A PARENT-FRIENDLY GUIDE | AGES 2-6

The Airway, Myo, & Phase One Growth Guide

A simple consultation checklist for parents who want to understand what to watch, what to ask, and when to build a team.

Why this guide exists

The years between 2 and 6 are a time of rapid facial and airway development. This guide is designed to help you notice patterns, prepare for a productive appointment, and understand when an interdisciplinary team may be useful.

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This resource is not a substitute for professional medical or dental care. Keep your child's clinician at the center of any health decision.

START HERE

Why ages 2-6 deserve a closer look

You may hear a “wait and see” approach until the early school years, when more permanent teeth have erupted. This guide takes a different, airway-focused view: when a child between 2 and 6 shows signs of skeletal or airway concerns, the goal is not to rush into braces or orthopedic hardware. The goal is to understand what is happening now and build the right team early.

As of the date of this publication in 2026, Straight Smile Solutions® fully supports the active U.S. standard of care. That standard generally does not support initiating active mechanical orthodontics or orthopedic hardware (such as expanders or braces) before a child presents with an orthodontic issue involving at least some permanent teeth. Traditional intervention generally requires the eruption of at least the four permanent first molars and one or two permanent incisors. [1]

> **What “early” can mean**
>
> Early attention does not automatically mean early hardware. It can mean observing growth, checking breathing and oral habits, and coordinating with the pediatrician, an ENT, or an Oral Myofunctional Therapist (OMT) when appropriate. [1, 2, 3]

Think “team,” not “one quick fix”

- Pediatrician: overall health, sleep, breathing, and referrals when needed.
- ENT specialist: evaluation for possible upper-airway obstruction.
- Oral Myofunctional Therapist (OMT): tongue posture, swallowing patterns, and oral rest habits.
- Dental or orthodontic clinician: monitor facial growth, the developing bite, and timing of any future intervention.

The core idea is simple: address the whole child before assuming that a future orthodontic appliance is the answer. [1, 2, 3]

THE BIG PICTURE

What the dental literature says

You do not need to become an expert in pediatric dentistry to have a thoughtful conversation with your child's care team. These are the key points the source material highlights from the cited organizations.

American Academy of Pediatric Dentistry (AAPD)

The AAPD describes management of the developing dentition and occlusion as part of comprehensive oral health care. Its best-practice guidance emphasizes early diagnosis and interceptive treatment when appropriate, with timing based on the stage of dentition. The primary dentition period (ages 2 to 6) is identified as an important window for monitoring oral habits, craniofacial growth, and adverse development. Pediatric dental guidance also highlights screening for sleep-disordered breathing (SDB) and obstructive sleep apnea (OSA). [1, 2, 3, 4, 5]

World Federation of Orthodontists (WFO)

The WFO emphasizes that treatment timing matters, particularly during prepubertal growth phases. Clinical data cited in the draft describe using growth indicators to identify and intercept skeletal, muscular, and dental abnormalities before all permanent teeth have erupted. The draft also notes support for short-term interceptive approaches when appropriate. [1, 2]

A practical takeaway for parents

The question is not "Should my toddler have braces?" The more useful question is: "What should we be monitoring right now, and which professionals should be involved if we see a concern?"

PART 1

Visual signs to track at home

Use this page as a conversation starter, not a diagnosis. Check the signs you notice and bring the list to your child's appointment.

Mouth breathing	Your child's mouth rests open while watching TV, playing, or sleeping. [1]
Sleep-disordered breathing	Snoring, gasping, noisy breathing, or excessive sweating during sleep. [1, 2]
Mentalis strain & lip incompetence	Your child has difficulty closing the lips naturally over the teeth, or you see a puckered or dimpled chin when they try to seal the lips. [1, 2]
No gaps between baby teeth	The draft notes that healthy toddler smiles often show gaps between baby teeth. Tight, very straight primary teeth can be a sign of limited room for adult teeth. [1, 2, 3]
Dark circles under the eyes	Persistent dark circles despite what appears to be adequate sleep may be worth mentioning to the child's clinician. [1]

Keep perspective

A single sign does not tell you what is wrong. The value of this list is that it gives you specific observations to discuss with a licensed professional.

PART 2

Questions to ask at your child's consultation

These questions are designed to help you understand your clinician's philosophy. Listen for a thoughtful plan to monitor growth, investigate possible airway or oral-function concerns, and coordinate care when needed.

1. Screening & growth philosophy

Ask this

"My child is under 6. If you notice narrow jaw arches or a collapsing bite right now, do you prefer a wait-and-see approach, or do you coordinate with other specialists early?"

Collaborative answer may sound like...	Traditional answer may sound like...
"While active dental hardware isn't the U.S. standard of care for a toddler without permanent teeth, we monitor growth closely and actively partner with ENTs, pediatricians, and myofunctional therapists to address the underlying concern early."	"There is nothing we can do at this age. Come back when they lose all their baby teeth or turn 7 or 8." [1]

2. Interdisciplinary care

"How do you feel about building an interdisciplinary team for my child's facial and airway development?"

Collaborative answer may sound like...

"We highly value a collaborative approach where the pediatrician, ENT, and myofunctional therapist all work together so everyone's voice is heard."

Traditional answer may sound like...

"We don't typically loop in outside medical specialists unless there is a severe medical crisis." [1]

PART 2 CONTINUED

Go a little deeper

3. Airway & myofunctional integration

“How do you evaluate for lip incompetence, mentalis strain, tongue-ties, or mouth breathing?”

A whole-picture answer may include...

“We evaluate the entire soft-tissue profile, tongue rest posture, and swallowing patterns to identify non-orthodontic interventions we can start right away.” [1, 2]

A narrower answer may sound like...

“We look strictly at dental X-rays and how the teeth fit together.” [1, 2]

“If active appliances like expanders aren’t appropriate yet for a child with only baby teeth, what non-hardware steps do you recommend to support healthy growth right now?”

A collaborative answer may include...

“We focus on breathing retraining, working with an oral myofunctional therapist to correct oral rest posture, and addressing any airway obstruction with an ENT.” [1]

4. The ultimate goal

“Is your goal for an optimized, collaborative early intervention to maximize skeletal growth so thoroughly that future teenage braces or Invisalign become entirely optional?”

Collaborative answer may sound like...

“Yes. By building a wide, healthy foundation through an interdisciplinary approach early, adult teeth often erupt naturally, eliminating the need for a heavy Phase Two.” [1, 2]

Traditional answer may sound like...

“No, early screening won’t change anything; every child will still need full braces or aligners as a teenager.” [1, 2]

PUT IT INTO PRACTICE

Your appointment prep sheet

Before the appointment, jot down what you have noticed. You do not need to interpret it - just describe what you see and when you see it.

- My child often breathes through the mouth during the day.
- My child snores or breathes loudly during sleep.
- My child gasps, sweats, or seems to work hard to breathe at night.
- My child has trouble keeping the lips closed comfortably.
- I notice chin dimpling or mentalis strain when the lips close.
- The baby teeth look very tight with little or no spacing.
- I notice persistent dark circles under the eyes.

Bring this with you

A short list of your observations plus the questions in this guide can make a busy appointment much more productive.

Three things to ask yourself after the visit

☐ Do I understand what my clinician is monitoring right now?

☐ Do I know what would trigger a referral to another professional?

☐ Do I have a clear next step and a timeline for follow-up?

IMPORTANT

Legal Disclaimer for Parents

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> **A note for families**
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> Use this guide to prepare for conversations, not to self-diagnose. Your child's licensed healthcare professionals should evaluate individual concerns and determine what care is appropriate.

Literature citations for reference

1. American Academy of Pediatric Dentistry. Management of the Developing Dentition and Occlusion in Pediatric Dentistry. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: AAPD; 2025:497-515.

2. American Academy of Pediatric Dentistry. Policy on Screening and Management of Sleep-Related Breathing Disorders in Children. The Reference Manual of Pediatric Dentistry.

3. World Federation of Orthodontists. A critical approach to growth indicators. Journal of the World Federation of Orthodontists. 2017;6(3):92-99.

4. World Federation of Orthodontists / Artese et al. Very early orthodontic treatment: when, why and how? Dental Press Journal of Orthodontics. 2022;27(2).

FOR PROFESSIONALS

Interested in Phase One education for your practice?

If you are a pediatric dentist, general practitioner, or orthodontist who wants to break away from traditional “wait-and-see” models and confidently integrate airway-focused, face-first Phase One interceptive care into your practice, Straight Smile Solutions® offers vetted, one-on-one professional clinical coaching and digital courses tailored to help you scale early-intervention protocols safely. [1]

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