

## Tutorial

# Can you just say no?

Becky Winchell

### Suggested Citation

Winchell, B. (1991). Can you just say no?. *International Journal of Orofacial Myology*, 17(3), 18-19.

DOI: <https://doi.org/10.52010/ijom.1991.17.3.6>



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common developmental interferences is presented and the one most likely to be the cause for the individual with the tongue-thrust is identified. For the majority of patients

an airway interference of some sort during a developmental stage, or currently, seems to be the primary etiological factor in the tongue-thrust swallow.

## The Breath of Life

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The purpose of this table clinic was to enlighten orofacial myologists to the effect of mouth breathing, the functions of the nose, and benefits of diaphragmatic breathing. As clinicians, we find habituation difficult if not impossible in the presence of airway obstructions and interferences.

The effects of mouth breathing can be seen by increased calculus formation on the teeth as well as dehydration of the oral tissues. Restriction of the maxilla can result from decreased tongue pressures on the palate. Air positive swallows seen with mouth breathing are a major factor in formation of abnormal palatal vault height. As therapists we know that lip incompetency results when an oral airway must be maintained. Studies have also shown up to 40% less oxygen is delivered to the brain per breath via mouth breathing. When nocturnal mouth breathing that results in sleep apnea occurs, 84% of the subjects stop breathing for periods of 6-30 seconds. When we stop breathing we create oxygen imbalances in the blood gases, thus creating a tremendous strain on the heart. Seventy-five percent of heart attack victims mouth breathe at night.

These are only a few of the concerns that demonstrate detrimental effects of mouth breathing. As our table clinic suggested, orofacial myologists should be aware of the nose and normal nasal function. The nose normally produces clean mucous to filter the air every 20 minutes. These secretions should measure approximately one quart a day. Nasal air needs 75-80% humidity. The cilia in the nose perform 10 sweeping strokes per second and the nose processes 500 cubic feet of air daily (which is equivalent to a small roomful). Nose turbulence is 20 m.p.h. but can reach up to 200 m.p.h. during heavy exertion. Colds and nasal allergies will decrease cilia motion and stimulate overproduction of mucous. Isn't it ironic how many patients we see who do not blow their noses? When patients are made aware of the necessity to clean the nose daily, normal nose function will become easier.

The head contains eight sinuses and excess mucous production can affect sinus pressures. This problem is compounded when the patient does not clean the nose.

Sixty-five percent of inferior turbinate hypertrophy is due to allergies. When these turbinates are enlarged, the restricted airflow will affect the entire airway. The most frequently seen pediatric nasal pathology is inferior turbinate hypertrophy.

The nasal passages also regulate the pressure of the air during inspiration and expiration. Proper regulation of the breath is of utmost importance in stress management. Diaphragmatic breathing helps to control stress by gently massaging the internal organs and allowing a more complete transfer of blood gases, especially into the lower lobes of the lungs, where there is greater concentration of blood. Only 6-8 breaths per minute are necessary with this type of breathing, whereas thoracic breathing requires 16-20 breaths per minute. A partial vacuum is created because the chest wall expands, pulling the lungs outward. This creates more strain and stress by pressure produced on the vagus nerve.

When learning better oral functions, our patients need to know the benefits of a patent nasal airway and diaphragmatic breathing. We encourage our allergy patients to seek medical care and use many of the new medications proven effective in increasing nasal airflow.

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## Can You Just Say No?

Becky Winchell, B.A.

Perhaps one of the most difficult tasks set before the beginning therapist is selecting the types of cases that will have the most successful outcome for the patient.

It is a task that does become easier with experience, but it is always a challenge! The following is based on my experiences over the last 20 years and represents a



collection of observations that might constitute a valid basis for "saying no" to therapy.

### PHYSICAL LIABILITIES

Deep palatal vault on adults with no correction available

Patient has severe allergies — how and if they are being treated?

Severely enlarged tonsils and no treatment scheduled (age is a factor)

Patient in need of a lingual frenectomy and it will not be done. Tongue of older patient may never have the mobility that is necessary for success.

Severe open bite. You would be working against a tremendous force. Could it be closed down somewhat before you begin?

A class II, so severe that patient cannot close lips. You would be asking too much from the patient without intervening orthodontics.

Neurological dysfunction. Sometimes very difficult to detect, but it can certainly cause difficulties.

Pain sensitivity, when orthodontics causes considerable discomfort. The patient will be much more cooperative if treatment is delayed.

Mental retardation, or severe motor disorders in

patients. Success will be limited. Set realistic goals for improvement.

### EMOTIONAL LIABILITIES

Social Interferences

Numerous outside activities

Poor relationship with parents or other family members

Poor motivation

Unrealistic goals by the patient. Adults have a tendency to want a "quick fix."

### SUGGESTIONS

Determine your initial perceptions of the patient. Learn to trust your instincts.

Perhaps a "delay" can be a key tactic, rather than saying "no." However, your candid and honest reasons for saying "no" should bring respect for your professionalism. The field of orofacial myology has had its credibility damaged because of failure rate. The taking on of "impossible" cases does us all great harm. Your referral source wants you to succeed, so you really do have the opportunity to be more selective and realistic. We *all* want to win, and it is possible if you can choose the therapy patient that has the very best chance to succeed.

## Communication the Easy Way

Gayle Snyder, M.A.

One of the many things we do as orofacial myologists is to communicate in writing with patients and related health professionals. Documentation of patient progress is included in this category as we are often required to submit copies of patient files for insurance purposes. Additionally, concise record keeping is beneficial in these days of medical litigation. Without a system, written communication can become time consuming and often ineffectual. With a system, even one simplistic in nature, this task becomes an important but less time consuming part of an orofacial myology practice.

This article is divided into three sections: (1) how to communicate with referral sources and related health professionals, (2) how to communicate with patients/parents, and (3) how to communicate with yourself (record keeping).

### I. Communicating With Health Professionals

Forms used in this category:

- a. 3-part NCR Referral form
- b. Thank you for referring card
- c. Assessment report
- d. Patient progress reports — 4 during active treatment
- e. Final report

All referral sources should be provided with forms to refer patients. A 3-part form, one copy to the patient, one for the referring office and one for the therapist, makes it easier for you and the referral source to keep track of

patients. A thank you note to your referral source shows appreciation for the referral, and keeps your name in his/her mind.

The Assessment Report should be brief but concise, describing what was observed, providing a diagnosis and a prognosis for success. Most referral sources appreciate a simplified report due to the volume of material they receive. Copies of the assessment report are sent to all related health professionals who are involved with this patient.

It is essential that progress reports be sent during the patient's active treatment. A short progress note sent after each phase of treatment is recommended. Copies of all progress reports are sent to each member of the team. It is also beneficial to give a copy of the progress report to the patient. Of course, a final report is sent when the patient is dismissed from treatment.

### II. Communicating With Patients/Parents

Forms used in this category:

- a. Letter confirming first appointment
- b. Consent for exchange of information
- c. Office Policies form
- d. Patient/Parent observation form
- e. General guidelines to prepare for therapy
- f. General guidelines during the therapy program
- g. Patient questionnaire
- h. Patient mail-in evaluation

The first written communication with the patient is an