Total Feeding Solutions

Breastfeeding Solutions LTD & Milk Matters

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Tongue Tie Information

What assessment system do you use?

We use a number of diagnostic tools to help establish if baby has an organised suck and swallow pattern, and whether they are using their lips and tongue to form an effective seal on the breast or bottle.

Part of this includes completing the "Hazelbaker Assessment for Lingual Frenulum Function"; this helps us to score both appearance and function of the tongue, and helps to give an idea as to whether treatment of the tie may help you and your baby.

Sometimes baby may be a little disorganised for another reason apart from due to a tongue tie, so we find alongside taking a full history, alongside observing baby taking some of their feed can be a really helpful part of the picture too.

How is tongue tie treated?

Tongue tie division (frenulotomy) is a very simple procedure and only takes a few seconds.

The baby is swaddled and his head is held securely while sharp, sterile, single use, blunt ended scissors are used to snip into the frenulum (the membrane under baby's tongue). Some babies sleep through it, while others may fuss for a few seconds – generally the calmer the caregiver, the faster baby will settle.

Occasionally babies do cry for a few minutes or longer following the procedure, which does not appear to be related to type of tie or its location. NHS guidance suggests an average crying time of 15 seconds (Bath and North East Somerset, Tongue tie information for parents).

After the release, some babies may experience a fussy period where they find feeding difficult and may cry more than usual. This often only lasts a few hours, but some can be out of sorts for up to a few days afterwards. It is not always clear if these babies are in pain, whether they are struggling to get used to their more mobile tongue and the new sensation, or whether muscles not toned become fatigued. The majority of babies will continue as if nothing much has happened to them.

Concerns about any pain or upset which may be associated with the procedure, and will be temporary, have to be balanced against the distress being caused by the symptoms related to the tongue-tie.

Babies with tongue-tie may suffer distress and discomfort from wind and reflux. Furthermore babies who can't suckle appropriately may struggle and have to feed for exhaustingly long periods or with excessive frequency, in order to get the milk they need to survive from the breast or bottle. Feeding should be pleasant and a source of comfort for babies.

Is anaesthetic used?

No, anaesthetic is not commonly used in the UK for infant frenulotomy; numbing can prove distressing for infants who may then be unable to feed effectively, and there is also the risk of reaction to any topical agent used. Thus it is considered that the risks of local anaesthesia outweigh the benefits.

For young babies a small amount of their milk feed is usually given beforehand, as the sugar can help to provide pain relief for minor procedures. For older babies paracetamol may be given (according to box guidance/dosage) both before and after if required. Ibuprofen is not a suitable pain reliever either before, or for 48 hours post procedure, due to potential anti-coagulatory properties that may affect clotting (resulting in the risk of increased bleeding).

Whilst frenulotomy is considered a minor procedure, the following risks must be considered:

1) **Risk of reattachment**.

This is by far the most common complication and is a source of much controversy. Some feel that if the tongue-tie is divided completely then reoccurrence is unusual, others are adamant a strict regime of "active or aggressive wound management" (which involves rubbing the wound site and lifting the tongue) is required to prevent the wound knitting back together.

We first need to consider that some "recurrences" are down to incomplete original treatment of the tie. Some practitioners have been taught to only cut half way back, or don't believe the back or posterior section of a tie need releasing. Although uncommon, if baby is particularly small with a very tight mouth, it may also be difficult for the practitioner to access all the frenulum during the initial treatment. Most prefer to take a cautious approach of advising parents they have treated as much as possible, but that they may need to return again at a later date.

Mrs Abbas will always check the revision is complete and that there is no remaining restriction or tension under the tongue before returning baby to you.

Despite this, all practitioners questioned by the Association of Tongue Tie Practitioners had experienced recurrence, and the reality is we have no controlled published studies to which we can refer.

Reattachment in terms of the edges healing back together can only occur during the initial healing period. Some observe the middle section of the rhomboid shaped treatment site is most likely to knit first, which in turn pulls the other edges closed like a zip; resulting in just a single line remaining where the revision site was.

To try and combat this some as mentioned recommend "disturbing the wound", by rubbing the area and stretching the wound site (several variations of this practice can be found online). Others report that in practice the area still healed together with a number of practitioners noting thicker, more fibrous scar tissue following this type of aftercare. It's important to note massaging the site if scar tissue forms, is also different to massaging an open wound site.

Some theorise further frenulum buried deep in the muscle at the base of the tongue may move forward as the mouth grows, or that sometimes the tissue re-grows – the reality is nobody really knows as the area hasn't been extensively studied. It also has to be remembered that the studies showing frenulotomy to be effective in improving feeding, did not involve the use of stretching and massage.

This means nobody can give parents definitive advice about the best thing to do post procedure – we can't state something is "essential" or will guarantee outcome. We must also consider distress caused to the baby and adults who have tried different techniques report wound pressure/massage is particularly painful. In practice this increases risks of oral aversion and can cause baby's mouth to be sore numerous times per day, causing some to report a delay in feeding improvement.

Mrs Abbas's recommendations can be found in your aftercare sheet.

2) **Risk of scarring at the wound site**

All procedures carry a risk of scarring and if scar tissue contracts it may become inelastic and restrict function. Many practitioners don't recommend parents touch the area at all, and yet report reattachment figures comparable to those (typically USA practitioners) who employ "rigorous protocols."

Others like Allison Hazelbaker in her book 'Tongue-tie: Morphogenesis, Impact, Assessment, and Treatment' (2010) states that "the formation of scar tissue is not supported in the literature and is an 'unreasonable concern".

Some babies may be naturally more predisposed to scarring; for example keloid scarring appears to have a genetic factor (AHNAK) and be more often linked with darkly pigmented skin. I have also witnessed one baby several years ago who developed a small pyogenic granuloma (relatively common skin growths that are small and round and most common in children) – this didn't appear to cause him any distress and spontaneously resolved within a couple of weeks.

3) **Risk of bleeding.**

Whilst a few babies don't bleed at all, the majority of infants experience light bleeding post procedure that resolves within a few minutes. Immediately following the procedure Mrs Abbas applies a small piece of gauze to the area and baby is returned to you to feed. We recommend that you bring your baby hungry for their appointment; suckling on a breast or bottle drops the tongue and naturally applies pressure to the area, making it the most comfortable and effective way of stopping bleeding.

If baby struggles or refuses to feed and/or cries, the elevation of the tongue may cause the bleeding to continue for longer than typical. In this situation we encourage babies to suck a gloved finger, or alternatively a pacifier to help calm them and reduce blood flow to the area. Most babies even if crying will stop bleeding spontaneously within 5 minutes.

Where bleeding is heavier than typical or prolonged, Mrs Abbas will follow guidelines as per the attached sheet headed "Management of Bleeding for Healthcare Professionals". As an experienced midwife and certified tongue tie practitioner, the decision about when to intervene further is based on the amount of blood loss, duration of bleeding and age and condition of the baby.

Mrs Abbas has Kaltostat present at all revisions as standard practice (reducing the risk of continued bleeding to 1:10,000) and our nearest A&E department is approximately 1 mile away in Lindley if further medical intervention is required.

4) **Risk of secondary bleeding.**

Occasionally there may be a small amount of further bleeding or "oozing" (small amounts of blood mixed with saliva) at the site of the division after you have left clinic. This is usually caused by baby strenuously crying, putting his fingers in his mouth and catching the wound site, or a bottle teat or nipple shield inadvertently slipping under the baby's tongue disturbing the area.

Prior to tongue tie release, baby's tongue often sits at the bottom of the mouth when they cry, whereas following treatment the tongue can begin to elevate.

To minimise the risk of this happening, it is advisable to ensure baby's tongue is down by sliding the teat down the top lip and allowing baby to latch on (rather than pushing it into her mouth).

As above the pressure applied by feeding or sucking will typically stop this bleeding within a few minutes. Very rarely (1 in 60,000 cases) heavier secondary bleeding may occur – in this instance please consult the attached sheet headed "Management of Bleeding, Guidance for Parents".

5) Risk of infection

Infections in the wound site are rare and we, like many other practitioners have never seen a case in practice. Southampton hospital has been performing the procedure since the early 1990s, and note one mild infection which resolved quickly with antibiotics.

In 2010 a more serious case occurred when a young baby developed a typically hospital acquired bacteria called Klebsiella Oxytoca and then septicaemia following a frenulotomy. The news report relating to this can be accessed here http://www.bbc.co.uk/news/uk-england-essex-22081044

If baby is receiving breastmilk, the antimicrobial properties are likely to further reduce this already very small risk.

All equipment used including gloves, scissors and gauze packs are sterile, single use, disposable and sealed until immediately before the procedure.

6) Risk of swollen sublingual salivary glands & increased saliva (temporary)

Sometimes a restricted frenulum is anchored below the gum margin and pulls tight on the small salivary glands located nearby. These babies can usually be identified by their wet top or bib, particularly after ten or eleven weeks when saliva production increases. I have wonderful footage showing baby's saliva glands squirting each time the tongue was lifted, so babbling, eating or attempts at protrusion could all result in a pooling of saliva – which if the tongue isn't working well can also be difficult to swallow.

When saliva glands are pulled tight, releasing the tie can disturb or irritate the area, and on rare occasion can cause the glands to temporarily increase in size – so they present like small kidney beans underneath the tongue. This typically resolves within 24-48 hours.

Some have theorised risk of permanent damage to the salivary glands from frenulotomy, however the release is directed away from the glands and there have been no reported cases in practice

It is very common for babies to be especially drooly during the healing period following tongue tie release. This is a physiologically normal response to the procedure, as the body produces extra saliva to keep the area clean and support healing.

If you have any questions about any of the above please don't hesitate to contact us.