



Buteyko Breathing Clinic Practitioner Training

Buteyko Practitioner Training Ireland 10th to 20th July 2013 inclusive

Practitioner Trainer

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Patrick McKeown is an accredited practitioner by the Late Dr Buteyko

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Background to the Buteyko Method

The Buteyko Method was developed in 1952 by Russian Doctor Konstantin Buteyko.

The Method involves;

- Unblocking the nose using breath hold exercise
- Switching from mouth to nasal breathing
- Correcting breathing volume to normal levels
- Adopting various lifestyle guidelines conducive to good health

Many people in the Western world breathe too much (clinically known as Chronic Hyperventilation). This results from factors of modern living such as processed food, stress, high temperatures of homes, excessive talking, overeating and lack of physical exercise. Typical characteristics of an over-breather include mouth breathing, regular sighing, taking large breaths prior to talking, breathing loudly during rest, etc.

The Buteyko method is more commonly taught for upper and lower respiratory conditions such as asthma and rhinitis due to its ability to produce quick results. The most common symptom of rhinitis is nasal obstruction which in turn contributes to snoring, sleep apnoea, disrupted sleep, crooked teeth, cranio facial changes and more.

Habitual mouth breathers often find it difficult to permanently nasal breathe. As soon as they close their mouth, they may feel suffocated or a want for air. Unless this feeling of a hunger for air is eliminated, mouth breathing will continue. The Buteyko Method unblocks the nose and eliminates the feeling of suffocation enabling a permanent switch to nasal breathing.



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About us

Patrick McKeown was accredited by the Late Dr Buteyko in Moscow. Since 2002, thousands of patients have attended his courses making it one of the busiest Buteyko practices in the western world. (www.asthmacare.ie, www.snoring.ie)

He has written six popular books including the best seller *Asthma Free naturally*. In addition, Patrick has produced a DVD set for adults and for children. Free video segments are available from www.ButeykoDVD.com and www.ButeykoChildren.com

Patrick's books are available online at www.Amazon.co.uk or www.Amazon.com

His latest book called *Buteyko meets Dr Mew* brings together the Buteyko Method and the work of Dr John and Mike Mew. Finally, Patrick has trained Buteyko practitioners from thirteen different countries.



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Craniofacial implications from habitual mouth breathing

A good-looking face is determined by a strong, sturdy chin, developed jaws, high cheekbones, good lips, correct nose size and straight teeth. When a face develops correctly, it follows that the teeth will be straight. Straight teeth do not create a good-looking face, but a good-looking face will create straight teeth.

Consensus from thousands of oral facial myologists, hygienists, dentists, orthodontists and published papers worldwide is that for the face and, consequently, teeth to develop correctly, a number of factors must be employed by the growing child. Such factors include:

- 1) Mouth closed with lips gently together;
- 2) Three quarters of the tongue resting in the roof of the mouth, with the tip of the tongue placed before the front teeth;
- 3) Breathing through the nose;
- 4) Correct swallowing;

During the 1960s, dentist Egil P Harvold recognised that “oral respiration associated with obstruction of the nasal airway (blocked nose) is a common finding among patients seeking orthodontic treatment.”¹ To determine the relationship between mouth breathing and crooked teeth, he conducted a number of experiments by blocking the noses of young monkeys with silicon nose plugs.

“The experiments showed that the monkeys adapted to nasal obstruction in different ways. In general, the experimental animals maintained an open mouth. All experimental animals gradually acquired a facial appearance and dental occlusion different from those of the control animals.”¹ The mouth-breathing monkeys developed crooked teeth and other facial deformities, including “a lowering of the chin, a steeper mandibular plane angle, and an increase in the gonial angle as compared with the eight control animals.”²

Harvold claimed to be able to reproduce the equivalent of most human dental irregularities; “Any common type of dental irregularity can be produced experimentally in monkeys with normal dentition.”³

It is well documented that mouth-breathing children grow longer faces. A paper by Tourne entitled, *The long face syndrome and impairment of the nasopharyngeal airway*, recognised that “the switch from a nasal to an oronasal (mouth and nose combined) breathing pattern induces functional adaptations that include an increase in total anterior face height and vertical development of the lower anterior face”.⁴



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In another paper, Dr Carl Schreiner comments that “Long-standing nasal obstruction appears to affect craniofacial morphology during periods of rapid facial growth in genetically susceptible children with narrow facial pattern”.⁵

In a paper entitled, *Care of nasal airway to prevent orthodontic problems in children*, “a mouth breather lowers the tongue position to facilitate the flow of air in to the expanding lungs. The resultant effect is maldevelopment of the jaw in particular and deformity of the face in general. Setting of the teeth on the jaw is also affected. All these make the face look negative. So, to prevent orthodontic problem in children, it is necessary to detect the nasopharyngeal obstruction and treat the same accordingly.”⁶

In a study of 47 children between the ages of 6 to 15 years that was done to determine the correlation between breathing mode and craniofacial morphology, “findings demonstrated a significant predominance of mouth breathing compared to nasal breathing in the vertical growth patterns studied.” The paper concluded that, “results show a correlation between obstructed nasal breathing, large adenoids and vertical growth pattern.”⁷

Another study involving 73 children between the ages of 3 to 6 years that was done to determine the influence of mouth breathing on dentofacial growth and development concluded that “mouth breathing can influence craniofacial and occlusal development early in childhood.”⁸

In a paper entitled “Malocclusion and upper airway obstruction,” 49 children with confirmed nasal obstruction were studied. The paper noted that “the main characteristics of the respiratory obstruction syndrome (blocked nose) are presence of hypertrophied tonsils or adenoids, mouth breathing, open bite, cross bite, excessive anterior face height, incompetent lip posture, excessive appearance of maxillary anterior teeth, narrow external nares, V-shaped maxillary arch (top jaw).”⁹

When the tongue is not resting in the roof of the mouth, the jaws are impeded from growing forward and are instead set back from their ideal position. This contracts the airways, contributing to breathing difficulties and sleep apnoea. In addition, the nose will seem larger, similar to that of a roman nose. The “nose is more pronounced in an ideal occlusion (straight teeth) but in the various malocclusions (crooked teeth) where the maxilla (top jaw) is underdeveloped it appears larger, although in fact it is smaller.”³

“Lack of growth affects the whole face and is associated with flat cheeks, unattractive lips, large noses, tired eyes, double chin, receding chins and sloping forehead, features that will be readily recognised when there is a pronounced crowding of teeth.”¹⁰



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Given the extent of information available, it is surprising that few dentists seem to be aware of the craniofacial effects from mouth breathing. The journal *General Dentist* noted that “the vast majority of health care professionals are unaware of the negative impact of upper airway obstruction (mouth breathing) on normal facial growth and physiologic health. Children whose mouth breathing is untreated may develop long, narrow faces, narrow mouths, high palatal vaults, dental malocclusion (crooked teeth), gummy smiles and many other unattractive facial features. These children do not sleep well at night due to obstructed airways; this lack of sleep can adversely affect their growth and academic performance. Many of these children are misdiagnosed with attention deficit disorder (ADD) and hyperactivity”. The paper further states that “if mouth breathing is treated early, its negative effect on facial and dental development and the medical and social problems associated with it can be reduced or averted.”¹¹

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Mouth breathing, snoring, and sleep apnoea in adults and children

Here, we examine the literature to determine whether sleeping with the mouth open is a causal factor for snoring and sleep apnoea.

“Open-mouth breathing during sleep is a risk factor for obstructive sleep apnea (OSA) and is associated with increased disease severity and upper airway collapsibility.” The study which involved 52 patients found that “the more elongated and narrow upper airway during open-mouth breathing may aggravate the collapsibility of the upper airway and, thus, negatively affect OSA severity.”¹

In another study, 385 patients with obstructive sleep apnoea were examined through a questionnaire. Results showed that upper airway symptoms were common, with 61% of patients reporting mouth dryness, 52% with nasal stuffiness, 51% with dryness of the nose, 30% with sneezing, 24% with mucus in the throat, and 17% with a runny nose.²

Ohki et al. performed a study to determine the relationship between oral breathing and nasal obstruction in patients with obstructive sleep apnea. The study involved 30 normal subjects and 20 patients with snoring or sleep apnoea. Researchers found that chronic nasal obstruction and resultant mouth breathing may induce obstructive sleep apnea.³

In a paper entitled, “How does open-mouth breathing influence upper airway anatomy?”⁴, Lee et al. tested the hypothesis that open-mouth breathing during sleep may increase the severity of obstructive sleep apnea. After an analysis of 28 patients, researchers concluded that “open-mouth breathing is associated with reduction of the retropalatal and retroglossal areas, lengthening of the pharynx and shortening of the MP-H in the upper airway.”⁴

After reviewing texts and articles on Medline, the centre for research disorders in Cincinnati, Ohio concluded that obstructive sleep apnoea, sleep fragmentation, and disturbed sleep often result from nasal obstruction.⁵ The authors of the paper observed that “since breathing through the nose appears to be the preferred route during sleep, nasal obstruction frequently leads to nocturnal mouth breathing, snoring, and ultimately to OSA.”⁵ The paper advised that allergic rhinitis and other upper respiratory disorders should be treated more aggressively.⁵

Mouth breathing, snoring, and sleep apnoea in children



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A Polish study noted that children with sleep respiratory disorders wake up tired, with blocked noses, were breathing through their mouth, tire easily, have concentration problems, are irritated, and demonstrate hyperactivity that may resemble ADHD symptoms. The paper further states that “long-term disease leads to exacerbation of all-systemic symptoms, results in cardiovascular complications, induces developmental inhibition and cognitive dysfunction, and is responsible for school/social failures and reduced life quality.”⁶

In a paper entitled, “The nose and sleep disordered breathing: what we know and what we don’t know,” performed an analysis of medical literature on the subject.⁷ The analysis confirmed that “SDB (sleep disordered breathing) can both result from and be worsened by nasal obstruction.” It was stated that “nasal congestion typically results in a switch to oronasal breathing that compromises the airway.” Furthermore, “oral (mouth) breathing in children may lead to the development of facial structural abnormalities associated with SDB.” The paper concluded that the change to mouth breathing that occurs with chronic nasal obstruction is a common pathway for sleep-disordered breathing.⁷

Mouth breathing was also recognised to be a factor in a study to determine the prevalence and association of sleep disorders and school performance. Based on a total of 1,164 completed questionnaires on children aged between 7 and 13 years, it was found that the overall prevalence of snoring was 38.9% with 3.5% habitually snoring. “Allergic symptoms, daytime mouth breathing, shaking the child for apnea, restless sleep and hyperactivity were significant and independent risk factors and sleep-related symptoms for HS.”⁹

A study was conducted to determine the risk factors of habitual snoring and symptoms of sleep-disordered breathing. Based on a study of 1030 children aged from 12 to 17 years, it was found that “habitual snorers had significantly more night time symptoms including observed apneas, difficulty breathing, restless sleep and mouth breathing during sleep compared to occasional and non-snorers.”¹⁰

And finally, data from 248 medical charts of mouth-breathing children were analysed to determine the prevalence of obstructive sleep disorders in such children. It was found that 58% of children were primary snorers and 42% had obstructive sleep apnoea. The paper concluded that, “primary snoring and OSAS are frequent findings in mouth breathing children.”¹¹

There is no doubt that mouth breathing is a significant causal factor for snoring and sleep apnea in both adults and children.



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Investigating the Buteyko Method as a treatment of rhinitis in asthma

The objective of a study undertaken by Dr Adelola et al. from the Department of Otolaryngology at Limerick University Hospital in Ireland was to investigate the effectiveness of the Buteyko technique on the nasal symptoms of patients with asthma.

Method

26 volunteers with a diagnosis of asthma and chronic rhinitis, ranging in age from 23 – 60 years were recruited from the general population. Training took place weekly for three weeks by Buteyko practitioner; Patrick McKeown. Participants were followed for three months. Each participant completed quality of life scores to rate their nasal symptoms at the beginning of training and three months post training. Validated evaluations consisted of the sinonasal outcome test (SNOT)¹, nasal obstruction symptom evaluation (NOSE)² and visual analogue scale.

Results

The study showed a significant reduction of nasal symptoms in asthmatics across all three evaluations. For example, NOSE evaluation surveys nasal congestion or stuffiness, poor sense of smell, snoring, nasal blockage or obstruction, trouble breathing through the nose, trouble sleeping, having to breathe through the mouth, unable to get enough air through the nose during exercise or exertion and feeling panic that one cannot get enough air through the nose. This evaluation showed a 71% reduction of rhinitis symptoms in asthma at three month follow up.

Test	Baseline Mean Measure	3 Month Mean Measure	Improvement
Visual Analog Scale	66.65	18.25	72.60%
Nasal Obstruction Symptom Evaluation	12.03	3.46	71.20%
Sinonasal Outcome Test-22	44.07	12.34	72.00%

Table one: Pre- and post-test mean scores of visual analogue scale (VAS), nasal obstruction symptom evaluation (NOSE) and sinonasal outcome test (SNOT-22)



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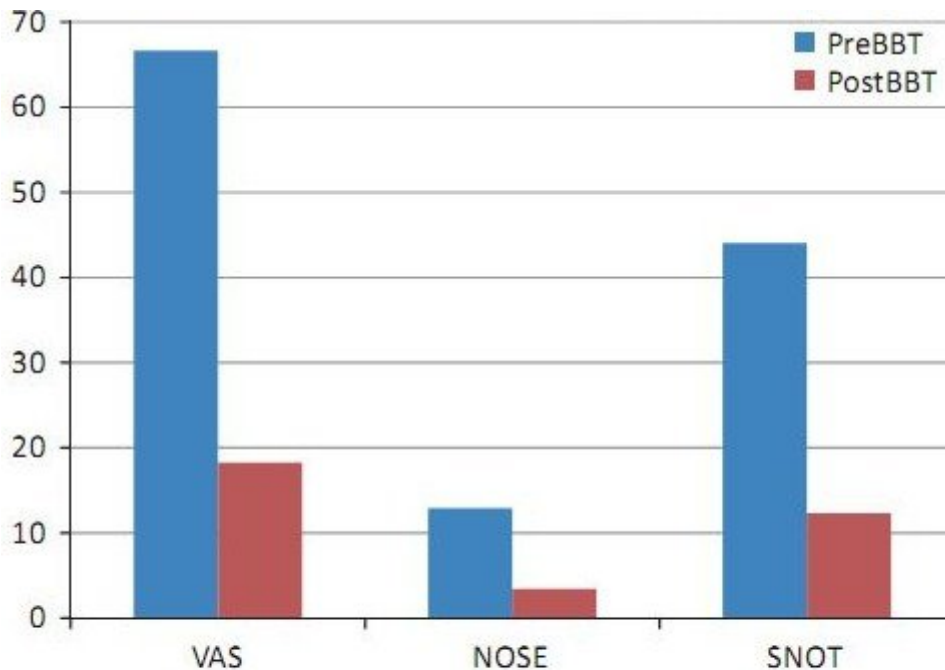


Fig. 1. Pre- and Post-test Mean scores of Visual analogue scale (VAS), Nasal obstruction symptom evaluation (NOSE) and Sinonasal outcome test (SNOT-22).

References:

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How effective is the Buteyko Method for asthma?

The Buteyko Method has been subject to six trials in the western world. Average results concluded a significant improvement to quality of life with 70% less asthma symptoms such as wheezing, breathlessness and coughing, a reduction of 90% in need for reliever medication and a 40% to 50% less need for preventer steroid medication within three to six months. (this improves over time)

Where measured, a direct correlation was demonstrated between breathing volume, reduced symptoms and need for reliever medication. Lung function was maintained the same after the trial. Taking into account that preventer medication was halved with no deterioration of lung function, this was indeed very positive.

The conclusion of Gisborne trial (1) as published in NZ Med J is as follows;

"BBT is a safe and efficacious asthma management technique. BBT has clinical and potential pharmaco-economic benefits that merit further study."

A table comparison table taken from page 3 of NZ children's trial 6 as published in NZ Med Journal

	Brisbane 1	Gisborne 2	Nottingham 3	NZ Children 4
Beta-agonist reduction (reliever)	95%*	85%	100%*	66%
Inhaled steroid reduction	49%	50%	41.5%**	41%

**Nottingham did not attempt reductions in inhaled steroid use until assessment of airways hyper-reactivity was finished.

The British Thoracic Society recently upgraded the Buteyko Method to "B" classification indicating that there are "high quality systematic reviews of case control or cohort studies" and "High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal."

The Mayo Clinic has listed the Buteyko Method as one of the most promising alternative treatments for asthma. See <http://www.mayoclinic.com/health/asthma-treatment/AS00032>



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Course breakdown

- Upon registration- The Buteyko Breathing Clinic training manual and DVD set is provided. This enables new practitioners to become familiar with theoretical elements of the method.
- Training practitioners attend ten days of practical and theoretical training during which they learn how to teach the Buteyko Method to their patients.
- Training practitioners observe and assist Patrick work with up to 40 patients with varying complaints.
- Extensive training manual, reading list, power point presentations, books, DVDs are provided
- Indefinite follow up support is provided by practitioner trainer Patrick McKeown
- Accreditation by Diploma of Buteyko Method
- Practitioners are **registered on the ButeykoClinic.com** website.



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Course syllabus

Buteyko Breathing Clinic training course concentrates on the practical application of the Buteyko Method. This is vital to ensuring your success. Please find course summary below;

Introduction

- Introduction to the Buteyko Breathing Clinic Method
- Chronic Hyperventilation
- Basics of respiratory physiology

Assessing the patient

- Assessing patient and determining your approach
- How to measure the Control Pause correctly
- How to determine if your client is measuring CP correctly

Breathing Exercises

- How to stop coughing
- How to stop wheezing, stress and anxiety
- How to unblock the nose, relieve constipation and more using breath hold
- Reduced breathing with varying approaches
- Correct breathing during physical exercise
- Breath holds during physical activity and sports
- How to teach children using steps and reduced breathing

Working with the patient

- Expected results from your patients
- What to do when results are stubborn
- Anticipating the cleansing reactions
- What exercises to use with different people and complaints
- Nuances to be aware of with different patients
- Various approaches when sensitivity to breathing is poor

Theory

- Asthma, snoring, sleep apnoea and anxiety. The link with chronic overbreathing.
- The Bohr effect, pH, functions of carbon dioxide.
- Maximising sports performance



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Application form

All information submitted will be treated as totally confidential. Please select and copy application form onto an Email or word document.

Complete and email directly to Patrick McKeown at patrick@buteykoclinic.com

Name in full:

Address:

Tel. No (inc STD code)

Email:

Current occupation

Qualifications

Education details

Further education/other courses

Details of previous Buteyko courses/experience (if relevant)

Please add here any further details you wish in support of this application and reasons for wishing to enrol on the course, i.e., career / general interest / self-development, etc.

How did you hear about this course?

Please note:- students giving up the course of their own volition before its completion are not entitled to a refund of course fee.



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Cost of Buteyko practitioner training and accreditation: €2,000

Please note that a deposit of €500 is required when booking your place. Please email completed application form to Patrick at patrick@buteykoclinic.com

(copy and paste one page application form onto Email or word document and email to Patrick)

An invoice will be Emailed to you and payment can be made through Paypal.

Upon payment of deposit of €500, an E-training manual, DVD sets and books will be sent to you to enable commencement of training.

Payment of fees by bank lodgement

Alternatively, you could email Patrick McKeown at patrick@buteykoclinic.com

Patrick can forward you the bank account details whereby a lodgement can be made direct from your bank.

Payment by cheque

Cheques should be made payable to Patrick McKeown and posted to:-

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