
**MATERNITY AND NEONATAL UNIT
GUIDELINE:**

TONGUE TIE (ANKYLOGLOSSIA) MANAGEMENT AND REFERRAL

SCOPE:

Maternity and Neonatal Unit

AUTHOR:

NNU Quality Coordinator

PURPOSE:

To provide a framework for assessment of tongue tie, referral and procedural guidance if frenotomy (snipping of the frenulum) is undertaken.

DEFINITIONS:

The sublingual frenulum attaches the tongue to the floor of the mouth. There is a spectrum of what is considered normal. Ankyloglossia, also known as tongue tie, is characterised by the presence of a thickened, tightened or shortened sublingual frenulum that changes the appearance of the infant's tongue. In some cases there can be change in the function of the tongue which can cause significant breast feeding difficulties.

Complete ankyloglossia in which there is extensive fusion of the tongue to the floor of the mouth is very rare.

Frenotomy is a simple incision or snipping of a tongue tie.

The reported incidence is between 2.8 and 10.7% of infants (Berry 2012)

In the published literature there is disagreement regarding the significance of tongue ties, the timing of any intervention and who the most appropriate person is to carry out any intervention. This guideline cannot unify varying opinions and should be used as a guide to the current practice in TDH.

GUIDELINE:

All infants, whether healthy or ill, should have an examination of the mouth as part of their newborn examination. The goal of this examination is to identify any abnormalities of the oral cavity of which ankyloglossia is only one.

If tongue tie is suspected and ascertained to be a cause of breast feeding complications, a full assessment of the baby's anatomy and feeding should be done prior to referral.

Before considering this procedure the baby should be in good general health and have a normal newborn examination.

Bottle fed babies can also have feeding difficulties with tongue tie.

Assessment

There is no single reliable tool for assessment that will adequately predict the degree of problems of an individual baby.

Some tongue ties are asymptomatic and cause no problems. Not all infants with tongue tie will need intervention other than good breast feeding support and guidance. There is no relationship between frenulum length and feeding difficulties.

The **symptoms** that the tongue tie causes are the focus of assessment.

Breast feeding difficulties resulting from tongue tie can present as problems latching on the breast. This causes nipple pain and damage, prolonged feeding, poor weight gain and frequent inefficient feeding. Mastitis may occur and lactation may be impaired due to poor drainage of the breasts.

The tongue tie can be described by the appearance of the tongue and the frenulum, the tongue's range of movement both transverse and laterally, and ability to extend the tongue forward over the lower lip or gum.

Infant signs and symptoms *may* include:

- Poor latch or inability to latch
- Weak suck
- Clicking sound while nursing (loss of suction)
- Difficulty in establishing an adequate seal and vacuum in the mouth to maintain a deep grasp on the breast
- Chewing and biting down on the nipple
- Falling asleep at the breast having not fed well
- Ineffective milk transfer
- Weight loss, dehydration, jaundice
- Inadequate weight gain
- Irritability and unsettledness
- Fussiness and frequent arching away from breast
- Fatigue within one or two minutes – can get jaw tremors

Assessment tools are available for midwives/nurses/doctors who wish to use them. Observation of feeding is essential.

The following assessment tool should be used with caution by practitioners who have not had specific training as the ability to elicit specific reflexes and score a baby's best performance is essential if there is a wish to avoid over diagnosis.

- The Hazelbaker Assessment Tool for Lingual Frenulum Function (HATLFF). (See appendix 1).
- Catherine Watson Genna (Ed) (2012) *Supporting Sucking Skills* 2nd edition has useful assessment information. Also available on her website: [Quick Help](#)

Midwives/Lactation consultants – a referral to a community based lactation consultant following discharge should be considered, see Tongue Tie Pathway (appendix 2).

It is essential that breast feeding is observed to eliminate other reasons for breast feeding difficulties which may be resolved with repositioning and improved feeding technique.

Bottle feeding

Tongue tie can cause bottle feeding difficulties which can present as very slow feeding, dribbling and excessive wind.

Referral

- Referrals can be made to the Community Lactation Consultant Service. The Lactation Consultant can assess the anatomy and function of the oral cavity, breast feeding issues and identify tongue tie and, if necessary, outline treatment options to parents. To refer to the Community Lactation Consultant service e-mail clinical details to info@breastfeedingeastcoast.nz or ring 021 170 9208. The Community Lactation Consultant will refer to the appropriate treatment provider (see Tongue Tie Care Pathway appendix 2).
- Midwives can accept referrals if the baby is still under midwifery care and less than 6 weeks old. Midwives are able to include frenotomy in their scope of practice if they have completed appropriate training and demonstrate competence in the procedure (Midwifery Council 2011). It is recommended that midwives only treat anterior (type 1 and 2) tongue ties.
- Paediatrician referral: it is essential that a mother and her baby have a feeding assessment completed prior to written referral to the Paediatrician for assessment. If possible, the assessment should be completed by a Lactation Consultant.
 - The Paediatrician will assess the baby and advise the parent(s) of the most appropriate management.
 - The Paediatrician may wish to refer the baby to ENT
 - From one month of age a referral should be made to ENT department. Older infants may require a general anesthesia for the procedure.

Vitamin K – all babies must have Vitamin K administered at birth or at least one day prior to the procedure, with informed consent from the parents. IM Vitamin K is recommended.

Informed consent

It is important that parents have the procedure and any risks explained prior to agreeing to it. Written consent should be obtained using a TDH Consent Form.

Pain relief

Babies appear to experience division of the tongue tie as “virtually pain free” (Amir 2011). However, sucrose solution 66% 0.2-0.5 ml may be given with parental consent prior to the procedure as pain relief (see guideline).

Frenotomy procedure

The baby should be swaddled securely and an assistant should stabilise the head. This procedure is usually performed with sharp blunt ended scissors which are used to divide the frenulum by 2-3 mm. A grooved retractor can be used. Complications are rare but include post-operative bleeding, ulceration, infection and damage to salivary ducts and reoccurrence of the tongue tie.

Hepatitis C positive mothers are advised that breast feeding should be postponed until the wound has healed.

Following frenotomy

Following the procedure infants should be observed for any bleeding. The parent(s) should be advised about post frenotomy care and stretching exercises. This is important to prevent reoccurrence of the tongue tie.

It is essential that after frenotomy has been performed, there is support and guidance to assist effective breast feeding and resolve any issues such as sore nipples or mastitis. It is also important that there is follow up by LMC or referring agency to provide continued support with feeding where required and evaluate and document outcomes from the procedure.

Management of Ankyloglossia without Frenotomy

Infants who are unable to correct their suck can benefit from assessment and a breast feeding plan (see appendix 3 – Non-latching baby care plan) which includes:

- Maintaining a full milk supply with regular expressing
- Focusing on a deep asymmetrical latch
- Maintain practice at the breast after partial alternate feeding
- Oral exercises to reduce posterior tongue elevation and retraction

Management of breast feeding difficulties while awaiting assessment

It is important to have a breast feeding plan in place in order to feed the baby and support breast milk supply (see appendix 3 – Non-latching baby care plan)

Strategies to consider include:

- Feeding position can facilitate improved ability to achieve a latch; laid back or upright deep latching positions
- Nipple shield if nipples are sore
- Finger feeding
- Topping up the baby with EBM
- Expressing after feeding to ensure adequate stimulation to promote lactation

ASSOCIATED DOCUMENTS:

Sucrose analgesia for simple neonatal procedures NNU guideline
Vitamin K administration to a newborn baby Maternity and NNU guideline
Use of nipple shields – Maternity and NNU guideline
TDH Consent to treatment – surgery/other procedure form

Appendix 1 - Hazelbaker Assessment Tool for Lingual Frenulum Function (1998 version)

Appendix 2 – Tongue Tie Care Pathway

Appendix 3 – Non-latching baby care plan

REFERENCES:

Watson Genna, Catherine (ed) (2012). *Supporting Sucking Skills in Breast Feeding Infants* (2nd Ed)

Burrows, Sally; Lanlehin, Rosemary (2015). Is frenotomy effective in improving breastfeeding in newborn babies with a tongue tie? A literature review. *British Journal of Midwifery* 23.11

Edmunds J, Miles S.C, Fulbrook P. (2011) Tongue Tie and breastfeeding; review of literature. *Breastfeeding Review* 2011 Mar 19(1); 19-26

Canadian Paediatric Committee, Canadian Paediatric Society(CPS) Ankyloglossia and breastfeeding. *Paediatrics and Child Health* 2002; 7(4), 269-70

NICE Interventional Procedural Guidance 149 Division of ankyloglossia for breastfeeding. December 2005

Berry J, Griffiths M, Westcott C 2012, A double-blind, randomized, controlled trial of tongue-tie division and its immediate effect on breastfeeding. *Breastfeed Med* 7:189-193

Authorised By (HOD Paediatrics)

Authorised By (Clinical Care Manager Woman, Child & Youth)

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Appendix 1



Appendix 2



Tonguetie Pathway
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Appendix 3



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