DR. NANCY LIVE

Featuring: **DR. LAWRENCE KOTLOW**

"ORAL TIES IN INFANTS: EFFECTS ON BREASTFEEDING AND AIRWAY."

Cooper Family AND Pediatric Chiropractic

Dr. Nancy: Hello everybody. Welcome to Dr. Nancy live on Wednesday. I am so excited today to have with me Dr. Larry Kotlow from Rochester, New York, right?

Dr. Kotlow: Albany.

Dr. Nancy: Albany, New York, right. He's a dentist who's been in the tongue tie world for a long, long time. So first tell me a little bit about your background, how you got into all this.

Dr. Kotlow: Well, basically I've been in practice now 46 years. When I first came into practice and I saw older kids with tongue ties, my training in Cincinnati Children's Hospital is if we'd admit them, then they go home the same day. Well back here in the East, they didn't do that. It was overnight for two nights and if you wanted to do it, you had to get a physician's okay for the general anesthetic. So I said, this is ridiculous.

Dr. Kotlow: So I started using electrosurgery and I did that for almost 25 years. But it didn't really work on the babies because electrosurgery is a burn and some of these one- and two-year-olds were in a lot of pain and they actually started to dehydrate. About in 1996 I got involved with laser dentistry and I found that lasers cut quickly, almost painlessly depending upon which laser you're using, and I can be in and out of the mouth in about 10 seconds and there's no swelling. I've done over 40,000 laser surgeries in the last 20 years with no infection. So I started writing some articles about using lasers on neonates. There weren't a lot of people 20 years even looking at these babies, and a large number of people out there who are doing it and lecturing have been in my office or heard me lecture.

Dr. Kotlow: So when I first started, I had people flying in from every state in the union and about 15 different countries. But as I got more and more involved, then I started getting more involved in laser dentistry to the point where the laser I use now, which is carbon dioxide, I helped develop it with the company to make it kind for kids. The lasers, there are other lasers out there such as diode lasers, they are really a glorified Electrosurge in most cases, even though it's a laser, but that is contact and it can burn a little bit. But it still works really well. I used it for five years.

Dr. Kotlow: Erbium lasers also are good, but they don't have the same ability to prevent bleeding. But in skilled hands you don't really get much bleeding. The CO2 laser that I've worked on developing fixes both teeth, bone, hard and soft tissues. So it's the ideal laser to use and we can control the beam size with a computer. So we're down to where we can be half a millimeter. It's very precise, rarely ever bleeding. The people out there who think it's a fad because we buy lasers, no. My lasers were paid for before I bought them. I don't need to do frenectomies to make money on my laser. But the fact is, it's very kind to the tissue. There's no swelling, no infections as I said. It's fast, in and out. No general anesthesia.

Dr. Kotlow: I think no child should ever be put in the OR to have a frenectomy when you can do it in 10 seconds in the office, and they don't have to be NPO, they don't have to go in. I asked one of the hospitals here what it would cost to put a baby in the hospital to do a frenectomy and said a minimum between the OR post and pre OR work $5,000 and that didn't include the surgeon. And we can do it for under $800 in the office and quick and fast. It's just a matter of finding the right person to do it, not somebody who is charging for two frenums or three frenums at the same time, but you get one fee in the most part.

Dr. Kotlow: And it's very beneficial for both the mother and the baby, and I like to include the father, because if the mother and the baby are not doing well, he sure is not doing well.

Dr. Nancy: That's true.

Dr. Kotlow: So that's where it got started. And you know I've created my lecture series, SOS For Tots and I've written the books.

Dr. Nancy: Yep. Got his book.

Dr. Kotlow: You can buy the books online on my website, you can order them through my office. Then I also have an atlas I put together. So all of the articles I've written and all of the books, except for the SOS For Tots, are online. Just go to my website and download it for free. So that's how I got started.

Dr. Nancy: And we have your website going across the bottom down there so they can do that. So let's talk about what is... How does somebody know if they have a tongue tie or their baby has one?

Dr. Kotlow: Well, first of all, if you want to define a tongue tie, you'd need to define it in three different ways. Number one, you have to look at function. You have to look at appearance. But the most important thing is symptoms. Because if someone says to me, every baby who comes to your office gets their tongue clipped. I don't like the word clipped, that's a four letter word. It should be revised. And I said, "That's not true." Babies don't get to me unless they have a problem.

Dr. Kotlow: On my website, you can download the infant examination sheet and there's about 10 or 12 symptoms the mother may have, such as bleeding nipples, breast abscess, thrush, a whole bunch of different things, inability to latch, depression. And on the baby's side, again, there's probably 12 different things such as milk leaking out, reflux. Reflux is really one of the biggest problems I see along with just not latching. And too many of these kids are placed on adult anti-reflux drugs because they have a shallow latch and they're sucking air into their belly, and classically if your baby's having a problem and spitting up a lot, feel their belly. If it's hard as a rock after they take any food, that's not reflux, that's air-induced reflux and all the drugs in the world won't help it. What you have to do is improve the latch.

Dr. Kotlow: So the first thing I'm going to get is symptoms, okay. When the parent calls, we ask them symptoms, we get that. They come in and they fill out the form or they do it online. And then the next thing, which is again not done correctly, is

how to physically examine your baby. It doesn't matter if you have a physician or any other primary care provider, the parent can do it, and that is place the baby's head in their lap facing the same direction as their face and take their index finger and just run it under the floor of the mouth from where like the molars would be. If you get an interference, then you know you have some kind of a tie.

Dr. Kotlow: You can't look in the mouth and say, "Oh it's fine," in the mother's lap because you're going to miss all those ties that are distal to the salivary duct, which some people call posterior. I like to call it a distal tie, which the physician said it doesn't exist. Okay. You know, there's the old expression, if a tree falls in the forest and no one hears it, does it make any noise? Well, just because someone examines the baby on your lap as a mother and they say there's nothing wrong, that doesn't mean it.

Dr. Kotlow: If you've got the symptoms with the exception of maybe pyloric stenosis, it's the only thing that I've seen in thousands of babies, and once you release it, they improve within 24 to 48 hours. So there's no need for the drugs, which studies show can cause broken bones when they're five or six years of age because they're not absorbing calcium correctly.

Dr. Kotlow: So, the first thing is symptoms. The second thing is to do a good examination. When you do the exam, you want to check the cheeks. There are buccal ties, not a lot, but maybe 10% of the kids. If you run your finger across, you can't release the cheek and the baby can't pucker, it's going to create a smaller mouth. I think I've done one or two mandibular ties and barely any buccal ties on the lower jaw.

Dr. Kotlow: And then the upper lip, again, you have to take it and pull it all the way up. Does it blanche, does it turn white on the babies? And you're going to do that also because I kind of like to think of nursing as a coordination. So if this is the tongue and you only do the tongue, you can't get the lip because the lip will stay back here.

Dr. Kotlow: So, again there's people out there who say the lip tie has nothing to do with it. Well, I'm going to do what I think is best for the baby and the mother and if they follow my directions, most cases it's not going to heal back together. They get good pre-care and post-care and that's where I like to have my lactation people and my body workers, cranial psychotherapists, chiropractors, and older kids myofunctional therapists. You know we have to work as a team together.

Dr. Kotlow: But you know, you got people out there who are saying they're the most important part of the team and before you do anything, you've got to see this person, or you've got to do that person. Well you know what? When you have what I call a class four tongue tie, that means the tip of the tongue doesn't move, you don't need five people examining that kid and doing all sorts of interesting twists and turns. You need to release the tie when it's at the tip of the tongue for many, many reasons. Okay. And then you also work with the body workers and every... well, my parents sign a consent. It says after surgery they will return to their... if there are cranial psychotherapists, they'll go back or their lactation consultant they'll go back.

Dr. Kotlow: But it goes the other way around too. You know, they've seen six pediatricians and three ENTs and five lactation people who say there's nothing wrong, but their symptoms don't go away. But they do go away after somebody goes in there and releases the ties.

Dr. Nancy: So what do you say to somebody that says, "Well, my child sticks their tongue out okay"?

Dr. Kotlow: Okay, well then you've got to go back to the idea. How do you breastfeed? What's the mechanism of getting milk out of a mother's breast? Okay? First of all, if you asked me if I would be having this conversation 45 years ago when I was in dental school, I would have laughed. I'd have said, no way. Okay? But now I have this conversation all day long. But the bottom line is, the back of the tongue has to move up and down. So if you can take your tongue and bring it forward, but the back doesn't go up and down, you're not going to create that vacuum that's going to get the milk out, because it's not compression.

Dr. Kotlow: The other thing is the same kids are the kids who can't take a pacifier because here's your tongue tethered to the floor of the mouth. Here's the breasts, your finger or pacifier, which there's another discussion. But okay, if you're going head to head, what's going to happen is the tongue can't go under whatever's going in there. So basically you're pushing it back into the throat and shutting the airway now. Well, as much as they want to eat, breathing is the main primary, first thing they have to do. And if you're shutting the airway down, they're going to break their latch. They're not going to use your pacifier. They're not going to suck on your finger. And this is the kids, oh, the doctor says he's a lazy nurser and sucker. And what happens is you're really cutting the airway off and that's why the baby is breaking the latch, not because he's lazy or anything.

Dr. Nancy: Yeah. So it's important to get that tongue up to the roof of the mouth.

Dr. Kotlow: Well, even you as an adult, the resting position for your tongue is behind your upper front teeth. Okay? And as we go further into the discussion and you understand that we're not doing this just for breastfeeding, but there's a large number of children out there who are mouth breathers. They have some anoxia and what's happening is in the first 90 days of a baby's life, their brain is growing at 1% per day, and by age two it's at about a little over 55% of the adult human brain.

Dr. Kotlow: So if that first 90 days that baby's airway is compromised because the tongue is blocking the airway when they're sleeping, when they're nursing, in whenever it is, the reduced oxygen flow, they have some hypoxia or anoxia, then that's going to show up four or five years later. There are studies out there, they're not anecdotal, that are showing some kids who are hyperactive, ADD and ADHD, it may be because they had lack of air oxygen as an infant.

Dr. Kotlow: And there's a great video called finding Connor Deegan, and you can get it on YouTube. It's a story of a kid who was absolutely impossible and they classified him defiant behavior and all sorts of things. And he had an airway problem, his tongue, his tonsils and his adenoids. No one ever looked, and once they got his airway open, he did a 180 degree

change. And I always show that in my lectures and I've had so many parents come up to me to tell me that that's their kid, and a couple have even told me that was their kid because the child committed suicide in their teens because they just never bonded.

Dr. Kotlow: There's another thing called the attachment theory and that is that bonding between the baby and the mother is a natural thing. And if it doesn't occur, the mother is going to go into postpartum depression. And I see it all the time. A few weeks ago I had a mother come in and she just came in, couldn't even talk, she was crying chronically. She got sent here for me to look at the baby and when I said to her, you know, you're not bonding to your child here, that's what's contributing to some of your depression. She's seeing a psychiatrist and all sorts of people. I said, "Let's take care of the tongue tie and the lip tie," because they were significant and come back in a week and she did. And I said, "How are things?" They're better. She came back in two weeks and she told me, she said, "You know, I feel great now. I'm not really depressed." I said, "Did you go tell your psychiatrist once we fixed your baby's tongue, you got better?" And they did, and he said, "I'm still a nut." But that was beside the point.

Dr. Kotlow: I look at myself when I lecture as wearing many hats, okay. I'm a surgeon. We're doing... again, as a dentist, we're treating not directly but indirectly postpartum depression. We're treating behavior down the line. We're treating the ability for that baby to nurse properly and all of the symptoms that go on.

Dr. Kotlow: You know, somebody asked my baby didn't get his tongue fixed until three months old. Well, you know, did they do the lip is the question. Have they fixed the airway? Have you had the tonsils evaluated? I mean, you have to look at the whole picture, but sometimes again, hyperactivity can be due. So these are the kids that I say, look at your baby. Look at your child. Do they have circles under their eyes? Venous pooling? Do they have big black and blue circles under their eyes? Do they wake up and wander all over their bed all night? Do they wake up a lot at night?

Dr. Kotlow: These are symptoms that that baby is not getting good sleep. And if they don't get what we call REM sleep because they're bouncing around, they don't rest. So they're tired all day long. And as an adult, you know when you don't get a good night's rest, you know how it is working with an adult who's miserable because they haven't slept well. Well, think of a child who doesn't even understand.

Dr. Kotlow: So yeah, the question is a three-year-old who didn't have the tongue and lip done correctly, it was so-called clipped by ENT, the anterior portion was released, but not the rest of the tongue.

Dr. Kotlow: It's like an avalanche of complaints. Okay. First they say it's a fad. This is the medical community. It's not a fad. As I mentioned to you earlier when we were talking, when my kids were born in the '70s, first of all my daughter never had milk. She didn't nurse because we got all our formula from the hospital for free. Now hospitals are supposed to be baby friendly and if your pediatrician gives you formula, you should find a new pediatrician because unless your baby is allergic to your milk, they should be more breast friendly. They should be looking for ways to improve the baby's ability to latch.

Dr. Kotlow: So these babies who are given formula back in the '50s and '60s never had a problem because they didn't have to. They did have problems on the bottle, but it was no big deal. The so-called hippie movement in the '60s started to change things. Everybody wanted to go natural. So today instead of only 20% of American women nursing, we have close to 90% and we have, say 5 million babies being born. So you know, that means only 500,000 aren't nursing and that's usually either the mother doesn't want to or they've had breast surgery or they're on drugs from medication because of whatever reason and that passes through the milk and they don't want the baby to get it, versus like 80,000 40 years ago.

Dr. Kotlow: So it's not a fad. It's a real problem and it's easily fixed. No OR, 10 minutes, but you need a doctor who's going to sit down with you to go over your symptoms. We show parents a 10 minute, 12 minute video, which goes over why their symptoms are there. We explain to them what we're doing, how we're doing it, why it shouldn't be a pair of scissors, why the baby doesn't need general anesthesia, why they need to see the other parts of the breastfeeding team. And then we show them the post-surgical care done properly so that it doesn't heal back together.

Dr. Kotlow: And someone says I never get anything healing back together, that's because they're doing it wrong because they're not fully releasing the tongue. And unless the parent does a full release and after care, follow with their lactation person and body workers, it's just not going to... it has a great potential to heal back together.

Dr. Kotlow: So the first thing the medical community has to understand, it's not a fad. It's a real problem with a window of opportunity, the earlier the better to eliminate the other problems that we might see down the line.

Dr. Nancy: So what are some of those problems that you might see down the line if nobody gets them revised?

Dr. Kotlow: Well, number one, we talked about reflux and adult drugs. We talked about brain development, ADHD and ADD. Those are two biggies. Later on down the line, depending on the severity, it may affect speech. Sometimes it's borderline and someone says they don't do it and then as soon as they start to introduce solid foods the baby chokes and gags and spits up because they can't swallow the food. You can't chew the food. After you eat, your tongue goes all around your mouth. What it does, it's cleaning your teeth for you. That's what it's really doing. And that's what you want to be able to do.

Dr. Kotlow: You know, I have stories I like to tell, three girls in one family and they always went out after church on the weekend on Sunday and got ice cream, and she was always yelled at. They said [inaudible 00:19:52] ice cream all over your dress?" Well, her tongue was right to the tip of the tongue. Once we released it, she was fine.

Dr. Kotlow: There's some great studies that show sleep apnea and these babies down the line, like I said, it can create problems. But think of the problems as a kid, easy to bully or the bullies because he falls asleep in school because he doesn't get a good night's rest. No one's ever looked at it, and I'm not saying there's a causative relationship, but I'd be very

interested to find out and see how many of these crazy people out there who go out and shoot people up, never bonded to their parents, had an adversarial relationship, no one ever looked to see if they had an airway problem, whether it's tonsils, adenoids, tongue.

Dr. Kotlow: But it's really interesting that when I call pathologists and talk about kids who died from SIDS, I asked what was the tongue position? And they said what's a tongue tie? So we need to alert the medical community as well as the dental community because you still have people out there who say, well, the tongue is the tongue. That's it. And we never get this in our residency programs. We never get it in our dental school and it doesn't go into medical school. So unless you attend a course where someone knows what they're talking about and gives you the information, you go back and put it into your practices, you just don't get it.

Dr. Nancy: Yeah, it's amazing too the kids that I work on that are tongue-tied feel so different compared to... I mean there's some severe ones, and after the tie is over the difference how they feel. I'm still amazed every day how one little piece of skin can affect all the way down to the toes. It's crazy with the frenulum, how tight it makes it.

Dr. Kotlow: Yeah, but... I know you didn't mean what you just said.

Dr. Nancy: I know. I didn't mean that, but...

Dr. Kotlow: It's not one little piece of skin. [crosstalk 00:21:43] body fascia from head to toe.

Dr. Nancy: Right. Just the tie.

Dr. Kotlow: Okay. But it's interesting when my assistant is holding the baby who's really tight.

Dr. Nancy: Yeah.

Dr. Kotlow: She has her hand behind the baby's head and as soon as I release it, she feels a pop in the neck because the hyoid is dropping down and the neck is suddenly released and you can feel it. If you ever hold a baby who is really tied tightly and you release it, the second I finish the release, there's a pop in the neck that is good, because all of a sudden everything is released.

Dr. Nancy: Yeah.

Dr. Kotlow: Okay. There's a dissection on the internet. There's a study on the internet that shows a dissection of a body for the body fascia, and when they take the toes and they wiggle the toes, the tongue moves.

Dr. Nancy: It's amazing.

Dr. Kotlow: You know, the question comes up are there studies that link anxiety with tongue ties? Well, first of all, are you referring to going to the dentist? Are you referring in general? Okay. Because if you're severely tongue tied and you're not getting a good night's sleep, you're going to develop more stress. With the tongue tie, yeah. All these people who are out there with those machines so they can breathe through their nose, I attended a course and I asked how many people in this room examined that person for a tongue tie before you give them a machine? And not one person raised their hand. Okay.

Dr. Kotlow: So you know if you're not getting good airway and you're not getting oxygenation and if you're eating and gagging, if you're going to the dentist and gagging, okay, that's going to create anxiety. I don't want to say the tongue cures all problems, but I would say that a tongue tie in an adult can cause TMJ, can cause shoulder and neck and head pain. If you've got a chronic pain, that's going to cause anxiety and stress in your body. So the answer is yeah, I can see that. I don't see it in kids as much, but I do see it in kids when they come into the dentist and they don't want x-rays. They're afraid to lie down in the chair and you put them down, and as soon as you look in their mouth, their tonsils touch, they have no airway. So some of these kids, I said to the parent, I can't even work on them in the office. Let's get the tonsils out of there.

Dr. Kotlow: The pendulum, when my kids were born, take them all out, then it's taken nothing out. So you've got to be careful who you see. Because there's an awful lot of the medical community who is not up-to-date on obstructive sleep apnea in children. The American Dental Association has a policy, all children should be examined for any kind of sleep apnea, and we have a form we fill out and there's like 25 different symptoms and if they rate them from zero to three, and if they're up there in all threes, you know, I send them to ENT, please remove tonsils and check the adenoids and then if necessary, I'll do the tongue.

Dr. Kotlow: So there's a lot of good reasons out there why we should be looking for this and not with blinders and say, oh we don't do that anymore. Because again with ENT, oh, we usually take them out. Now we don't do that anymore. And you know, he sends patients out the door and they come in here and I send them to somebody else and they come back crying you changed our whole family dynamics because my kid is now awake and doing better in school. He's doing better with his siblings.

Dr. Nancy: What do you think about the ALPHA appliance? What's your opinion on that?

Dr. Kotlow: There are different appliances out there that do expansion, they open the airway up, they move the jaws forward. And I'm a firm believer in early orthodontic intervention to help open airways and try to prevent the need for extracting teeth. So you know, the Alpha is one appliance, there are other appliances out there. ALPH seems to work good on the younger kids and they are fixed appliances that don't require patient ability to do anything and take it in and wash it and keep it clean, just on their teeth. So yeah, they're excellent orthodontic appliances that help with airway management as well as tooth position.

Dr. Nancy: Okay. Let's see here. I'm trying to think if we covered everything. What are some other signs? I know like on a breastfeeding mom, the white on the tongue could be a sign.

Dr. Kotlow: Well you've got to be careful because a lot of these kids are put on thrush medication. If you take a wet two by two or a toothbrush, it just comes off the tongue, because if they're really tight, milk dries on the tongue and it looks like thrush, so look for the through for the web like and the cheeks and the palate to diagnose that. But the white on the tongue is usually because a baby is not adequately swallowing and clearing the liquids and it's kind of sticking around on the tongue and just take a small soft toothbrush and it usually will come off with no bleeding underneath. And then you know it's just dried milk.

Dr. Nancy: So then also if a child has a lot of dental decay.

Dr. Kotlow: Well it's going back to what I said earlier, your tongue acts as a toothbrush, it moves around. The other thing, the tongue acts to separate in utero, especially the upper jaw, and it's the floor of the maxillary sinus. So if you have a real high arch palate, it means you're constricting your maxillary sinus also, which may contribute to airway problems.

Dr. Kotlow: So the the tongue can affect tooth decay later on down the line as well as the upper lip. So we get back to the upper lip, people say, oh, it doesn't do anything. Well not every single mother who sleeps with their baby is going to get tooth decay, but every baby I see under say a year, 18 months right now, unless you're on a bottle and sleeping with it, coming in and they're sleeping with the mother at night, and at night your salivary flow shuts down so it doesn't dilute the milk and then you've got again, a whole bunch of people oh, breast milk doesn't contain sugar, well it sure does and if that sits on the teeth it breaks down the lactic acid.

Dr. Kotlow: Because what I saw on my practice when I first started were all these babies who were sleeping with a bottle in their mouth, and what happened is they were getting decay. But that all happened on the back of the teeth. Now I'm seeing the kid across the front of the teeth and these are the babies who are sleeping with the mom, nursing three or four times a night and the milk, when their tongue tied pools up. So it's not the breastfeeding that's causing, it's the upper lip tie within the folds holding milk on the facial surfaces and that's what's causing decay.

Dr. Nancy: And drooling, would that be-

Dr. Kotlow: Actually they drool even more after surgery because it stimulates salivary flow.

Dr. Nancy: Right. Okay.

Dr. Kotlow: Some babies... teething starts at birth, so some babies are early teethers and that's why they're going to salivate.

Dr. Nancy: And then you suggest the myofunctional therapy in the older kids, right? At what age?

Dr. Kotlow: Any child who is old enough to follow directions I try to refer to a myofunctional therapist.

Dr. Nancy: Okay. And for those that don't know, that's like exercising to retrain the tongue, right?

Dr. Kotlow: It's working the whole head and neck too, all the muscles and stuff for the head and neck and face. Anytime I see five and above, ideally I would like them to have a week or two of myofunctional therapy first, but if they drive four hours and they haven't, we'll do the surgery and then make sure they get to the right person. It's not cut and dry. It's not one person's job, no matter who's out there yelling and screaming about it. We need to work as a team and understand the finances of patients, distances people will drive for their child, but we also have to take into account that you can't send a patient home because they didn't do step one before step two, but we can always go back and do step two.

Dr. Nancy: Right.

Dr. Kotlow: Ideally, people should go in sequence but sometimes it's not possible. Milk tongue, there's a lot of things parents say, but that's really not milk tongue. What it is is milk dried on the tongue because it's not being cleaned off.

Dr. Nancy: Yeah, and then they could be put on antifungal medicine or something thinking it's yeast.

Dr. Kotlow: Yeah. I've got patients who are coming in, they're told they're allergic to their mother's milk and they're on $100 a day formula because they were throwing up, filling their body full of gas and everything, and we fixed their tongue and it goes off. Again, it's not 100%.

Dr. Nancy: Right.

Dr. Kotlow: And if the baby's got true allergies to milk. But I've gotten mothers put on milk-free, dairy-free diets. I've got kids with nasogastric tubes that come out in 48 hours. So what I'm saying is, to be perfectly clear, if there's any physicians on it, is that part of the differential diagnosis when a baby has a nursing problem, breathing problem, airway problem is not drugs. It's look at the tongue in the appropriate way to see if that could be a contributing cause before you put the parents through endoscopies and expensive x-rays and drugs and medication. Make it simple.

Dr. Nancy: Yeah. Use that as... Include that in their testing, you know?

Dr. Kotlow: Well I would like every physician when they see a baby for the first time to use my initial examination, which is on my website, they can copy it and do it themselves. So when that mother comes in the first time there's 20 questions about breastfeeding, and if she's got a lot of... sometimes I'll tell mothers go buy a lottery ticket, because you've got so many Xs on here that you got to go buy it. But you've got to understand the symptoms in order to take care of it, and if you don't understand the symptoms you can't take care of it.

Dr. Nancy: That's true. Well is there anything else? Anybody watching, have any questions to ask Dr. Kotlow before we sign off today, or do you have anything else you want to add to our interview today that you might not have covered? You covered a lot of information. Pretty much everything that I think that's in your book too. But get the book, it's great reading, SOS For Tots. It's on Amazon.

Dr. Kotlow: Yeah, but buy it through my website. You'll save money and time.

Dr. Nancy: Okay. Buy it through his website. Let me put that back up again.

Dr. Kotlow: The website, if you go there, it will show you. Just click on it. Also, if you're a professional and you want to hear my lectures, I'll be in Houston, Texas this weekend lecturing, Friday and Saturday. And then in October I'm in LA and San Francisco. They're on my website. And then I'll be in Rochester, New York in September with Michelle Emanuel. We'll be talking together.

Dr. Nancy: The tummy time.

Dr. Kotlow: Tummy time team.

Dr. Nancy: Yeah. Tummy time team. Let's see here. Yeah. Bri, the website's on this crawler below. Can you see that? She's asking where you can get the books to download. You also have an atlas also on the PDF you said on your website?

Dr. Kotlow: Yeah, go to my website and go to articles, go through there. It shows you how to do an exam and everything else. You can also just call my office and tell the staff you want a book and they'll give you the information to mail a check to the office and send it directly.

Dr. Nancy: And that's the book he showed me. It's a little bit hardcover and it's full of [crosstalk 00:33:41].

Dr. Kotlow: If you want the hardcover atlas, that one you'd have to call for because that's not available online or any place.

Dr. Nancy: Yeah.

Dr. Kotlow: But you can download the soft cover and make a hard copy of your own if you want. There's nothing on my website that you can't use.

Dr. Nancy: You're very generous. We really appreciate that.

Dr. Kotlow: I think it's part of fun doing what we're doing. There is nothing that I can think of in pediatric dentistry or dentistry alone that when we do a procedure takes care of usually three people, the mother, the father, and the baby. And it gives you... because I get a response from all the patients after surgery and the letters we get, how we change families lives, how we gave their baby back to them and it's heartbreaking some of the things that come into the office that are just because the baby is tied and they should not have had that problem, and it's so easily to be fixed.

Dr. Nancy: I agree. We have a fellow chiropractor, she's going to see you in Rochester, Dr. Bethany.

Dr. Kotlow: Okay, I see it. We'll be there. It won't be the full SOS For Tots, but it will be about 60% of what I talk about and then 40% what Michelle's going to talk.

Dr. Nancy: Awesome. Well thank you so much for coming on tonight. I really appreciate it. Thank you for what you do. Thank you for training everybody around us. We need more dentists doing what you do. We have a few in town, but we need more.

Dr. Kotlow: Well, anytime you want me back, just give me a call. It's a pleasure. I'm glad you called me.

Dr. Nancy: Great.

Dr. Kotlow: I enjoy doing it. Thanks a lot.

Dr. Nancy: Okay. We have one last question. What's the earliest age to fix the tongue tie?

Dr. Kotlow: Well, let's take a quiz. What'd you think the earliest I've ever done a baby?

Dr. Nancy: Let's see. Dah, dah, dah.

Dr. Kotlow: You're wrong. I had a baby, it was the third baby in the family. They had a home birth and they were local. They called me because it was right to the tip of the tongue. The mother said I don't want to see that baby until it's fixed. It was one-hour-old.

Dr. Nancy: Oh nice.

Dr. Kotlow: Before that, it was my granddaughter. She was 24 hours and 15 minutes. One hour. So unless I start making deliveries in the office, it's not going to happen any better than that. It was their third baby, it was right to the tip and it was during the day and they said come.

Dr. Nancy: Yep.

Dr. Kotlow: You know, a tongue tie and a lip tie and a bubble palate. The high palate is the result of the tongue not causing the upper jaw to spread in utero. Obviously, releasing the tongue if it's really tight will help it go to the palate in cases of an infant, that palate is two bones and as a child and it can be spread, but many times... I mean, obviously the chiropractor, I know some really good body workers who've worked with kids and and enabled structural changes in the oral cavity. But if that doesn't work, like you said, you've got the Alpha appliances, got other orthodontic appliances, we can spread the palate to fix it to a certain degree. But you know, for me, in the infants it's suck training and body work, yes.

Dr. Nancy: Yeah, yeah. We give the parents some things to do at home too to help with the palate to kind of spread that out.

Dr. Kotlow: Yeah, it's why we work as a team.

Dr. Nancy: That's right. It's a great team. Well, thank you so much for coming on, Dr. Kotlow. We really appreciate it and for everybody watching today, thank you. If you find this valuable, please share it. It's some great information and we'd love to have you back another time.

Dr. Kotlow: Just give me a call.

Dr. Nancy: All right. Thank you.

Dr. Kotlow: Thank you. Bye bye.

Dr. Nancy: Bye.