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Is Your Child a Mouth-Breather? There's New Help at the Dentist

By Janet Carlson

"If you can see or hear your child breathing, that's a problem," said Dr. Benedict Miraglia, a dentist in Mount Kisco, New York, who spoke at a recent seminar, "ADHD and The Role of Sleep," in Hartsdale, New York. Seeing or hearing what should be silent and invisible is a clue to obstructed airways — which are often associated with snoring and sleep apnea, and increasingly, in children, with jaw malformation, a bad bite, sleep-deprivation and even ADHD and ADD — all of which can stem from mouth-breathing, which he says is also associated with degenerative inflammatory diseases later in life.

In an April 2013 *New York Times* piece titled, "Diagnosing the Wrong Deficit," clinical assistant professor of psychiatry at the NYU School of Medicine Dr. Vatsal G. Thakkar points to ways in which sleep deprivation can masquerade as an attention deficit disorder. "Researchers and reporters are increasingly seeing connections between dysfunctional sleep and what looks like ADHD, but those links are taking a long time to be understood by parents and doctors." Still, we've come a long way in the last couple of years, according to the American Academy of Physiological Medicine & Dentistry, the seminar's host.

Most parents bring their children to the dentist because they're concerned about crooked

teeth. “The teeth are incidental,” said Miraglia during his presentation showing dozens of before-and-after photos of young children ages 3 to 12 who started out with crooked, crowded teeth, lower lip hanging open (a telltale sign of the mouth-breather), a “flat” profile from cheek to neck lacking in topographical distinction and tone, and slower overall body growth.

A dentist trained in airway management gets to the problem that’s more urgent than crookedness: oxygen! These children need more air, especially at night when the brain should be calmly doing its prefrontal cortex housecleaning to clear away the free-radicals generated during a busy day of thinking, reacting, processing. Instead, these brains are in a state of high alert in efforts to get more O2 delivered. Survival is more critical than housecleaning and uninterrupted sleep. The child may have no difficulty falling asleep and show no obvious signs of insomnia. Nevertheless, the brain is not resting and the sleep is not restorative.

Here’s how the dots connect between mouth-breathers and attentional issues: A goodly percentage of children diagnosed with ADHD and ADD display the symptoms because they’re suffering from sleep-deprivation, and often, that’s due to mouth-breathing because of obstructed airways that can be caused by a variety of things including: allergies, a high, narrow palate, a deviated septum that constricts the nasal area, enlarged turbinates (those are the gizmos in the nose that clean and humidify air on the inhale) or even diet. Nasal breathing is healthiest and most efficient; mouth-breathing is a last resort.

Certainly, not all children with attentional issues are mouth-breathers, and not all mouth-breathers have attentional issues, but according to Dr. Sanjeev Kothare, director of pediatric sleep at New York University, “Sleep deprivation impacts 25-40 percent of children. And two-thirds of ADHD kids have disordered breathing during sleep.”

At the AAPMD seminar, Kothare explained that while in adults, sleep-deprivation may manifest as sleepiness and sluggishness, in children, it shows up as hyperactivity, impulsivity and lack of focus. Anxiety and depression can also result. Clear up the airway issue and in some children, the attentional issue is improved or resolved.

There’s a new approach to treatment among a small but growing group of dentists,

orthodontists and sleep specialists. New York City dentist Michael Gelb, D.D.S., is one of these experts who first look at what might be disturbing sleep and breathing. He points to the work of scientists like Christian Guilleminault at Stanford's Sleep Medicine Center, a pioneer in the area of obstructive sleep apnea who has studied premature babies born as mouth-breathers with high, narrow palates. "Many researchers have also shown how mouth-breathing leads to a long face, receded jaw and future TMJ and headache issues," says Gelb. "It's key to open the airway as early as possible — age three isn't too early. It's not necessary to wait until all the teeth are in. We believe in developing the upper jaw and bringing the lower forward instead of pulling the upper jaw back to meet the retruded lower."

What does such intervention accomplish? It not only opens the airway that these structures otherwise scrunch into too narrow a space in the neck, but also brings the whole face into proper proportion in what Miraglia repeated like a mantra during his presentation: "Forward, down and w-i-i-i-i-i-d-e."

Miraglia also insisted, "No need to take out teeth to make more room!" (At least, not in children with narrow arches.) Treatment can widen the upper and lower arches and allow teeth to find their ideal alignment using custom-made plastic nighttime appliances, braces and... tongue exercises! Ideally, during infancy, the breast-feeding baby's tongue pushes at the upper jaw above where the front teeth will come in, and this helps the upper jaw to move forward where it belongs.

Our western "soft" diet after breast- or bottle-feeding isn't helping. We were meant to shift over to hard food right away — no surprise, this early chewing contributes to good jaw development. It's rare to see a healthy bite in children today, according to Miraglia, whereas a hundred or so years ago it was the norm. "Malocclusion is a disease of Western society." But orthodontic intervention, including those tongue exercises, can correct the receded jaws of mouth-breathers up to age twelve. After that, head-and-neck growth is pretty much complete, so improvement prospects are more limited and take more time and determination.

In the after photos he showed, taken at intervals through 12 months, not only were his young patients' teeth well aligned, but face-shapes were brought closer to "normal" proportions.

The dramatic improvement elicited “ohs” and “wows” in the audience. But far more important than the cosmetic effects: These children could breathe through their noses at last — and some of them even showed spurts on the growth chart.

If your child is a mouth-breather, take her to the allergist and pediatric ENT, yes. But don’t stop there. Find a dentist or other airway expert who can join in treatment of the whole picture for the whole child. You’ll sleep better for it.

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Janet Carlson
Writer, author, media-trainer

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