSP.)

Does this mean that we should change from advising our patients from sleeping on their back to advising our patients to sleep on their right-side? The larger question is: should we be making any recommendation about sleep postures? While a causative relationship has not been determined between OSA and nocturnal gastroesophageal reflux (GERD) (Gerson & Fass, 2009), there is a co-occurrence of approximately 58% to 74% (Shepherd, 2010; Morse, 2004; Green, 2003; Herr, 2001). Some studies indicate that in patients experiencing difficulties with reflux left side sleeping position is preferred over sleeping on the right side (van Herwaarden, Katzka, Smout, Samsom, Gideon, Castell, 2000; Khoury, Camacho-Lobato, Katz, Mohiuddin, Castell, 1999). While sleeping in the supine position was not mentioned in the American Gastroenterological Association's Position Statement sleeping with the head of the bed elevated was noted as a possible life-style modification (Kahrilas, Shaheen, Vaezi, 2008). Based on this cursory review of the potential influence of something as seemingly benign as recommending a 'proper sleep position' there may be serious consequences for some individuals in the population we serve. Perhaps we should be prudently cautious when making recommendations and question ourselves to ascertain if the recommendations we make are clearly within our scope of practice.

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