Case Report

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Ellen Stoody

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Myofunctional Therapy Case Summary

Ms. Ellen Stoody
Senior Dental Hygiene Student KVCC

I. Description of the Patient

A forty year-old white female was seen in our Kalamazoo Valley Community College Myofunctional Therapy Clinic for an initial evaluation on November 11, 1982. The patient had been referred by her orthodontist because of mobility and periodontal involvement of the mandibular anterior teeth. The orthodontist suspected that the patient's tongue-thrust swallow and tongue resting posture were contributing to this problem.

II. Dental History

In January, 1980, the then thirty-eight year old patient consulted an orthodontist because "she had trouble chewing and didn't like the way her teeth looked." At this time her husband had dental insurance which partially covered orthodontics and the treatment was affordable. The orthodontist diagnosed the patient as having a skeletal Class III malocclusion with centric occlusal contacts on the second molars only. A treatment plan including oral surgery was set-up. The team approach called for orthodontic intervention with full banding to align the dentition followed by a mandibular resection and extraction of the third molars by the oral surgeon. At this time the patient was made aware of her tongue-thrust swallow and told by the oral surgeon that the swallow would adapt to the post-surgical environment.

In October of 1980 the patient received full banding with special brackets for post-surgical ligation. The surgery was performed in January, 1982 after the correct dental alignment had been acquired. The orthodontic bands remained in place until July of 1982. Shortly after removal of the bands the patient complained of tooth mobility and sensitivity especially in the mandibular anteriors. Because the patient had no soft tissue memory of centric occlusion, she was sent to the periodontist for a perio/occlusal evaluation and equilibration. When this did not resolve the problem, the orthodontist placed a fixed lingual arch wire from tooth #27 to #22. This was done in August of 1982. In October of 1982 the patient was referred to the myofunctional therapy clinic at KVCC.

III. KVCC Initial Evaluation Summary

A. Occlusal Evaluation

In November, 1982 the patient had a Class I molar relationship, 2mm. overjet, incisal one-third overbite, and no diastemas or crossbites. She had a slight dental asymmetry of mandibular alignment 2mm. to the right.

There was Class II mobility in #26,25 and Class III mobility in #24, 23. There was 3mm. recession on all of the incisors with 6mm. periodontal pockets. A subsequent radiographic survey showed widening of the periodontal ligament and 6mm. bone loss from canine to canine. There was also resorption of the root apices.

B. Lip Posture and Tongue Rest Position Evaluation

The patient was observed to have lip closure at rest. Her self-report stated that she had always breathed through her nose and was still doing so. Prior to surgery lip closure was more difficult and her tongue habitually rested on the occlusal surfaces between the arches. Since surgery the tongue assumed a floor-of-mouth rest posture with the tip curled behind the mandibular anteriors. Recently, however, the patient had been attempting to elevate the middle of the tongue against the hard palate. This was the result of having been told by the orthodontist to "hold a mint up on the roof of your mouth and swallow that way."

C. Tongue Coordination Evaluation

The tongue was large and hyptonic with poor coordination of elevating, lateralizing right and left, and extending (no tip formation). The depressor movements and lingual frenum were normal.

D. Swallow Evaluation

The patient had made a valient effort to swallow correctly based on the orthodontist's instructions for a normal swallow. This was achieved with great difficulty, however, and her habitual swallow was a forward push against the anteriors and a bilateral thrust in the posterior.

E. Emotional Evaluation

The patient was angry and anxious. Her investment of over \$10,000 in treatment seemed to be threatened by further complications. She was bruxing and clenching in addition to trying to learn a new swallow behavior with very little guidance. The clenching was concomitant with pressing the tongue against the teeth.

IV. Therapy Progress

Therapy was initiated on December 1, 1982 and progressed on a weekly basis until April 13, 1983. At this time the highly motivated patient was dismissed from therapy and placed on three month recall.

V. Follow-up

A. First recall (7/6/83) - the normal swallow remained generalized as assessed by our recall criteria and the patient's self-report. The tooth mobility had decreased slightly.

B. Second recall (2/1/84) - the normal swallow was completely generalized with no conscious effort on the part of the patient. The rest posture is normal except for special circumstances (see below.). The tooth mobility at this appointment had been reduced to normal in #26 and #23. There was Class I mobility in #24 and #25. The periodontal pockets had reduced to 4mm. and the recession remained the same.

VI. Current Status Summary

The patient is still wearing her lingual arch wire. She has also identified a potential problem. When concentrating on a repetitive eye-hand psychomotor task (she gave sanding the floor, peeling vegetables, etc. as examples) she finds herself clenching and pushing her tongue forward against the mandibular anteriors in the old habitual pattern. The patient has resolved this by placing rubber orthodontic bands on the tongue tip as a reminder for correct tongue placement. Her next visit to the orthodontist is in May and she hopes to have the fixed arch wire removed at that time.

The patient's seventeen year old son is currently in therapy. He was referred by the same orthodontist and has full banding for a Class III malocclusion.

NOTE:

A. Mobility Index

N, 1, 2, 3 or I, II, III are frequently used, sometimes with a + to indicate mobility between numbers.

B. Recording

Although subjective, interpretation may be considered as follows:

N = Normal, physiologic

1 = slight mobility, greater than normal

2 = moderate mobility, greater than 1mm displacement

3 = severe mobility, may move in all directions, vertical as well as horizontal.

From:

Clinical Practice of the Dental Hygienist, Esther M. Wilkins, 5th ed. Philadelphia, Lea & Febiger, 1983.