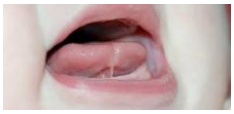
Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

FACULTY OF PAEDIATRICS
ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Management of Tongue Tie in Early Infancy

Types of Tie

Anterior Tie (Types I and II)



Posterior (submucosal)Tie (Types III and IV)

Frenotomy could be considered in healthy infants with a tongue tie who present with a problem feeding.

All professionals agree that tongue-tie on its own without feeding problems does not necessarily require frenotomy

Good lactation/feeding assessment is crucial to support babies with a tongue tie.

It is uncertain whether anklyoglossia (tongue tie) is a congenital oral anomaly or whether it is a normal variant.

A small number of mothers may experience breastfeeding difficulties. This has been attributed to apparent tongue tie in the infant , however many mothers experience no difficulty feeding infants with apparent tongue tie, and infants with apparent tongue tie generally have no difficulty bottle feeding.

Presenting problems attributed to tongue tie are nipple pain, poor latch, poor feeding, slow weight gain, unsettled infant. However these symptoms are also common in first time breast feeding mothers .

There are many assessment tools (e.g. Hazelbaker), many are very time consuming and of uncertain value. Assessment can be done using the right sidebar:

What to do if tongue tie is suspected:

- Confirm that tongue-tie is present; this should include a full examination of the palate.
- Obtain a lactation consultant assessment prior to any referral for possible tongue tie release procedure. ~Breastfeeding may be attributable to non tongue tie issues
- Undertake an oral & systemic examination of the baby to exclude local causes such as cleft palate and systemic causes such as UTI, airway difficulties or cardiac problems.
- If the feeding problem persists, intervention at 2-3 weeks of age may be appropriate before feeding problems make breastfeeding so difficult that the mother stops feeding. If the tongue tie is very obvious and the feeding difficulties are severe intervention may be considered before this.
- Advice should be given on feeding in the interim by Lactation Consultant.
- Ascertain that the baby has been given Vitamin K, and there is no family history of blood dyscrasias.
- Referral by medical practitioner to an appropriately trained professional to assess severity of tongue tie and possible frenotomy.
  (See attached 'Tongue Tie Assessment Referral Form')

Follow the baby and mother up after the frenotomy. If feeding does not improve there is another cause for the difficulties. Some babies who undergo frenotomy continue to have feeding problems despite releasing the tongue tie.

Skilled breastfeeding advice and support is essential post procedure.

For healthcare providers performing frenotomy: see attached 'Frenotomy Proforma'

Assessment:

1.Mothers Symptoms:

Nipple pain; persistent over one week's duration.

Breast pain, mastitis, engorgement beyond normal initial feeding issues.

Distorted nipple shape after feed, bleeding or ulcerated nipples.

2.Feeding history:

Failure or likely failure to regain birth weight by 2-3 weeks of age.

3.Look at Latch:
Is the infants latch correct?

Is latch being maintained?

Check position of baby at breast.

4.Listen and look:
Clicking sounds while feeding.

Pooling milk around mouth during feeds.

Gasping, struggling on the breast.

Bobbing around, latch slips

5.Look and palpate :

Extension (sticking out tongue), elevation (lift of the body of the tongue in the mouth, not just the tip - should reach at least halfway up to the palate) and lateralisation (side to side movement of the tongue - often better to one side with tongue tie).

Frenulum extends anteriorly to tip of tongue or lower gum line (abnormal).

No visible frenulum, but tight band palpable under the tongue, query posterior tie.

References:

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2. Hogan M, Wescott C, Griffiths M. Randomised controlled trial of division of tongue-tie in infants with feeding problems. J Pediatr Child Health 2005;41:24
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4. Buryk M, Bloom D, Shope T. Efficacy of neonatal release of ankyloglossia: a randomised, trial. Pediatr 2011;128:280-6
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8. Griffiths DM. Do tongue ties affect breastfeeding? J Hum Lact 2004;10:409
9. Power RF, Murphy JF. Tongue tie and frenotomy in infants with breastfeeding difficulties: achieving a balance. Arch Dis Child 2015;1:489-494

This algorithm has been produced by the National Clinical Programme for Paediatrics and Neonatology. It is aimed at medical, nursing and health and social care professionals.

This algorithm has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach.

Clinical material offered in this algorithm does not replace or remove clinical judgment.

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Tongue Tie Assessment Referral Form

Must be completed by referring General Practitioner or Paediatrician with Lactation consultant advice/input *r:*

Patient details:

Date :

Mothers Name: Contact Phone: Father's Name:

Baby's First Name: Surname: DOB:

Male ☐ Female ☐

Place of birth: Gestation

Birth Weight: Current Weight:

Reason for referral:

Maternal issues:	Infant Issues:
Nipple pain ☐	Can't latch ☐
Ulceration ☐	Can't maintain latch ☐
Mastitis (current or previous) ☐	Aerophagia ☐
Poor Supply ☐	Colic/ Reflux ☐

Feeding:

Exclusive BF ☐

Pumping ☐

Using shields ☐

Supplementation with formula ☐ % of feeds non BF ☐

Exclusive formula feeding ☐

Tongue functionality/ restriction:

Lateralisation ☐ Elevation ☐

Oral anatomy:Normal/ Abnormal

Ankyloglossia:

Anterior ☐ Posterior ☐ Comment

Referring practitioner:

Consultant☐ GP☐ CMO ☐ Other☐

Name Address

Contact Phone Number

Please note surgical intervention is only provided when there are established or predicted functional impacts of ankyloglossia.

Frenotomy Assessment Proforma

To be completed by practitioner/ surgeon

Ankyloglossia assessment

Pregnancy/ Birth history:	Normal	Complication:	
History of bleeding disorder:	Yes	No	If yes, specify:
Vitamin K at birth	Yes	No	
Family History of Tongue Tie:			

Symptoms/ problems:

Baby [ ] Not able to latch
[ ] Not able to stay latched
[ ] Constant feeds
[ ] Reflux
[ ] Weight issues
[ ] Windy

Mum [ ] Nipple soreness/ cracks
If yes: Pain score 1-10 _____
[ ] Mastitis

Frenotomy Procedure

Risks / Side Effects Discussed:

☐Bleeding (1 in 300)
☐Infection (1 in 10,000)
☐Salivary duct damage (minimal)
☐Difficulty / fussy feeding
☐Scarring/ reattachment : 3-10%

Parental Consent

I understand the implications of frenotomy as discussed above and give consent for the procedure to be undertaken.
I also consent to the use of non-identifiable photography to be used if asked. Yes ☐ No ☐

Signed: Date:

Surgeon:

Examination:

Tongue function impaired:	Extension	Elevation	Lateralisation	
Oral anatomy:				
Other:				
Anterior Component	1	2	3	
Posterior Component (tightness)	1	2	3	4(fibrous)

Procedure:

Routine stabilization, swaddle, retractor, division: Yes No

Blood Loss: Minimal Some Required prolonged pressure

Follow up:

Immediate

Improved bf? Yes No

Pain score? (1-10)