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Opinion
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Our Life without Sense Organs

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Opinion

Oro-facial functions include motility and oro-facial tonus, breathing and breathing, food and verbal oralities. When there are anatomical and/or functional dysfunctions, the impact on quality of life is major on the physical, psychological and relational levels. The Speech-Language Pathologists Competence Decree provides for the management of patients suffering from oro-facial disorders under the term «Assessment/Rehabilitation of Oro-Facial Abnormalities». The initial training informs the future practitioners to carry out a precise evaluation and details the main lines of rehabilitation. For some years now, some speech therapists have brought the notion of therapeutic touch to speech therapy, a different approach from that traditionally taught. Still little known and little used, the touch has yet demonstrated its effectiveness on oro-facial disorders.

Much pathology has major consequences on the anatomical structures and the functions of the face. This non-exhaustive list gives an overview of the scope of intervention of the speech therapist for the management of anomalies of the oro-facial sphere:

a. Genetic pathologies,

b. Neonatal malformations excluding syndrome (split),

c. Prematurity,

d. Cranio-cervico-facial burns.

Speech therapy consists of:

i. To prevent, evaluate and take charge, as early as possible, by acts of rehabilitation constituting treatment, disorders of voice, articulation, speech and disorders associated with the understanding of Oral and written language and expression;

ii. To teach other forms of non-verbal communication to supplement or supplement these functions.

The speech therapist is authorized to perform the following:

In the field of anomalies in oral or written expression:

a. Re-education of language functions in young children with motor, sensory or mental disabilities;

b. Rehabilitation of joint, speech or oral language disorders (dysphasia, stuttering), whatever their origin;

c. The rehabilitation of phonation disorders linked to a Palatine division or a Bicycle/pharyngeal incompetence; Speech-language rehabilitation is accompanied, where appropriate, by appropriate advice to the close circle of the patient.

The speech-language pathologist may propose prevention, health education or Screening, organize or participate. It may participate in actions concerning the Initial and continuing training of speech therapists and possibly other professionals, the fight against illiteracy or research in the field of speech therapy. The management of disorders of the oro-facial functions is made possible by medical prescription

We present here the main outlines of the speech-language assessment of the oro-facial functions, drawn from our meetings with professionals, our experiences in training and our readings of articles and books.

The evaluation begins with a series of precise questions, complementary to those asked systematically in the anamnestic survey, making it possible to understand the history of the patient and his disorders:

i. The history,

ii. The evaluation begins with a series of precise questions, complementary to those asked Systematically in the anamnestic survey, making it possible to understand the history of Patient and its disorders (G COUTURE, I EYOUM AND F MARTIN (1997):

a. The history of the disease,

b. Date of onset of disorder,

c. Etiology,

d. The circumstances of the occurrence,

e. The mode of appearance,

f. The anatomical structures concerned,

g. Treatments carried out or in progress,

h. Medical and family history.

The investigation is based on questions put to the patient, it allows to

Repercussions of any oro-facial disorders on its well-being.

i. The 5 senses: hearing, sight, smell, tasting and tact.

ii. Salivary and lachrymal secretions.

The Schirmer test makes it possible to objectify the complaint of hyper- or hyposecretion, using a

Blotting tape placed under the eye.

a. Sensations: tingling, heaviness, spasticity, edema.

b. Sensitivity: hot, cold, pain.

c. Functional oro-facial consequences (phonation, swallowing, mobility facial).

d. The impact on quality of life (type of discomfort and circumstances).

The Clinical Examination

The clinical examination makes it possible to highlight the presence of malfunctions

a. Anatomical oro-facial.

b. Examination of anatomical structures.

c. Exobuccal examination.

d. Symmetry and harmony of the floors of the face.

Anatomical Structures

Skull (volume and shape), eyes (shape, spacing, Palpebral occlusion, presence of an epicanthic fold, eyebrows). Nose (shape, implantation, aspect of the philtral area), ears (implantation, Shape, appearance of the helix and ear canal), cheeks, mouth (shape, position at rest), mandible (macro- or micromandibulia), neck. The presence of any cutaneous lesion should be noted (edema, swelling, wound, ports). In the case of cranio-cervico-facial burns, a balance sheet (DIEULOUARD, B. ISENBRANDT, 1998). Temporomandibular joints (degree of maximum buccal opening, By palpation of mandibular movements during opening / closing).

Endobuccal Examination

Teeth and dental articulation (integrity, hygiene, appearance, Gap, skeletal profile, occlusion), lips (aspect, labial brakes), cheeks, Palate and veil (aspect, shape, integrity, size), tongue (aspect, size of Lingual brake, volume), uvula (aspect, size and integrity). A morphological analysis grid included in the EVALO BB evaluation battery was realized by I. EYOUM. It makes it possible to identify anatomical criteria Characteristics of genetic syndromes.

Examination of functional movements

At the face: blink, smile / laugh, tighten lips, Dilate / tighten nostrils, blow / whistle, swell / retract cheeks, contract the chin.

a. At neck: raise / lower head, turn head to left / right, Contract neck muscles,

b. At the level of the tongue: shoot / slam the tongue, lick the lips,

c. In the temporomandibular joints: chewing, yawning.

Examination of oro-facial muscle tone

The balance sheet of the C.R.E.N.O.P.S. (1997) allows to evaluate the muscular force involved in the

Contraction of a muscle group. The rating is as follows:

a. No contraction

b. Draft movement

c. Possible contraction with effort

d. Normal contraction without effort.

The proposed movements question specific muscle units,

Examples:

a. Raise eyebrows: occipito-frontal muscle,

b. Tighten cheeks: buccinator muscle,

c. Blinking: orbicular muscle of the eyelids,

d. Dilate the nostrils: transverse muscle.

Examination of Facial Expressions

The expressiveness of the patient's face is studied through Mimicry (sadness, joy, anger, disgust, surprise) realized on order, on imitation then with a visual feedback (mirror). Examination of oro-facial functions (T, d, n, s, z), labial motility (p, b, m, f, V, ch, j), velocity motility (a, an, o, on, e, in).

Examination of the phonation

It makes it possible to demonstrate the presence of a Velar dysfunction (crack, hypotonia, shortness of the veil). The loss nasal can be objectified by the presence of fog on the Glatzel mirror of the phonation (S. BOREL-MAISONNY, 1969). The quality of phonation is denoted from I to III:

i. Phonation I: intelligibility is normal, no nasoning is observed.

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ii. Phonation II: the velar closure is incomplete. Nasal loss can

Be mild or severe, intelligibility may be correct or disrupted

iii. Phonation III: velar dysfunction is present, intelligibility is strongly altered, compensatory movements are put in place (blows of glottis, hoarse breath.).

Voice Examination

Study of timbre, flow, intensity, posture and Respiratory behavior, verticality during phonation (voice Conversational, sung and projected). Examination of swallowing (V. WOISARD and M. PUECH, 2003). General observations (position of the patient and caregiver during the meal, Inadequate environmental factors, etc.), duration and quantity of catches food - test of the swallowing of liquids by glass and straw to raise Possible disturbances (incompetent lip closure, difficulty in Lingual protrusion, sensory disturbances, disorder of coordination swallowing / breathing.). - notation of compensatory elements: facilitating swallowing positions, Adaptations of food textures, self-control ability of the patient, Spontaneous changes in the diet - consequences of swallowing disorders: loss of weight, dehydration, Lived food intake (avoidance, displeasure, isolation...). Examination of mastication (D. and J.-P. CRUNELLE, 2010 - L. MOUTON and T.LONCLE, 1998).

i. Quality of mastication

ii. Bolus homogeneity after chewing

iii. Bolus propulsion

iv. Origin of the difficulties of mastication (deficit of lingual motricity.

Limitation of buccal aperture, bite reflex, deviation or blockage mandibular. Review of the breakdown (C. THIBAULT, according to M. FOURNIER, 2007) the GUDIN test shows the majority use of ventilation naso-nasal. The patient is asked to pinch his nose, Two seconds and then releasing it. If the nostrils remain contiguous during Relaxation, ventilation is exclusively buccal. - the Rosenthal test consists of performing a series of 10-15 breaths Ample by blowing through the nose. If the series is interrupted or there are Neurovegetative signs (increased pulse, redness, sweating), the patient is considered an oral respirator.

Sensitivity review-Classification of the nausea reflex: the threshold of triggering the reflex. Nausea may be assessed from tactile stimulation. C. SENEZ (2002) a 5 stages of triggering (Stage 0 indicates no reflex and

Stage N is the normal response to endobuccal stimulation):

i. **Stage 1:** the triggering zone is located in the posterior regions of the Palace and language

ii. **Stage 2:** the trigger zone is located after the palatal arch and the Posterior part of the back of the tongue.

iii. **Stage 3:** the reflex is triggered when the palatal vault is stimulated

iv. **Stage 4:** the stimulation of the apical part and the palatal arch triggers the Nauseous reflex

v. **Stage 5:** the trigger zone is located at the level of the gums, lips.

In stages 2, 3, 4 and 5, vomiting, regurgitation, redness may occur associates. Evaluation of proprioceptive sensitivity: thermal, algic and tactile. The Sensory Integration and Praxis Test (J. AYRES, 1989). Sensory integration. Complementary examinations: biofeedback, EMG, electrogustrietry, examinations Radiological, stapedial reflexes, self-questionnaire of quality of life.

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