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Commentary

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# THE ROLE OF THE ORAL MYOLOGIST WITH ORTHOGNATHIC SURGERY -- A PATIENT/ THERAPIST'S POINT OF VIEW

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The trauma of orthognathic surgery on muscle function has frequently been overlooked by oral surgeons. The attitude of many surgeons is that the muscle fibers will adapt to the new structure in a short time. The purpose of this paper is to dispute this attitude and to address the need for the oral myologist to assume an important role in the healing and post-surgical treatment of the patient.

Three years ago, I made a decision to try and have my own Class III malocclusion corrected with orthognathic surgery and orthodontic treatment. This decision was based partly on the fact that I was developing bone loss in the maxillary molar areas, and the periodontist identified this as the result of "traumatic occlusion." He felt that if I did not have my occlusal problem corrected, I would continue to have bone loss which would ultimately lead to periodontal surgery and probable loss of teeth. Being a dental hygienist as well as an oral myologist, I decided to follow through with his suggestions.

I wore fixed appliances for six months prior to the surgery. The oral surgeon performed a LaForte I Maxillary Advancement and a Genioplasty. In this surgery, the oral surgeons sectioned my hard palate into three sections and advanced it forward. At the same time, they removed the tip of my chin. This would change the Class III profile to a normal Class I profile. A surgical splint was made to hold the position of the advancement. Unfortunately, the splint did not fit properly, and consequently the surgery over-corrected me to a Class II relationship. I had to wear headgear post-surgically to pull my maxilla back to a Class I relationship.

My jaws were in fixation (wired closed) for almost four weeks post-surgically. My diet consisted of thin liquids the first week, and then I progressed to dairy-like products and raw eggs. It had become very difficult for me to speak clearly, and this slowly returned to normal approximately two months after the surgery. I wore the fixed appliances for seven months following the surgical procedures.

Psychologically, I felt very depressed during the recovery stage. My face was swollen, black and blue, and then yellow around the cheeks and eyes. I did some stretching exercises for improvement of range of motion, and tried to drink nutri tious liquids as often as possible. In an effort to maintain good oral hygiene, I used hydrogen peroxide and a tooth brush on which I cut the bristles shorter in order to gain access to the molar teeth.

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I was in fixation for almost four weeks post-surgically and during this time I lost 25 pounds. I looked very different, having gone from a Class III to a Class II and then to a Class I in a very short period of time. My face felt as though I had groups of rubber bands pulled across it and my neck. When I finally did venture out into the world, my friends were shocked at the changes, as a matter of fact, I was not recognized at my bank or office. I felt like a freak.

The role of the oral myologist/myofunctional therapist has been defined as "balancing oral facial muscles and teaching proper tongue rest posture." I feel strongly that the oral myologist needs to assume more responsibility than that. For example, the oral myologist needs to play an active role in the post-surgical healing and the reestablishment of proper muscle function as well as proprioception following orthognathic surgery. The oral myologist can also be a supportive member of the "team approach" to orthognathic surgery.

The myofunctional therapist can encourage patients to eat at frequent intervals (every two hours for the first few weeks after surgery) as well as instruct the patient in proper home care during the healing process. The support that I lacked in post-surgical healing would have helped the procedure be a more positive experience instead of such a traumatic shock.

Some of the exercises which I used to help facilitate movement are:

1. Have the patient make "EE, OOH, AAH" sounds while exaggerating lip movement.
2. Brush the facial skin with different coarseness paint brushes and ice to facilitate proprioception of the facial nerve.
3. If not in fixation, have patient yawn while moving the tongue out and down (mobilizes the TMJ).
4. If not in fixation, have the patient place tongue under the lower and upper lip.
5. Have patient practice correct tongue rest posture and tongue pops.
6. Encourage the patient to move his/her neck with head rolls and shoulder lifts and rolls.

The nutritional aspect of this type of surgery must not be underestimated. In order to promote proper healing, a high calorie diet must be followed. As reported previously, I lost 25 pounds in a very short period of time. The myofunctional therapist can encourage the patient with tasty reipes for soups and drinks. The first week after surgery the only thing that can be tolerated is very thin liquid. The secound and third weeks, the patient can use dairy products or blended foods. Many of the oral surgeons are now using new techniques where the patient does not need fixation. In these cases, the patient can be introduced to soft foods in three to five days post-surgically.

I feel the patient will greatly benefit from having their own "therapist" or support person. The doctor will benefit by having a trained auxiliary to depend on for assisting patients with their problems and answering any questions which may arise. And, last but certainly not least, the oral myologist will benefit by having diversification and the challenge of helping someone through what could be an extremely traumatic procedure.