Assessment and Management of Babies with Tongue-tie

1. Purpose

Tongue-tie can interfere with a baby's ability to suckle efficiently at the breast.This may lead to nipple pain and trauma, poor breastmilk intake and a decrease in milk supply over time (Ballard et al 2002, Geddes et al 2008, Garbin et al 2013).

Tongue-tie that is associated with clearly identified feeding problems may be treated with a lingual frenotomy procedure (division of the lingual frenulum). Where there are no feeding problems, a tongue-tie may be considered a normal variant and this procedure may not be required.

This guideline outlines the management of babies with tongue-tie at the Women's.

2. Definitions

Tongue-tie (ankyloglossia) is a congenital condition in which the lingual frenulum is abnormally short and may restrict mobility of the tongue (Lalakea & Messner 2003). It occurs in about 3% of babies (Ballard et al .2002) and is more common in boys. The lingual frenulum is a normal structure however if it is short and restricts the movement and function of the tongue it is referred to as "tongue-tie". The most immediate impact of a tongue tie is on a baby's ability to breastfeed effectively. A tongue-tie may also have an effect on oral hygiene and there is limited evidence on the effect it may have on speech development.

3. Responsibilities

Midwifery, Nursing and Medical Staff: Provide evidence-based care to babies identified with a tongue-tie through accurate assessment, planning, documentation and communication. Give parents accurate information and advice regarding tongue-tie and feeding of their baby. Consult with and/or refer to other healthcare team members when indicated.

Clinical educators, facilitators and preceptors in Maternity and Newborn Services: Educate staff regarding evidence based care and management of babies with tongue-tie.

Lactation Consultants: Provide primary or secondary lactation consultation recommendations to parents, midwifery staff, nursing staff and medical staff regarding tongue-tie.

Staff performing tongue-tie assessment and frenotomy are adequately trained and maintain their competence.

This guideline is related to the Credentialing and Scope of Clinical Practice Policy and the Credentialing and Scope of Clinical Practice - Nursing and Midwifery Procedure.

4. Guideline

4.1. Signs associated with a significant tongue-tie:

- tongue cannot extend beyond the baby's lips
- tongue cannot be moved sideways
- tongue tip may be notched or heart-shaped
- when the tongue is extended, the tongue tip may look flat or square instead of pointed.

Breastfeeding problems, such as:

- nipple pain and damage
- a misshapen nipple after breastfeeding
- a compression / stripe mark on the nipple after breastfeeding
- the baby loses suction regularly on the breast whilst feeding
- a clicking sound may be heard whilst the baby is feeding
- poor weight gains.

4.2. Tongue-tie assessment and frenotomy procedure

- A credentialed lactation consultant or doctor should conduct a thorough assessment of breastfeeding and baby tongue mobility to determine whether release is required. (see appendix for Tongue-tie accreditation for RWH clinicians)
- A complete history should be taken prior to physical assessment to exclude other causes of breastfeeding difficulties, including if there is a history of bleeding disorders in the family
- Before tongue-tie release is considered, identify if the baby has had intramuscular Vitamin K administered at birth or the parents have chosen to administer oral Vitamin K. Tongue-tie should be delayed until 24 hours after baby has received intramuscular Vitamin K or 24 hours after the baby has completed 2 oral doses of Vitamin K
- The baby's mouth should be carefully inspected to exclude any other oral pathology e.g. cleft of the soft palate
- Using the Hazelbaker Assessment Tool for Lingual Frenulum Function (HATLFF) (updated 2012), score the appearance and function of the infant's tongue.
- If the clinician recommends release according to the HATLFF and the frenulum is visualised to be a thin membrane, consider release (Lalakea and Messner 2003)
- The parent/s should give written informed consent prior to the release
- An appropriately credentialed staff member should perform tongue-tie release
- If the frenulum is thick and release considered appropriate, the baby should be referred to a an appropriate specialist
- Babies may have the procedure performed without anaesthesia with little discomfort up to around 4 months of age
- The baby is placed supine with the elbows held flexed securely close to the face. The tongue is lifted gently with gloved finger and thumb so as to expose the frenulum. With sterile scissors, the frenulum is released by approximately 2 to 3 mm at its thinnest portion, between the tongue and the alveolar ridge, into the sulcus just proximal to the genioglossus muscle. Care is taken not to incise any vascular tissue (the base of the tongue, the genioglossus muscle, or the gingival mucosa). There should be minimal blood loss, i.e., no more than a drop or 2, collected on sterile gauze (Ballard et al 2002)
- The infant should be returned immediately to the mother for feeding. Reassessment of nipple pain and infant latch should occur post release
- There is no specific care required following the procedure. Occasionally a small white healing area may be seen under the tongue;this is normal and should resolve within two weeks of the release.

5. Evaluation, monitoring and reporting of compliance to this guideline

To be developed.

6. References

1. Academy of Breastfeeding Medicine Clinical protocol #11: Guidelines for the evaluated management of neonatal ankyloglossia and its complications in the breastfeeding dyad. www.bfmed.org
2. Ballard JL, Auer CE, Khoury JC. Ankyloglossia: assessment, incidence, and effect of frenuloplasty on the breastfeeding dyad. Pediatrics 2002; 110 (5): e63
3. Better Health Channel www.betterhealth.vic.gov.au

4. Hogan M, Westcott C, Griffiths DM. A randomised controlled trial of division of tongue-tie in infants with feeding problems. Archives of Disease in Childhood 2004; 89 (Suppl 1):A5

5. Lalakea ML, Messner AH. Ankyloglossia: does it matter? Pediatric Clinics of North America 2003;50:381-97

6. UNICEF UK Baby Friendly initiative. Helping a baby with tongue tie www.babyfriendly.org.uk/tonguetie.asp

7. Legislation related to this guideline

Not applicable.

8. Appendices

Appendix 1 – Tongue-tie - Accreditation for Clinicians

Appendix 2 – Assessment of Lingual Frenulum Function (ATLFF), MR1822

Appendix 1

Tongue-tie – Accreditation for Clinicians

Assessment and management of symptomatic tongue-tie should be performed by an experienced clinician who has undertaken approved observation and supervised practice (as per the Tongue-tie Accreditation Guideline).

To achieve accreditation RWH clinicians are required to perform an assessment on a minimum of 10 infants who are suspected to have a tongue-tie (under supervision). In addition, the clinician is required to observe the release of a minimum of 5 tongue-ties and correctly perform under supervision, a minimum of 5 satisfactory releases.

Clinicians must perform a minimum of 10 tongue-tie releases annually in order to maintain accreditation.

MR1822

the women's
the royal women's hospital

Assessment of Lingual Frenulum Function (ATLFF)

UR number: _____

Surname: _____

Given name/s: _____

Date of birth: _____ Gender: _____

(AFFIX PATIENT LABEL)

Mother's name: _____

Baby's name: _____ Baby's age: _____

Date of assessment: _____ Assessor: _____

FUNCTION ITEMS

Lateralisation

2 Complete
1 Body of tongue but not tongue tip
0 None

Lift of tongue

2 Tip to mid-mouth
1 Only edges to mid-mouth
0 Tip stays at alveolar ridge **OR** tip rises only to mid -mouth with jaw closure AND/OR mid-tongue dimples

Extension of tongue

2 Tip over lower lip
1 Tip over lower gum only
0 Neither of the above **OR** anterior or mid-tongue humps and/or dimples

Spread of anterior tongue

2 Complete
1 Moderate **OR** partial
0 Little **OR** none

Cupping of tongue

2 Entire edge, firm cup
1 Side edges only, moderate cup
0 Poor **OR** no cup

Peristalsis (progressive contraction)

2 Complete anterior to posterior (originates at tip)
1 Partial: originating posterior to tip
0 None **OR** reverse peristalsis

Snap back

2 None
1 Periodic
0 Frequent **OR** with each suck

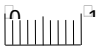
APPEARANCE ITEMS

Appearance of tongue when lifted

2 Round **OR** square
1 Slight cleft in tip apparent
0 Heart shaped

Length of lingual frenulum when tongue lifted

2 More than 1cm **OR** absent frenulum
1 1cm
0 Less than 1cm



Attachment of lingual frenulum to inferior alveolar ridge

2 Attached to floor of mouth **OR** well below ridge
1 Attached just below ridge
0 Attached to ridge

Elasticity of lingual frenulum

2 Very elastic (excellent)
1 Moderately elastic
0 Little **OR** no elasticity

Attachment of lingual frenulum to tongue

2 Posterior to tip
1 At tip
0 Notched OR under the mucosa at the tongue base

SCORING

Function Item score: _____

Appearance Item score: _____

Combined score: _____ /

Frenotomy recommended: YES / NO

ASSESSMENT

14 = Perfect score (regardless of Appearance Item score. Surgical treatment not recommended).

11 = Acceptable Function score only if Appearance Item score is 10.

<11 = Function score indicates function impaired. Frenotomy should be considered if management fails. Frenotomy necessary if Appearance Item score is <8.

ASSESSMENT OF LINGUAL FRENULUM FUNCTION

MR/1822

RWH

April 2014