Podcast Intro and Airway Dentistry Overview

Your genes hold the answers to your family's overall health. I'm Dr. Paula Kruppstadt and on the Get to the Root with Hope for Healing podcast, I sit down with experts in genetics, functional medicine, and family care to explore what's really going on beneath the surface so you can stop guessing and start healing.

From personalized insights to practical tools, we bring you whole family wellness that starts at the root. Welcome to part two of the Get to the Root podcast on pediatric dentistry with Dr.

Amy Ludeman. welcome again, Amy. And I'm going to let you explain to listening audience what your credentials are as far as airway medicine goes, because that is newer.

And now I would say all the pediatric dentists that we're exposed to, we are starting to see that not all, but many of them are exposed it. And it's like, if they're not, it is like you're missing a huge piece of caring for a child.

So would you explain to everyone what airway medicine is? Okay. Well, I would say that in general, in my training and, you know, and my contemporaries, we really did talk about airway dentistry at all.

I think it was in 2018 when the ADA had sort of a conference and basically at that time mandated the dentist since we were seeing patients twice a year.

And many patients weren't going to the doctor near as often. Once you've don't do your annual visits as a child, you know, just lots of things happen.

And the pediatricians and the physicians were not seeing it, so they said dentists need to be looking. So I think that definitely was a huge factor in why dentist started looking more.

I can't really say what is taught in residencies, right now, but you're right, there's a much more of an emphasis on it. There's not a specialty like there is in, pathology or oral surgery or things like that.

I would say orthodontists, pediatric dentists and some general dentist are now looking more at it. And just like a number of other things, the training comes after you get out, right?

So it says a dentist, you have an option to see what you're interested in. And right now, that's kind of the hot topic. But as far as training goes, I kind this is a really passionate topic for me.

I've been helping with children and airway probably since around 2000 when I first kind became aware of it. And I hosted an interdisciplinary study club for almost 10 years.

In the first number of years, we just focused on zero to six month old. Then we moved zero- to three-year-old because I had a child die of SIDS in my practice.

That was a big eye-opener. I'd only met the child once. So it's a very passionate topic for me. And in general, what I notice is that when people talk about airway dentistry, they're talking a lot about measurements.

They're interventions, whether it be from a medical standpoint, CPAPs or other devices to help manually move the jaw open or do things at night to, from structural standpoint help airflow, which I'm not saying should not be done.

And then when we're talking about growing children, even adults, I won't go into adults because I am a pediatric dentist, but growing I feel like there's this emphasis on The pallet needs to be expanded X number, you know, of millimeters, and this needs but a great nervous system, great tone, and they don't have a breathing problem.

I've seen people with big airways that are structurally big, but their nervous is terrible, they're floppy, their airwaves are collapsing. It's not just about size and structure, it's about the entire person.

And you see a person's airway looking at them standing in front of you. You see their air way and how they hold their body. So airways is so much more, but I guess an answer to your question, there's a lot of courses out there that now teach dentists about airwaves and they're talking about tongue tie.

What Tongue Ties Are and Why Function Matters

They're talking about palate expansion. They are talking what dentists do well, which is look at structure and think about how do I modify that structure to be what I think it should look like for a healthy airway.

And I'm actually teaching in Scottsdale early next year, and my course is when a big air way isn't enough. Because I will see as people are going through this learning curve of all these things, they get to a point and they're like, well, I did all this and I do the pallet expansion and the numbers are this.

And why is my patient still wetting the bed, still anxious and not focused in school, and still mouth breathing all day long? Like, what am I missing?

So I don't know if that was a great answer to the question. Yeah, it's a good intro because something you said in your first pediatric dentistry podcast was form follows function.

follows function. Yes, and as I'm visualizing what that means. So let's go right to birth and I'll draw in a few things, but I would like you to talk about what is a tongue tie?

And how could or would a parent know that that's an issue, whether they're breastfeeding, attempting to breastfeed, or formula feeding? So we're looking at a baby, we are comparing and contrasting, and what is it, what are they looking for?

Because we have kids come into the practice all the time and no one has ever recognized that they have a tongue tie. or even a lip tie or ties on other parts of their tongue.

And we still miss all these things. We defer to an expert like you, but how do you know and what should a parent know, especially beginning at the beginning of life?

Disclaimer, I could really go off here. So I'm going to try to follow a path. Okay. First thing is when a baby is born, we now know there's some study out there.

I have a lot of friends, like I said, they're osteopaths. When babies are born even via C-section, but definitely via vaginal birth. There's something that is called occipital compression.

And about 95% of babies have occiputal compression, at least, if not 100%. And it's normal. It's the cranium sort of being squished to come out. The reason I mention that, is because if you turn the skull upside down of a newborn, the occiput is not one bone until age nine.

Four little pieces. A nerve that runs right through the occiput, that when there's compression is affected, it is motored to the tongue. I need to mention that because, God, if every baby could get oximetry compression at birth, it would be so fabulous, right?

But that doesn't happen. So now we're going to move into talking about tongue ties. I needed to mentioned that though, because in the world of tongue tie, I think it's really important that people have a team approach.

And I hate cut and go because it just can create such a disaster. How do you know? They're so okay, let's see. So occipital compression is present. And the reason it's important, if you think your baby has a tongue tied because they're not latching on well, they are having, you know, it is out there all over all the different things that you can

have affecting your ability to latch, their clicking, taking in air, falling off, can't get a latch.

There are so many different thing. But all of that can happen because the motor to the tongue isn't functioning well. Compression. The other things. So it's really important to have someone that is skilled at looking at a baby from a functional and structural standpoint, check that baby first.

Because if you have a Baby that has tongue dysfunction, whether it is from occipital compression or something else, and you go and do a surgery on it, the dysfunction is still there.

the tongue is still going to function the way it has been, and it's going create a new phrenum, which is pretty much going be identical, but now it is more going scar tissue in.

So it really important that someone make sure that none of the functional issues are coming from that point of view. So people that can address that, you mentioned osteopath but chiropractic body work.

Okay. So babies, basically we say form from the cranium down. I only work with chiropractors that really understand infants and developing babies and fascia and are gentle.

Babies and small children do not need their back cracked or their neck cracked. because that's not where the issue is. They need someone that understands the whole system and is gently releasing the fascia and so forth.

So as we've talked about other things, we're meant to be in harmony and balance. That's really important. Having someone who's cracking little babies' backs and things like that is really inappropriate and not going to help the situation, in my opinion.

Yes, having an osteopath or a chiropractor who has got the extra training and infants and who really works with this population and working with the And then having a lactation consultant.

I can tell you why this is also important. And lactating consultant is amazing. Remember when my daughter was born, I had her had three times. It was only in the hospital like a day and a half, but three time she was in there because I was like, it's not gonna happen.

it still like whatever. and I've had patients come into my practice that didn't have lactations or that had one that was maybe just not as skilled or whatever.

And the baby had been green lighted from the body worker and the functional worker, which was the IBCLC, to have the surgeon who did the surgery. Nothing feels different.

So my IBSLC goes in the room and she's like, oh my gosh, the positioning of the the way the mom's latching, all that. She fixes all of that and like oh, my God, that's amazing.

So, IBCLCs do so much and even I've had, you know, babies come in with severe tongue ties, but with a really great IBSLC, they're able to do it to where it's so less painful and effective.

So you really need those two perspectives. And sometimes if it is a little bit older child or more complicated, there are speech language pathologists or occupational therapists who specialize in infants and feeding and they can also help.

My first go-to would be an IBOCLC. So those are really important pieces. And in our study club that, you know, did zero to three-year-olds, and we were talking about feeding and infants at tongue-tied for probably seven years, that's all we talked about.

Our study Club, which is people all over the greater Houston area said our goal before cutting a baby was that we had them functioning at the most ideal way they could be.

Like everything was ideal about their body, their cranium, they're function, everything else prior to cutting. That's the ideal. And then when you do the surgery, you can expect to have a great outcome in lots of different ways.

Sorry, that's what I mean. It's a big topic for me, and it's not just about looking and going, oh, I see it. Because this is another thing. So we talked about babies in the last episode having born very retronathic.

Their lower jaw is very set back. The mom probably had breathing issues at birth. That affects how their lower job grows. So when they come out, if you have a baby with an airway issue, the phrenum is laying across the genioglossus muscles, which are…

So can you tell everybody what the… Yeah, so this little string I see. Under the toe. Got you. So everybody has one. But that phrenum is a little attachment that lays across these muscles that are airway dilator muscles.

If you have a patient of any age that has an airways as a primary issue at that time and you just go in and cut the phrentum and then you haven't really dealt with the air way issue, that new phrendum it's going to form tighter and shorter most likely because it is more important to hold the area way open than the way you speak or swallow.

So it's really important to know that ahead of time. And sometimes you have to address some of the nervous system and all the other things related to airway.

A true tongue tie is fibers similar to webbed fingers or web toes.

Birth, Bodywork, and Team-Based Infant Assessment

So, it is incomplete apoptosis. When you're inside the womb, everything is like a little web. And apoptosis is when everything separates and those extra cells go away.

And underneath the tongue, when you have a true tongue tie, which you can look at histologically, it's incomplete apop-tosis. However, sometimes you could have phrenum that looks like ancaglossia, but it is really just, you think of more armored fascia that has something.

with the rest of the body. And one of procedures that we would do in our practice, laser-assisted functional therapeutic release, laughter, sometimes goes baby lace, oral lace different things, but we're using a very specific laser that it can release the fascia onto contact.

That was a differential diagnostic tool because when I would use that, if I saw that front end double or triple in size, like right there in the clinic, I'm like, "I don't think I have a structural problem here." And sometimes they would have an immediate like, Oh my God, breastfeeding was better.

This was, better, this was. Better. Do I need to do it? It's like I don't know yet, but if it tightens back up, I know I. Need more people on the team because something else is going on here.

Does that make sense? Yes, very much so. So here's a, here is a question. If a parent has no idea that they may have a child that has a tongue tie airway issue, what would be the way that an infant might position themselves when they're laying down?

Like, let's say they are on their side. What would they look like to try to make an air way? That might be a clue. Yeah, so in general, if you lay an infant down on their back, they should be able to have their mouth closed and breathe quietly.

If that infant is struggling and, you know, wiggling, crying, twisting, turning when you're laying them on the back that's a pretty good sign they have an airway issue.

That's not normal. I'm not sure if that's what you mean. And again, you can have lots of more C-shape, but that could not just be a physical restriction, it could be the tongue functioning as though it's restricted because there's

dural tension throughout the entire baby or there are other things going on.

For parents who are watching this, they're like, I wonder if my kid has a tongue tie. I should have my kids assessed for a I would probably start with an IBCLC and just assess how is the feeding, how's the function.

Or if you go to your pediatrician or your pediatrics dentist or someone else or you neighbor says that looks like a tongue tie. Again, the thing for me is yes, go and have someone look at it.

In Brazil, they have a law that they passed 2016 maybe. All infants in the first 48 hours of life have to have their tongue inspected and they a validated protocol.

And the reason that is in Brazil like other countries, the government helps to pay for problems. Here, that's not the case. So there is enough research, particularly a lot out of Brazil, it says if you have a tongue tie, here are all the things that you might have to deal with later from a medical, dental perspective.

So it's a no brainer to go and have within the first 48 hours of life, this validated protocol that's hundreds now, thousands and thousands of babies at thousands hospitals.

It's validated. So if the baby qualifies on that as restricted, they get it done. That's the priority. If it is questionable, then they have to come back at X amount of time and do some things in between.

Yeah, so I think it's really important that we have someone look at it. But if you have somebody look it, it doesn't mean like, oh, its restricted. Yeah.

Let me cut it right away. Even if it is an obvious one, in my opinion, you need to do a little bit of work in the ways that you've been talking about before the baby is ready for a good outcome.

I'm so glad you unpacked that because I have grown so much more. I defer to that multidisciplinary team and, you know, we have a group of chiropractors in the area that do just outstanding mother-baby dyad and chiropractic care, like you were talking about the whole occipital area.

Now, what You mentioned that in Brazil, they have the whole list of all the other things. I'm thinking of a lot of the things that we tend to see, but what are the thing that are on that list potential challenges that a child that has a tongue that doesn't move appropriately?

Would you just kind of go through that, Amy? If your tongue is restricted, you cannot swallow properly. Of course, you'll be swallowing and eating, but you're going to have some type of altered swallow pattern.

Your tongue is the driver of growth and development for the face, jaw, and airways. If your pattern of swallow is altered, it's going show up in your whole face.

You're gonna have this color swallow This color color pattern as you grow cross spikes narrow crowding all that kind of stuff and again and the previous one we talked about how the width of your face is the Width of Your Airway we could think of it like that and in front of the spine behind the jaws is The Depth Of Your airway So if you have an altered swallow pattern, you are not going to grow forward and wide as you were meant to.

So that's dental problems, all sorts of them that can come from that and a variety of depending on what you adopt as your altered swallowed pattern. periodontal disease, airway, breathing issues.

And then altered swallow pattern and breathing issue relate to your whole entire system, right? So typically, if you have a tongue tie and you're not able to swallow properly, you are going to more likely be a mouth breather, not 100% of the time, but the tongue is restricted down and it's meant to rest up, which opens up that air way when it's resting the right way.

So when its resting down, you're more likely going to be a mouth breather and that creates a whole other host of

issues, right? Our nose is meant to clean the air as it goes back and when we're not nasal breathing, we are more dehydrated, our teeth are drier, more prone to cavities, are you know, genital tissues, tonsils and adenoids are taking on a lot of things that they might not otherwise be taking So there's all of that perspective.

And then the whole body itself is kind of like you might have a shoulder up. You're going to, if you look, I mean, that's what all our patients, we took certain pictures of them and it's fascinating to see how the gate, and we would also take videos of the walking, but how their hips are aligned, how they're feet are changed, all that has changed.

Yeah, I'll go into what happens if you throw braces on top of that or expanders on that whole system that's out of whack, but those are some of the side effects that come to the top my mind.

Yeah. And I will just say too, of course, if your sleep is impaired, then you have an epidemic of attention deficit hyperactivity disorder where all these kids and adults are receiving medications that it's their airway.

Yeah, they're not sleeping. They're, not getting anything quality. And then, nighttime when you sleep and your tongue is supposed to be pumping, lymphatics, you're no flushing the toilet at night.

All of the neurotoxicity stuff that is going on up here because of, the diet and the environment, everything else, that tongue exerts 500 grams of pressure on the palate on every swallow.

We swallow a couple of times on times a day. At nighttime in particular, all of that's supposed, to dump and it doesn't dump. And then food, I also forgot that, but like people who don't, who have tongue tie and can't swallow properly, they're generally not chewing the food as well.

So they've got all kinds of indigestion issues, constipation issues or diarrhea, all these other constitutional symptoms simply because of their inability to really chew the even eat certain foods.

A lot of them will, you know, can't swallow pill, they don't eat chicken because of this or that, and there's like texture issues because they can get it down because the can swallow properly, so it leads to a whole bunch of other.

Effects of Tongue Ties on Feeding, Speech, and Development

I'd like to thank Fagran Genomics for sponsoring our podcast. Without knowing what your precision genetics are, you don't have a roadmap. So please log on to our website, schedule a welcome call, and see what the Wellness Blueprint can do for you.

That's the premier and proprietary genetic panel that Fogran has allowed us to create. Yes. And you know, these kids who come in that have a lisp and everybody thinks it's cute, and then you look, but they're also presenting with, you label it, phonological disorder, go see speech therapy.

But if you don't have the speech pathologist that understands myofunctional therapy and how that ties in with everything, I have had just these beautiful stories, you know, families that come in and then all they needed was to have these tethered oral tissues addressed and the child has their voice back and everything comes into line.

Would you tell the story about the Child with Soto's Syndrome? Yeah, it's a great story. I think I was relatively, you know, a few years into treating tongue tie and also treating special needs.

We had a way that we did that. And so this one came in and he needed to first have sedation in order to get everything status quo because he had And so we like to get them settled.

And he wasn't a perfect one. In his case, we didn't send him out for all the stuff ahead of time because we had him sedated and I saw the tongue tie at that time.

So in that circumstance, you make the best call you can per patient. I went to ask the parents, rather than doing another sedation, he only had five or six words.

prior to the surgery. And I said, do you want to do the tongue tie today? We can do it. I didn't know it at the time, but later when it was in the New York Times or wherever, they were Googling tongue-tie.

But they also knew me and trusted. They're like, yeah, okay, go ahead. So he was speaking in full sentences that night. It was really powerful. After that happened, I had so many people call, which is a little bit of a different topic, But it broke my heart because from other countries, parents would call and what I was hearing was that they were being dismissed sometimes when they felt like their child had a tongue tie, especially when there was a special needs component to it, autism or other special your kid has X, so why do you even just leave him alone?

Why even bother?" But everybody should have the right to have that best airway that they can have, speak, breathe, eat, and all that kind of stuff. But that opened up a whole other world for me of just feeling so much compassion for what people are going through.

Yeah, I've seen plenty of stories. I had moms call me the next day and, oh, he said, mommy, for the first time. There's just so many wonderful stories that come of it when it's done and needed.

Yeah. I'll never forget. It's been probably about seven years ago, and I was newer to my functional medicine practice, even though I'm an older practitioner.

36 years now and I just didn't know what I didn' know. And you kept bringing up IBLBC and that's a lactation consultant for the listening audience. But I learned about tongue ties when I used to work for Texas Children's as a pediatric and newborn hospitalist and learned procedures and now I'm like, oh, I learn the wrong way, you just cut it and go.

but I will say that there were some really lovely stories the mom goes, Wow, this is great. My baby can suck. But one thing that broke my heart was this little infant and his parents were bottle feeding, but he was so restricted.

The formula just ran out of his mouth and, you know, there were obvious things that we could do. Also, if you don't consult a pediatric dentist, Ear, nose, and throat doctors will go, well, there's no tissue I can't cut or I cannot do anything here.

Would you care to explain what potentially like a submucous tongue tie or restricted tethered oral tissues and how you deal with that, with the whole picture?

If you don't see anything that you could do something to, how would you assess that? And I will say, there are some ENTs who are now really learning more and doing that.

So I think your question is when the patient has all of the signs and symptoms of tongue tie, but you can't really see a phrenum. And again, to me, I know that there people who were really well known in this country who would say I just cut, you know, and you kind of go in there.

The thing about what we've just been talking about, Paula, is that you made a difference in some of those baby slides and we can't really know, right?

I mean, my first infant tongue tie was working in a surgery center and I used electric artery and that mom was like, Oh, you know I have no idea what happened to him after that.

But yeah, there we do what we know. And sometimes even when we didn't follow all the best guidelines, good things can happen. Terrible things can happen too.

So with the submucosal, yeah, I would never cut on it, but that's when I come in with that non-invasive laser procedure and using that or a body worker.

Basically, that not invasive laser procedures is doing something that body workers can do like chiropractors and osteopaths and they're getting in there and finding out why is there nothing visible here but the tongue is usually

planted.

It's anchored to the floor of the mouth. So, that usually means there's something upstream or downstream going on that's causing that and we want to release all the adjacent tension and get things more ideal.

I have a presentation, a lot of presentations that I give, but on this one in particular, I actually show how it looks at once when they first come in and then we do the procedure same day.

You can see the frenum and the we sometimes have to do it several times and that frenom is crisp. and clear and easy to see. And that's the only time when I would assess and say, yes, this needs to be cut or not cut.

But you want to address that, you wanna look deeper into that when you can't see the front end and the function is so low. It's good that ENTs would cut in that situation.

Sometimes people do cut, they just kind of push everything down to get a view of it and then sort of go right there and hope for the best. That's almost always gonna be a situation where the healing is poor.

Yeah. Well, and when I think about how much more important it is for a dentist to assess because an ENT isn't necessarily thinking unless they're trained how the tongue sweeps and can get back to the teeth and clean the tooth and what we do with our tongue.

I love what you talked about the glymphatic system of the brain too, because I think it was 2014 they were able to image that. Gravity also helps pull all that debris and garbage out of while you sleep and making an airway and having optimal breathing there.

I also had a little girl who came in. She was anxious, she couldn't really speak very well, and the parents were really concerned. They thought she seems to understand what we're saying and she'll follow instructions.

But in the first few minutes I assessed her, I went, oh my gosh, You see this right here, she has terribly tethered oral tissues. And then she went and had her airway addressed by a pediatric dentist and the parents were like, you gave our daughter her voice back.

You've had the same thing happen. It's just a beautiful thing. I would say to Amy, what you said about the children that we see who have profound special needs.

And I see the same thing in the autism community. When you're a parent, you love your child more than life, and you would do anything within your ability to help them regain as much function.

Get your affairs in order. You need to have things taken care of so when you're not around, who's going to take care if your child? The only evidence-based therapy is applied behavioral analysis.

Special Cases, Submucous Ties, and Healing Challenges

Ignore diet, ignore all these other things and they just don't follow what would be reasonable medical standard of care to address, like you said, something as simple as an airway and tethered oral tissues to provide, you know, form following function.

You improve the function and then the form corrects itself too. What about The elf, can you just briefly, we've talked about all kinds of things, but you mentioned it, what happens when we throw static braces on the mouth?

But let's talk about the airway in the palate and what an elf is. Okay, I'd love to. I want to mention just a couple more things before we jump off of that.

And one just came to my mind when you were sharing that, and that is just to let families know that there is a brain to tongue pattern. It starts in utero and sometimes there's an issue with the brain-to-tongue pattern, apraxia as an

example, and it's often misdiagnosed or undiagnose.

And an aprazia child getting a tongue tie release without the proper preparation can be a really terrible situation. So I just wanted to mention that.

Then I know at some point you wanted talk a little bit about lips and buckle ties. I don't want to forget that Spartan, I'd love to talk about that as well.

Well, before you go on to the alf, can you explain what a lip tie up here is, how significant it may be or may not be, and then what buckle yet other ties may.

Yes, I would love to. So with the lip, most of us are born with what we call a class four or a Class 3 insertion. And I wish I had pictures, but if you lift the lift up, you can think of it like you could see mine kind of personal, like see the little string up there.

Yeah, okay, so that little string when it attaches all the way to where the gum stop and there's no teeth and even wraps around That's what we call a class four and that's pretty typical and then class threes It just kind of goes to the edge but doesn't wrap around so almost everybody's born with that insertion pattern But I haven't had this talk in a while, but a huge I want to say Three out of four or a higher percentage outgrow that by the time the adult teeth are coming in So from that standpoint, it's pretty normal to have a low lip attachment and it is not necessarily something to worry about.

When we're looking for a restricted lip, also a lip is generally not going to cause speech or feeding problems. It can impact a little bit, but it will not be like the tongue.

However, when it comes to nursing, let's say for example, When I'm assessing, I am trying to see can I hold the lip, not when they're screaming and crying and all tight, but you know, kind of playing, can i hold it and bend it back and can it flex to do that?

Even if it looks thick and ugly or whatever, like can't it move? Is it supple? And so what you're looking for is can that lip divert and go onto the nipple or the breast or bottle so that they're not leaking milk.

And if they can, then I wouldn't do a surgery on them because I know that most of them are going to outgrow it later. The second time the lip might become an issue, let's say it did well and they are doing fine, the baby teeth come in and it's a really thick one that goes through.

Again, this isn't the lip that's the problem, but if they're having a lot of processed foods, this is an area that can very easily get cavities with thick phrenum kind of in the way.

But they are typically doing other things, having cavites in other teeth. So if I'm having to restore cavités and there's some demineralization or issues here, I am going to want to release that lip at the same time.

Okay. And then for the buckles, we have like seven attachments all around, but the two that sometimes can become an issue is also here. Again, most of the time when you pull the lip out on an infant, that attachment is going to go pretty low.

But what we're looking for is tension, and these are quite different than the lip or the tongue. And something that I learned from working with body workers, really good ones, this is actually the end of an entire fascial train that runs right through the sternocleidomastoid.

It's impacted especially in torticollis and plagiocephaly babies. So you can sometimes release this one and have a whole change pretty fast. However, I prefer working with a body worker who like gets them really ready for that because if you release it and all of this hasn't been addressed, it'll just tighten right back up because you're going to have a freno.

So if it's in an appropriate place and it is not real supple and moving, It can affect the way they swallow, the they eat, holding, you know, milk leaking, things like that.

But just cutting it, can form and be tight again, even though it might be a little higher up. point is body worker doing all that they can do to release the tension because our fascia were connected from head to toe, our tongue is connected to our toes and all of that.

So this is very, very commonly associated with babies with preferences, torticollis and things like that, and if you have a baby with torticalis, do not release that tongue tie until they have had a green light from bodyworker.

So torticollis, would you let everybody know what that is? That's after eight weeks of life, your baby should not typically have a head preference where their head's more often one way.

And then torticalis can be at birth, you can have it as an adult, but it's basically where things are kind of twisted and tilted and the baby tends to be down and to the side more oftentimes.

When you check them, like if you lay them on the back, if roll them one-way and they're fine, when you roll the other way, they can't even really lay their head flat.

So that is, again, babies formed from head down and sometimes, especially if a baby's had like a vacuum birth or these other kinds of births, that creates patterns in the fascia that go throughout the whole body, torsions and things like that.

And so that can show up in rest of the body and function and those things really need to be addressed before you start cutting any tissues, even if it's an anterior tongue tie.

But you will have times where a body worker says, okay, Amy, you know, like I've done X, Y, and Z, I have gotten maybe as far as I can. I need this released now.

And then they go right back in and are working with it. Otherwise, it can get restricted again, so to speak. All I was just to mention is that I always tell families it's not hard to do a tongue tie release.

And so I would get a lot of re-consults like, oh, doctor, so-and-so may have not done a good job or whatever. Anytime you've had a tongue tie surgery, I always assume it was done well and right the first time.

And my first thing is let's figure out what's going on and caused it to either scar down and heal poorly. It's not really a reattachment because the fibers are ablated, but like why did it heal this way?

Figure that out. They have a second. a third and even a fourth surgery and, you know, oral aversion and trauma and all of that. And we had just briefly, it's multifactorial why it could scar down like that, one thing when we do our wellness blueprint, I had mentioned that is we identify something called tumor necrosis factor alpha and if that doesn't work appropriately, There are things that you can do to optimize lowering the inflammation in the body.

Lip Ties, Buccal Ties, and Torticollis

But as you said, it's all these things all together. I love what you brought up about, because it also makes me think about headaches. It's headaches in children.

A child should never have a headache. When we think of cranial torsion and the way things Just recently, Dr. Cheng Ran, who I know you know Dr Cheng very well, that looking at patients with connective tissue issues, Ehlers-Danlos, and how that feeds in and then what can happen to the fascia, fasci, as you say, fasha fasca, tomato tomato, but how the cranium when it is distorted and you know, you don't know what you do know.

You don t know until you look at somebody and their shoulders riding higher than the other, or you put your hands on their hips and one leg's riding high than other.

And I'm like, my first stop, go see the chiropractor. Unless it's a terrible scoliosis, it s game over at that point in time. But it is like you body workers are it.

I mean, they're fantastic. So now, Tell us about the… Okay. That's a great segue. So my really good friend, Tasha Terzo, she wrote the Alpha Coach book and that's great book if you're curious about it.

But she has a video where she'll show a cross bite and putting a… You might want to do this in your practice. You put a tongue depressor between the teeth so you disclude them.

And then you have the patient lean back over and sometimes there's no scoliosis. It's actually stemming from the teeth. The mouth. Yeah. Wow. Her passion is teaching osteopaths to go inside the mouth because if they treat a patient and have what's all good and then they get off the table, bite their teeth together and walk and they're like back in the office again, they are missing something here.

And she teaches dentists to not just look here, but to look at the rest of the patient. That's a great segue into ALF. In my mind, there's two approaches, which is what I talk about with families when I do comps.

There's the traditional approach, and then there is this less traditional process, more osteopathic. Osteopath philosophy is that everybody has everything they need inside of themself from the time of conception to be their best self.

Our goal is to just get connected with their system to see if there's any barriers. A tongue tie might be a block or barrier, and then to enrich the environment, which is what you do with all these supplements and things that we take in our family that help with what we're genetically predisposed to, minerals, whatever, all of that stuff.

So ALF is really looking at the whole patient. And then when you're talking about expanders and a appliances that cross the midline. Sorry, yes. Can I ask you, what does ALF stand for?

Yeah, actually several people say different things, but it's advanced light forces type of appliance. It's just a functional appliance that's made with a really light force wire that resonates with the natural motion of cranial motion.

So an ALFE appliance increases cranio motion, and it mimics some of the things that should be happening anyway and helps you to get there to where you're creating that motion.

So traditionally braces, Invisalign, expanders, like all of these appliances that cross the midline and sort of lock on, they inhibit cranial motion So what you can think about is if you had a patient that had asymmetry in any part of their body, it's because some of the fascia is moving and some is restricted.

And then you put an appliance in and you're like, okay, they need to be this wide. So you start that widening process or whatever you are doing, every action has an equal and opposite reaction.

You can't change that law. That's true. And so the part that is, it's mobile will move and change. And you can't see this with your eyes, but I have shown when I teach dentists, like you see someone will post like, look at what I did to the airway and they'll show the face picture and then the side picture.

They're highlighting this tiny part of the airway and like, look how much bigger it is. What I look at is like we had a natural shape to the upper spine in the pre-picture.

And here's what our face looked like here. The post picture, we have no more curve in upper cervical because we did this force that pulled it out. If you measure the patient's more asymmetrical.

than they were to begin with. That doesn't happen to every patient, but that is what can happen. And to me, that's, again, about what we talked about at the very beginning of the other podcast is it's like me looking at you and saying, okay, let me do some calculations.

The first step that orthodontists use was based on one white kid. during the time of eugenics or whatever. It wasn't even healthy. So it's like me going, no, let's see, we need to do this and that.

Let me put the right forces in and let me get going. And I'm forgetting that what I am doing here is affecting the whole rest of the body. Alpha is different.

alpha is such a light appliance. it is not meant to be used as an expander.

ALF Appliances and Whole-Body Orthodontic Approach

Sadly, when dentists If they don't have enough training and if they're not able to kind of step out of this mechanical paradigm and they start using it in the same way that they would use the other appliances, they get frustrated.

They tell their patients it doesn't work, you know, all this other stuff. But ALF, the designs are generally very simple, especially in pediatric patients.

The first thing it does is creates more cranial motion. which is why sometimes we see miracles right away. It creates the motion similar to what the tongue would be doing, which aids in glyphatics.

it draws the tone like a magnet up to the mouth, Which is, why in a well-placed alf and in patient that's got what they need to have going on in that care, sometimes the first month nasal breathing, you know, sleep changes, bedwetting stops, that can happen like really, really fast because it's nervous system things that are changing.

And then the general summary of ALF is that the ALPHA again is not making the changes. The ALPH is helping the patient's tongue to come up to start functioning properly.

That tongue is the driver of growth and development. Proper function is to driver up the face coming forward. And so ALFF patients at the end of the day are more set symmetrical.

Their faces have come forward and wider, their shoulders. When I'm done with the case, shoulders are good. When they're to the side, I want shoulder, DMJ, shoulder hip, knee, ankle, all aligned in that view.

Yeah, we want the breathing well, sleeping well. And that's what you get. But you're doing it in a completely different approach, if that makes sense.

Yes, yes. So I really appreciate that explanation for everyone who's listening that there's alternatives to what you can do that it allows the body to function and move the way it's supposed to.

Well, Amy, I'm so grateful for your time today and you've really equipped our listening audience with some excellent pieces of information and encouragement and really drove home how important it is that the body needs to be functioning very well before you go in and do anything surgically or by laser, and I kind of refer to that as a surgery, you know, to loosen those tethered oral tissues.

And man, we could really learn something from Brazil too. Yeah, absolutely. It would decrease the cost. This is kind of the way I look at our precision genetics, too.

It's like, if I had known how my body worked and what I needed and didn't need, so many things that had happened would not have happened. But hindsight's 20-20, and we have these gifts, these blessings.

Now, before we go, would you please let people know what's going on in the Houston area that is a new passion of yours? Yeah I have to tell you this before I do because I know you can edit it out but your precision genetics have helped our family so much like my nephew who had the gene for celiac and we knew since birth.

Yes. And so I here at Autopathy and these other things that you shared with us have helped us. I mean, like I would have given her collagen and that makes her crazy and just other simple.

So I'm just so grateful for that. We loved working with you with patients because when we knew they had that TNF, we approached things quite differently from a surgical standpoint.

Well, I really appreciate hearing that. And, you know, for our listening audience, too, when we think about what she said, collagen, it's about another genetic finding called GAD1, glutamic acid decarboxylase 1. We think collagen amino acids, let's do that, vital proteins.

Well if it got a lot of L-glutamine, because L glutamine is something that helps the gut, well for a lotta people that's fine, but if you give it to folks, same with bone broth or chicken chicken bone broth versus stock bone or chicken stock.

It makes you nuts and anxious and you're like, this is supposed to be helping me. What's wrong with me? So we have no idea. Great. And your kids, it's just a disaster.

Yeah. Appreciate that information. Yeah, so I'm opening a new practice, which I am excited about, and I m opening up a practice that's just zero to three-year-olds because that s where I feel like there s a lack of providers that are able to kind of look at the whole patient and help get the team together and really help that population.

So I'm excited about that. Also something that I learned in my practice is that oftentimes when the little ones coming in and they're struggling, the parents are struggling a lot too.

And we kind of talked about this just guilt, or the birth trauma, not being able to breastfeed, all the different things that happen. I remember my husband, Evelyn, when I was trying to feed her and he's like, I thought this was supposed to be natural.

I can't do it, it doesn't feel natural. So all of that's happening and there's stress on the parents. And so I have another business called St. Tora that I've been working on and I decided to kind of open them in tandem.

What that means is that when families come and i'm able to support them with their babies, I also have, some people call it biohacking, but it's bio-tuning technology.

It's a way to help parents kind come back to center to empower them. Some of it is just as simple as grounding or a variety of things that are free if you want to do it out in the world, but it's just helping parents to have a space in that same place to go and use different pieces of technology.

We'll also have breath work and meditation support and people like you coming to speak to our families and supporting them in a way, kind of like a little support group.

So I'm really excited and hopefully that'll be the first quarter of next year. And yeah, I am really grateful to be stepping back in in this new way after a bit of a sabbatical.

New Practice, Parent Support, and Closing Reflections

Yes, and I just think the whole vision of helping mom and dad and the rest of the extended family because it's true when your child is suffering in any way at all or something as basic as being able to feed them and nourish their bodies and then a woman feeling totally inadequate because they're having trouble.

I remember with my firstborn and here I am a pediatrician, I ended up having a C-section which I never thought would happen. First of all, strike number one.

It never even crossed my mind. And my mom, who had never breastfed, I'm there trying to get my baby latched on. I have massive breasts, and I am trying get her latch on, And I feel so inadequate. I'm tight. And I know when I meet mom is here, it's like, okay, let's get you all propped up and comfortable in some pictures or pillows.

And if I had just had that help, it would have changed everything. It would've changed to everything and the moral

of the story is I have one more C-section and then by God's grace, I was able to have two V-backs after that.

So, you know, even though they say no more, It's like you can sometimes sneak them in and it's a blessing. to you is that, again, we all have this thing we come here to do, whatever it is.

We don't know. And if you had not had those experiences, you may not have had the compassion and the passion to pursue what you have and to help so many moms and kids.

I think that's a beautiful way to wrap up the podcast that people who are passionate, like you said, when you were 18, you didn't know what you did not know and you had dental phobia.

And it's true. It's like when we've walked through what our patients have walked, we're able to be loving and compassionate and kind and respectful and honorable and meet them where they are.

So, and that is the epitome of what the The core of functional and holistic medicine is addressing who we are spiritually, emotionally, mentally, in order that all those other downstream things flow from there.

And that's exactly what your vision is, I believe, addressing those core challenges, the body trauma that affects from the inside out. Again, thank you for your time.

This has been so fun, so informative, and I can't wait for our listening audience to be blessed by what you have to share with them. So much. Thanks for inviting me.

I really appreciate it. If this episode helped you, follow and share it with someone who needs it and leave a review. It helps others find us too. For a free consultation, visit our website at GetToTheRoot.com with a number 2 and schedule a welcome call.

We'll see you soon.