Oral habit

Oral habit can be defined as a tendency towards act or an act that has become a repeated performance, relatively fixed consistent, easy to perform and almost automatic.

CLASSIFICATION

- **Non-pressure habits**
- Mouth breathing
- **Pressure habits**
- Sucking habit
- Lip sucking
- Thumb and digit sucking
- Biting habit
- Nail biting/Needle holding
- **Postural habit**
- Chin rest
- **Miscellaneous**
- Bruxism

THUMBSUCKING

Thumb sucking is defined as the placement of the

thumb in varying depths into the mouth.

Classification of thumb sucking:

1.Normal Thumb Sucking

The thumb sucking habit is considered normal during the first one and half years of life.

2.Abnormal Thumb Sucking

When thumb sucking habit persists beyond the pre school period then it could be considered as an abnormal habit.

3.Psychological

The habit may have a deep-rooted emotional factor involved.

Etiological factors:

- Socio economic status
- Working Mother
- Number of Sibling
- Order of birth of the child
- stress
- Age of the child

Diagnosis of thumb sucking:

A- History

Frequency and duration of the habit, the feeding patterns and parental care of the child is also ascertained.

B- Assess the emotional Status

Extra Oral Examination:

Digits will appear reddened, exceptionally clear, chapped and a short fingernail.

Lips The position of the lips at rest or during swallowing should be observed. A short, hypotonic upper lip frequently characterizes chronic thumb suckers. Lower lip is hyperactive and this leads to further proclination of upper anterior teeth.

Facial Profile Usually convex profile.

Other features:

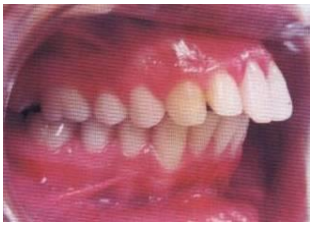
Active thumb sucking also have a higher incidence of Middle ear infections and frequently have enlarged tonsils accompanied by mouth breathing.

Intra Oral Examination:

The type of malocclusion produced by digit sucking is depend on the number of variables like position of the digit, mandibular position during thumb sucking, facial skeletal pattern, Intensity, frequency and duration of habit.

Effects on Maxilla:

- Proclination of maxillary incisors



- Increased trauma to maxillary incisors
- Increased in maxillary arch length
- Anterior placement of apical base of maxilla
- High palatel arch
- Atypical root resorption in primary central incisors

Effects on Mandible

- Retroclination of mandibular incisors
- Retrusion of mandible

Management

The strategy for management of thumb sucking should be started when the child shows any signs of the habit or whenever a familial tendency of the habit is discovered.

Preventive treatment:

1. Feed the child whenever he is hungry.
2. Never let the habit to be started, the practice must be discontinued at its inception.

Chemicals:

It is the least effective method. Bitter and sour chemicals have been used over the thumb to terminate the practice but with very minimal success.

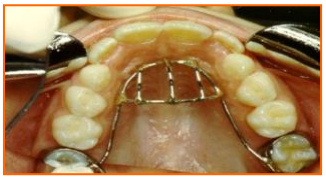
Anti thumb are also being marketed but they have also had a very moderate success.

Extra-oral approach: Mechanical restraints applied to the hand and digits like splints, adhesive tapes. Thumb guard is the most effective extra-oral appliance for control of the habit.

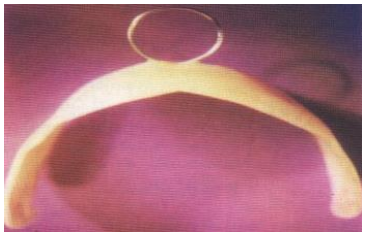
Intra-oral approach: In the oedipal period at the age of 5 years are inappropriate psychologically for this approach therefore the optimal time for appliance placement is between the ages of 3 and 4 1/2 years preferably during spring or summer, when the child's health is at its peak and the sucking desires can be sublimated inoutdoor play and social activity.

Following appliances are recommended

1. Removable or fixed palatal crib: It breaks the suction force of the digit on the anterior segment, reminds the patient of his habit and makes the habit a non-pleasurable one.



2. Oral Screen: Oral screen is a functional appliance produces its effects by redirecting the pressure of the muscular and soft tissue curtain of the cheeks and lips. It prevents the child from placing the thumb or finger into the oral cavity during sleeping hours.

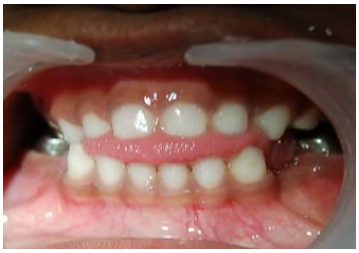
3. Blue Grass  appliance: It is a fixed appliance using a Teflon roller, together with positive reinforcement. Used to manage thumb sucking habit in children between 7 and 13 years.

4. Quad helix this is a fixed appliance used to expand the constructed maxillary arch. The helixes of the appliance serve

to remind the child not to place the finger in the mouth.

Tongue thrusting

Tongue thrusting defined as the forward movement of the tongue tip between the teeth to meet the lower lip during deglutition and in sound of speech, so that the tongue lies interdentally.



Classification of tongue thrusting:

- Physiological: this comprise of the normal tongue thrust swallow in infancy.
- Habitual: the tongue thrust swallow is present as a habit even after correction of malocclusion.
- Functional: the tongue thrust mechanism is an adaptive behavior developed to achieve oral seal.
- Anatomical: Persons having enlarged tongue can have an anterior tongue posture.

Etiology of Tongue Thrusting:

1. Genetic influence
2. Thumb sucking

3. Gap filling tendency
4. Macroglossia
5. Soft diet

Examination of the tongue thrust:

Check for size, shape and movement.

Palpatory examination:

1. Place water under the tongue tip and ask him to swallow normally

mandible rises and teeth are brought together but no contraction of lips or facial muscles.

Tongue thrust marked contraction of lips or facial muscles.

2. Place hand over temporalis muscle and ask him to swallow Normal-temporalis contract and mandible is elevated. Tongue thrust-no temporalis contraction

3. Hold the lower lip and ask the patient to swallow normal-swallow can be completed tongue thrust-patient can not complete swallow.

Treatrment Consideration: Tongue thrusting often self corrects by 8-9 years of age by the time permanent teeth erupt. If tongue thrusting is associated with other habits then the associated habit must be treated first.

- Myofunctional therapy: asking the child to place the tip of the tongue in the rugea area for 5 min and then asking him to swallow.
- Orthodontic Elastics: the tongue tip is held against the palate using orthodontic elastic.

- Lip Exercises: a string is tied to two buttons, one of the buttons is placed between the lips of the patient while the other is held by the patient outside. The outer button is pulled outwards and at the same time the inside button is resisting the forces thereby strengthening the lips on both aspects.
- Mechano-therapy:

1. Tongue crib.
2. Oral screen.

Mouth breathing

Mouth breathing may be defined as a habitual respiration through mouth instead of the nose.

Mouth breathing is commonly observed in children of age ranging between 5 – 13 years.

It is estimated that 85%of the mouth breathers suffer from some degree of nasal obstruction, while others are habitual mouth breathers.

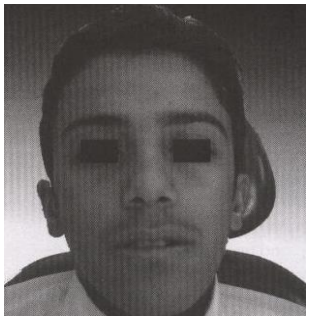
Classification:

- Obstructive
- Habitual
- Anatomic

Clinical feature:

The appearance of pigeon chest.

Oro-pharynx is dry and can produce low grade esophagitis.



Speech acquire nasal tone.

An enlargement of the lingual tonsils at the base of the tongue

Long narrow face

Lips are held wide apart

Upper lip is short.

Lack of tone of facial musculature.

Diagnosis:

1. Observe the patient.

Mouth breathers - lips will be apart

Nasal breather-lips will be touching

2. Ask the patient to take a deep breath through nose

Mouth breathers -No change in shape or size external nares.

Nasal breathers - Demonstrates good control of alar muscles.

2.Mirror test its also called Fog test, take two surfaced mirror and place it on the patient upper lip, in nasal breather the air will condense on the upper side of the mirror while in mouth breather it will condense on the lower side.

3.Masslers water holding test the patient is asked to hold the mouth full of water, mouth breather can not hold it for along time.

Management:

The main aspect of management of a mouth-breathing patient is to treat and eliminate the underlying cause or pathology that has created the haprocedures and appliances that can be used are

1. Deep breathing exercises.
2. Lip exercises 15-30 min/day for 4-5 months .
3. Oral screen.

BRUXISM

The clenching or grinding of teeth when not masticating or swallowing.

Classification

1. Daytime diurnal bruxism Bruxomania

Can be conscious or subconscious and may occur along with para-functional habits.

2. Night time bruxism Nocturnal bruxism Subconscious grinding, of teeth characterized by, rhythmic patterns of masseter.

Etiology:

- Psychological tension.
- Local factors such as reaction to an occlusal interference, high restoration, or some irritating dental conditionension.
- Systemic factors.

Clinical manifestation:

1.Occlusal trauma

2.Extreme sensitivity due to loss of enamel

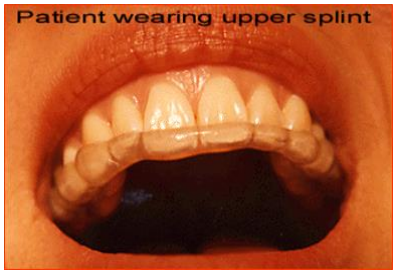
3.Tenderness of the jaw muscles on palpation

4.TMJ pain

5.Associated feature headache.

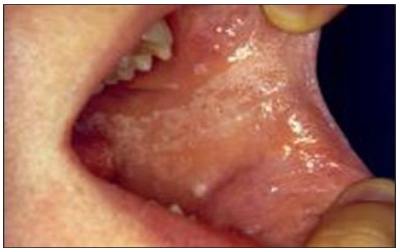
Management:

1. Occlusal adjustments of any premature contacts.
2. Occlusal splint and night guard.
3. Restorative treatment.
4. Relaxation training.
5. Physiotherapy.
6. Tranquilizers and muscle relaxants.



CHEEK BITING:

It is an abnormal habit of keeping or biting the cheek mucosa in between the upper and the lower posterior teeth.



Clinical feature:

Ulceration in the cheek mucosa at the level of occlusion.

Management

- Crib – A removable crib may be constructed to break the habit.
- Oral Screen – A Oral or a vestibular screen may also be used to break.

LIP BITING AND SUCKING: The lip sucking habit is a compensatory activity that results from an excessive overjet and relative difficulty of closing the lips properly during deglutition.

Classification

1. Lip licking/wetting of lips by tongue.
2. Lip sucking habits/pulling the lips into the mouth between the teeth.

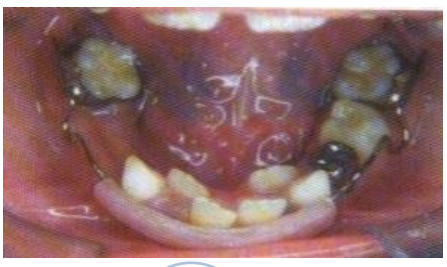
Etiology

- Protrusion of upper incisors
- Retrusion of lower incisors
- Muscular imbalance

Management

1. Psychological approach
2. Dental approach (Mechanical appliances)
3. Oral screen (as in Mouth breathing)
4. Lip Bumper

Lip Bumper is a fixed appliance which is fixed on the mandibular first and second deciduous molars. Full metal crowns or properly made orthodontic bands may be used for the abutment teeth. If the appliance is going to be used in place for any appreciable time, full metal crowns are more likely to hold up under the pounding of occlusal stresses.



MASOCHISTIC HABITS

The child may use the fingernail to strip-away the gingival tissue from the labial surface of a lower cuspid. The habit may completely denude the tooth of marginal and attached gingival tissue, exposing the alveolar bone. The treatment of this habit to break, consists or psychiatric assistance and taping the finger.

BOBBY - PIN OPENING

This habit was prevalent among teen-age girls, was the practice of opening bobby-pins with the anterior incisors to place them in the hair. Notched incisors and teeth partially denuded of labial enamel have been observed in girls with this habit.

At this age, calling attention to the harmful results is to stop the habit.