REF:CTM Obs 116

Identification and Management of Tongue Tie in Babies

Initiated By	Cwm Taf Morgannwg University Health Board Obstetrics and Gynaecology Directorate
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CHANGE HISTORY

Version	Date	Author Job Title	Reasoning
1	Ratified April 2023	Infant Feeding Coordinators	New guideline

AUTHORSHIP, RESPONSIBILITY AND REVIEW

Author Job Title	Infant feeding coordinators- maternity, neonatal, health visiting. Maxillofacial and ENT teams	Ratification Date Review Date	April 2023 April 2026

Disclaimer

When using this document please ensure that the version is the most up to date by checking the Obstetrics & Gynaecology Guidelines on WISDOM
PRINTED DOCUMENTS MUST NOT BE RELIED ON

Contents

Equality Impact Assessment Statement

This Procedure has been subject to a full equality assessment and no impact has been identified.

Related Guidelines

- Infant Feeding Policy and Guideline: Maternity / Neonatal Services / Health Visiting
- Reluctant Feeding Guideline
- Guideline for Alternative Feeding Methods in the Full Term Breastfed Infant
- Guidelines for the Safe Management of Expressed Breastmilk.

All appropriate staff in Midwifery and Health Visiting services who care for mothers and babies will be orientated to this guideline as soon as possible after its ratification. Staff should receive disseminated training to enable them to understand how to implement the guideline as appropriate to their role.

The topic of ankyloglossia and breastfeeding, including reference to this Guideline, should be included in the curriculum of infant feeding education and training for all maternity, health visiting and neonatal staff, and included in any available orientation sessions for new doctors, at a level appropriate to role.

Dissemination of this guideline to Paediatricans will be made to inform that they can also refer babies to ENT team in RGH via same process as Midwives/Health Visitors.

Purpose

- To ensure maternity staff and health visiting staff are supported in knowing how to provide early identification and assessment of feeding problems linked to tongue-tie in the baby.
- To help them provide skilled intervention to safeguard breastfeeding and / or the establishment of lactation, whether or not surgical frenulotomy is performed.

Key Principles

The difficulties experienced by some breastfeeding mothers of tongue-tied babies arise from the baby's inability to attach to the breast, resulting in an inability to effectively breastfeed and transfer breastmilk. Problems such as sore/damaged nipples, mastitis, low milk supply may be encountered by mothers and for babies they may have restricted tongue movement, weightloss, difficulty staying attached to

the breast. It is not possible to predict whether a baby will have breastfeeding problems just from examining the baby's lingual frenulum; completing a detailed feeding history with clinical assessment is necessary, including an observation of the mother and baby feeding together. This is because the mother's breast and nipple anatomy is also significant in this situation, as is an understanding of babies' innate early feeding behaviours. Early and effective teaching of breastfeeding skills for the mother is very important.

Identifying Need for this Document

Breastmilk is recommended as the optimal source of nutrition for infants. It contains immune properties that can reduce the risk for morbidity and mortality in neonates.

Research has shown that providing mothers' breastmilk to premature infants can help reduce the incidence of necrotizing enterocolitis, reduce infection rates, improve feeding tolerance, and improve neuro-developmental outcomes.

To breastfeed successfully, mothers require accurate and evidence-based information, and face-to-face, ongoing, predictable support which reflects best standards of care.

The possible effect of tongue-tie on breastfeeding is recorded in historical texts. Research in the USA (2,3,4,5) and in the UK (6,7) has confirmed that a significant minority of tongue-tied babies may experience breastfeeding difficulties and also that division of the frenulum alleviates these difficulties in most cases.

The NICE "Interventional Procedure Guidance 149, Division of Ankyloglossia (tongue-tie) for Breastfeeding"(8) states that there are no major safety concerns about division of tongue-tie, and that the procedure can improve problematic breastfeeding when carried out by a registered healthcare professional who has been trained to undertake it. It states further that evidence is adequate to support the use of the procedure, provided that normal arrangements are in place for consent, audit and clinical governance.

Communication

- All staff supporting the breastfeeding mother and baby will have access to a copy of this guidance via usual CTMUHB access for Policies and Guidelines.

- All staff supporting the breastfeeding dyad are required to work collaboratively across disciplines and departments, including

maternity and neonatal services, health visiting services and the OMFS department PCH and POWH and ENT RGH, in order to protect, support and promote breastfeeding, improve mothers' / parents' experiences of care, provide evidence based care of tongue tie, while at the same time protecting the health and safety of all concerned at all times, ensuring measures are taken to prevent cross infection of any diseases including Coronavirus, in line with health board guidance.

- Audit of clinical processes will be undertaken to ensure ongoing compliance with the standards outlined in this Guideline.

- If infections such as COVID increase once again, there is an archived COVID guidance and Tongue tie pathway that can be reinstated, updated and utilised should the need arise.

Diagnosis

1.1 A breastfeeding assessment should be completed at day two-three, five and 10-14 after birth or at any time to aid a full breastfeeding assessment.. If concerns are identified, a breastfeed should be observed with skilled assistance for the mother to position and attach her baby. Initiate Appendix A for management pathway for Tongue tie.

1.2 A feeding plan will be developed in partnership with the mother and reviewed within an agreed timeframe to evaluate if improvements to breastfeeding have been made.

1.3 If problems persist despite skilled support and a short/tight lingual frenulum is identified, then tongue tie may be considered.

1.4 Staff providing skilled support, this may be the IFC or staff who have had training to use the Bristol Tongue Tie Assesment Tool across maternity, health visiting, will visually examine the oral cavity using the BTAT (Appendix B). The outcome will generate a score. An observational score of **0-3** indicates a significant restriction of tongue mobility.

1.5 The assessment score from this tool should be clearly recorded in the infants medical records, Personal Child health Record (red book) if available and on the referral form submitted to OMFS/ENT, if a referral for frenulotomy is made.

1.6 The practitioner (health visitor, midwife or nursery nurse) caring for the baby should then carefully assess breastfeeding to confirm whether the tongue-tie appears to be problematic for effective

breastfeeding and milk transfer. This assessment must include **observing a full breastfeed** for signs of effective attachment and milk transfer.

1.7 In an effort to avoid an unnecessary frenulotomy the practitioner should offer the mother skilled assistance to improve the positioning of her baby at the breast, which may be enough in itself to help the baby achieve effective attachment. Different positions suit different babies, but whatever position is used, '**C.H.I.N.**' principles always apply (**C**lose, **H**ead free, **I**n line, **N**ose to nipple). The exaggerated latch technique can be used as shown Appendix B. If the breastfeeding problem resolves with improved positioning, continued support with the successful technique should be offered at every feed until the mother is confident herself. Repeated practice may be needed initially by new mothers.

1.8 In these circumstances, if the mother is still in a hospital setting the midwife caring for the mother will suggest that she considers staying in hospital, where she will receive skilled help and ongoing monitoring and support, until the infant is demonstrating effective attachment at the breast and milk transfer.

1.9 During any period when a baby is not breastfeeding effectively the mother will be supported to initiate and maintain her milk supply. Appropriately trained staff should teach the mother how to express her milk comfortably and effectively, and support her to express at least 8 times in 24 hours, including once at night. Practice should always be in compliance with the "Guidelines for the safe management of expressed breastmilk" (11) and the "Guideline for alternative feeding methods in the full term breastfed infant" (12).

1.10 In order to avoid inappropriate or non–essential referrals for a frenulotomy, babies should not be referred to the OMFS / ENT team during the first 24 hours after its birth. This is because babies are often reluctant to breastfeed during the first day of life, regardless of their tongue mobility. Staff should follow the health board "Reluctant Feeding Guideline" (13) for care of these babies, which includes supporting the mother to initiate her lactation by appropriate help with milk expression.

1.11 The only exception to this is,if there is an obvious and significantly tight tongue-tie present and the baby, in spite of showing feeding cues, has been unable to suckle at the breast at all, even with the skilled help of staff.

1.12 Parents will be signposted to in the NICE information for the public "Division of Ankyloglossia (tongue-tie) for Breastfeeding" (8).

1.13 The health board **Infant Feeding Coordinator** from each service of maternity, neonatal and health visiting will keep staff informed of any service provision changes and provide training and updates. They should be contacted to discuss a baby's need for referral. If an IFC cannot be reached, an email or voicemail message must be left for them, communicating the referred baby's details, including phone number, to enable appropriate follow up and audit.

Referral process

If, following assessment and discussion, a referral to the OMFS team or the ENT team is requested by the mother, **the** appropriately trained and skilled practitioner (health visitor, midwife or nursery nurse) should closely follow the appropriate referral pathway within this guideline; if there is decreased service availability, or delay in referral, an appropriate plan should be initiated to support the maintenance of lactation with the mother. Consider IFC support for care planning in complex cases.

Review, Monitoring and Audit

Mothers and infants will be supported with ongoing or additional breastfeeding support whilst awaiting and post frenulotomy if required. Mothers will be offered a review by or encouraged to contact the referring practitioner or service of referrer (if they are not available) if needed.

Cwm Taf Morgannwg University Health Board requires that frenulotomy intervention will be audited on an ongoing basis to ensure best practice and quality standards are met.

Mothers of babies who have been referred to the OMFS / ENT team should be contacted soon after their appointment for the completion by telephone of a standardised audit tool. The audit tool was devised originally by the CTUHB OMFS Clinical Audit team; a list of the audit questions are included for information in this document (Appendix F). Referred babies who are seen by the team but do not have the lingual frenulotomy carried out must also be included in the audit process.

Audit will normally be carried out as part of the IFC role, but can be designated to a member of staff who has had basic training around the topic of ankyloglossia and breastfeeding.

Audit results will be reported by the IFCs to the Postnatal Forum, Care Group Quality, Safety and Patient Experience forum, Strategic Breastfeeding group and to the OMFS team on an annual basis. An action plan will be agreed by the CTMU Postnatal Forum Care Group Quality, Safety and Patient Experience forum, Strategic Breastfeeding group and OMFS / ENT to address any areas of concern that might have been identified.

References:

(1) World Health Organisation (April 2020) **"F.A.Q. - Breastfeeding and COVID-19 for health care workers"**

(2) Messner AH, Lalakea ML, Aby J, MacMahon J, Blair E (2000) "**Ankyloglossia: incidence & associated feeding difficulties**" *Arch Otolaryngol Head Neck surg. Jan. 126(1)36-9*

(3) Ballard JL, Auer CE, Khoury JC (2002) "**Ankyloglossia: assessment, incidence & effect of frenulotomy on the BF dyad**" *Paediatrics Nov:110(5):e63*

(4) Masaitis MS, Kaempf JW (1996) "**Developing a frenotomy policy at 1 medical centre: a case study approach**" *J Hum lact:12:229-32*

(5) Dolberg S, Botzer E, Grunis E et al (2003) "**A randomised, prospective, blinded clinical trial with cross over frenotomy in ankyloglossia: effect on breastfeeding**"*Pediatric Research; 52:822*

(6) Griffiths DM MCh FRCS (2004) "**Do tongue ties affect breastfeeding?"** *J Hum lact 20(4):409-414*

(7) Hogan M, Westcott C, Griffiths DM – Wessex Regional Centre for Paediatric Surgery (2005)"**A randomised controlled trial of division of tongue tie in infants with feeding problems**" *Journal of Paediatrics & Child Health*

(8) National Institute for Clinical Excellence (12/05) "**Division of ankyloglossia (tongue tie) for breastfeeding**"

(9) Cwm Taf Morgannwg UHB (6th April 2020)**"Statement on changes to visiting policy, routine surgery and outpatient clinics at Cwm Taf Morgannwg UHB"**

(10) Welsh Government (21st May 2020)"**Staying at home and away from others**"

(11) Cwm Taf Morgannwg UHB (2020)"**Guideline for the safe management of expressed breastmilk**"

(12) Cwm Taf Morgannwg UHB (2020) "**Guideline for alternative feeding methods in the full term breastfed infant"**

(13) Cwm Taf Morgannwg UHB "**Reluctant Feeding Guideline"**

Appendix A CTMUHB Tongue Tie management pathway for midwifery and health visiting services

Breastfeeding problem identified at day 2-3 and 5 breastfeeding assessment*****, and / or at 10-14 breastfeeding assessment completed.

Observation of a breastfeed to be completed.
Use principles of CHIN.
Ensure principles of positioning are supported using CHIN and exaggerated latch technique / laid back nursing as in Appendix A **.**
If problem not corrected and ongoing breastfeeding issues, then f**indings are documented along with detail of feed observation.** Reassure parents that **around 50%** of babies with a tongue tie will B/F ok if feeding technique is good & we will help them with this **Appendix B**

If required refer to IFC or relevant trained health professionals to assess tongue mobility using BTAT and TABBY, assess breastfeeding and further support.

If following the breastfeeding assessment and BTAT baby feeds effectively then follow up contact details can be given if any ongoing concern or follow up support as appropriate.

If No improvement *and* it is the tongue tie*,* appears to impact on latching, milk transfer, nipple pain. Parents can be offered referral and given information including BTAT and Tabby and "NICE guidance for parents"

The appropriate referral should be made using quick referral guide Appendix D, and referral form Appendix F. A written plan to support feeding / optimise expressing to maintain lactation while awaiting procedure .Appendix C

Inform that additional support is often needed following division and refer to Infant Feeding Co-ordinator for mum to ensure support for ongoing breastfeeding skills if required.

*****Tongue tie assessment is more effective after baby is 2-5 days old as breastmilk supply needs to be abundant for an accurate assessment . In order to avoid inappropriate or non–essential referrals for a surgical procedure, **no baby** should be referred to the OMFS team or ENT team for a surgical frenotomy **during the first 24 hours after its birth,** unless there is an obvious and significantly tight tongue-tie present (see point 1.7).

If there are any gaps in service provision for division, initiate a plan to optimise breastfeeding and maintain lactation. Seek IFC support for care planning - see point 1.9, use **Appendix C**

Appendix B Bristol Tongue Tie Assessment Tool (BTAT) and Tabby

The Bristol Tongue Assessment Tool (BTAT)

This may be helpful when assessing reduction of a baby's tongue function, but it should be used in addition to the assessment of a full breastfeed by the referring practitioner

	0	1	2	Score
Tongue tip appearance	Heart shaped	Slight cleft /notched	Rounded	
Attachment of frenulum to lower gum ridge	Attachment at top of gum ridge	Attached to inner aspect of gum	Attached to floor of mouth	
Lift of tongue with mouth wide (crying)	Minimal tongue lift	Edges only to mid-mouth	Full tongue lift to mid-mouth	
Extension of tongue	Tip stays behind gum	Tip over gum	Tip can extend over lower lip	

Scores of 0 – 3 indicate a more severe reduction of tongue function

Referral for tongue – tie release can often be avoided:

When tongue movement is restricted, help the mother to improve her baby's positioning to aid attachment at the breast

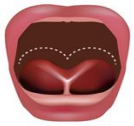
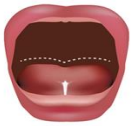
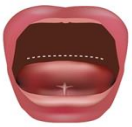
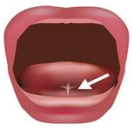
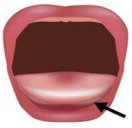
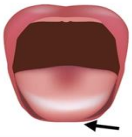
- ✓ **Is the baby held close to (or lying on) his/her mother's body?**
- ✓ **Is the baby free to tilt his/her head back?**
- ✓ **Are the baby's head and body in a straight line?**
- ✓ **Does the baby's nose start off opposite the nipple?**

Next, try the "Exaggerated Attachment Technique" - the aim of this is to deepen the baby's attachment & get more breast tissue into the baby's mouth:

The mother should cup the breast she is using with the hand from the same side, keeping her fingers well away from the areola (moving them too near the areola will spoil the attachment). Her thumb should indent the areola about an inch above the nipple; this should tilt the nipple back so it looks like it's pointing away from the baby. This will have the effect of making the breast under the nipple bulge forwards. Whilst maintaining this action, the mother should quickly bring the baby to the breast with head extended back & with a wide open mouth. Aim the nipple to the roof of the mouth, up & over the tongue, only removing her thumb when the baby has attached and has taken a few sucks. Help the mother practice this technique until she feels confident

If the above does not help:
Suggest 'laid back attachment'; Babies often attach more effectively when fully supported on mother's body and left to find the breast themselves; this may take a little time, and should be tried before the baby gets too hungry.

TABBY Tongue Assessment Tool

	0	1	2	SCORE
What does the tongue-tip look like?				
Where it is fixed to the gum?				
How high can it lift (wide open mouth)?				
How far can it stick out?				

Breastfeeding intervention techniques:
Assist the mother with attachment of baby at the breast, consider use of **cross cradle hold**, **lying on side** or other positions (whichever the baby likes best). Demonstrate the '**exaggerated latch'** and **'flipple' technique** to the mother to optimise the chance of successful attachment. Try **biological nurturing** (self attachment) with chin placed deeply below breast.

During any period when a baby is not feeding effectively at the breast, offer support to help her initiate her milk supply. Demonstrate using a knitted breast or show video to teach the mother how to hand express her milk comfortably and effectively, and support her to express at least 8 times in 24 hours, including once at night.

Support mother to do effective massage & breast compressions while expressing to aid milk transfer.

If baby still not attaching well & milk supply has increased, offer support to use a Nipple Shield - ensure the shield FITS correctly & is FITTED correctly as per pack instructions. Support mother to continue expressing briefly after BF with shield to safeguard lactation.

Monitor & review feeding closely - use breastfeeding assessment tool, objectively assess breastfeeding/lactation. Identify early red flags that could indicate problems.

If mother unable to BF even with shield: Support mother with **optimal expressing,** ensure threshold >750mls/24hr reached by Day 10-14 – safeguards future lactation.

Feed EBM to baby via alternative feeding method – **paced, responsive bottle feeding should be explained.** Use **BFI expressing checklist** to ensure structured, safe remote assessment of lactation.

Appendix C: Tongue-Tie Identified - Support for breastfeeding & lactation if surgical release is not possible /or delayed

Tongue tie identified in a BF baby – Overview.
Reassure parents that **around 50%** of babies with a tongue tie will B/F ok if feeding technique is good & we will help them with this. If still problems after a few days of support, then parents must be advised that division may not be available in the current situation but that we will support them with conservative measures to safeguard their lactation & keep baby fed with mother's milk

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Labour/birth events: These contribute significantly to early feeding issues, so for 1st 48hrs if baby is having difficulty with attachment, robustly follow **reluctant feeder guidelines** – maintain skin contact, support with hand expressing every 2-3 hours, give colostrum to the baby – syringe or cup, regular observations.

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BF intervention techniques: When assisting mother with attachment consider use of **cross cradle hold**, **lying on side** or other positions (whichever the baby likes best). See the 'avoiding tongue tie release' section of the BTAT for how to teach '**exaggerated latch'** and **'flipple' technique** to the mother to optimise the chance of successful attachment. Try **biological nurturing** (self attachment) with chin placed deeply below breast– ask for back-up from a BF Lead, IFC or more experienced colleague if you are not confident with this.

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Day 2 : If baby still not attached or suck swallow & mother is able to hand express ≥5mls*, start use of **electric breast pump** –
8 x in 24hrs. To begin with, express alternate breasts for about 5 mins each x 2 - i.e pump each breast **at least twice,** for a total of **20mins per session**. Support mother to do effective **massage** & **breast compressions** while expressing to aid milk transfer. Support mother to obtain a breast pump for use at home.

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Day 3/4 : If baby still not attaching well & milk supply has increased, offer support to use a **Nipple Shield -** ensure the shield FITS correctly & is FITTED correctly as per pack instructions. If unsure re correct use - seek advice from IFC or from colleague trained / experienced in their use**.** Support mother to continue expressing briefly after BF with shield to safeguard lactation. Ensure effective breast compressions used during feeds with shields.
*If mother prefers, use of a nipple shield can be started once threshold of ≥5mls EBM reached.

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Day 4/5 onwards: Monitor & review feeding closely - structured remote contact - use **breastfeeding assessment tool,** objectively assess breastfeeding/lactation. Identify early red flags that could indicate problems – early intervention will prevent potential hospital admission for eg mastitis, weight loss.

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If mother unable to BF even with shield: Support mother with **optimal expressing** ensure threshold >750mls/24hr reached by Day 10-14 – safeguards future lactation.
Feed EBM to baby via alternative feeding method – **paced, responsive bottle feeding should be explained.** Use **BFI expressing checklist** to ensure structured, safe remote assessment of lactation.
Keep situation under review as often direct BF or BF with a shield becomes possible as baby grows.

Appendix D: Quick Guide to Referral Process

Contact a CTMU Infant Feeding Coordinator for discussion /support /referral :

Carol Jones – 07967 366884 – carol.jones17@wales.nhs.uk
Rachel Evans – 07917077611 - Rachel.Evans18@wales.nhs.uk
Rosy Phillips - Rosanne.Phillips@wales.nhs.u
Fay Fear -07771 941542 –Fay.Fear@wales.nhs.uk

Discussion with support with latch
Lynne Powell (EYA Infant Feeding Advisor) 07973898047

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Health Professional referrals only
Midwife/Health Visitor/ Maternity NNEB/B/F Champion to ring
OMFS in **PCH** on ext **28142 Secretary Elena Simneova**
or email **referral**
ENT in POW on tel ext. number **52172** Secretary Aime Devoy send to aime.devoy@wales.nhs.uk and julie.evans20@wales.nhs.uk/SBU.OMFSReferralmanagement@wales.nhs.uk.
OMFS in RGH on ext 73533 Secretary Sarah Jeffery. Sarah.Jeffery@wales.nhs.uk
Ask for earliest available time for baby to be seen by an OMFS doctor, with a view to releasing the baby's tongue-tie if they think it is clinically appropriate.
Ensure you communicate the baby's **location** & mother's **contact number**.

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Complete a **Referral Form** and take / send /email it (whichever is requested) to the OMFS dept / ENT dept,
please copy in in the IFC if sent by email community or keep copy in Tongue Tie folder on ward.

Inform the baby's mother as soon as you know what day / time the baby can be seen.

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Continue to support the mother after baby's lingual frenulum is released; refer to "**Tongue Tie Identified – Supporting breastfeeding / lactation**" flowchart.

Ensure mother has both "**LACTATION SUPPORT – CWM TAF MORGANNWG**" flyer to take home with her (usually in Discharge Packs), and "**FOLLOWING FRENOTOMY**" flyer (in Tongue Tie folder) Ensure any need for ongoing support is passed on to community midwives' team or family health visitor.


Tongue Tie Audit form

Appendix F Tongue Tie Referral form

REFERRAL FORM for TONGUE TIE DIVISION

Date of Referral: Click or tap here to enter text.

Name of and role of Referrer HV/MW/State other if different Click or tap here to enter text.

Name BABY Click here to enter text.				**Name MOTHER** Click here to enter text.			
DOB: Click here to enter text.				**DOB:** Click here to enter text.			
Baby's Address Click here to enter text. Click here to enter text. Postcode Click here to enter text.				**Mother's Telephone Number** Click here to enter text.			
Hospital number BABY: Click here to enter text.							
Name of GP: Click here to enter text.							
Vit K given?	YES ☐	NO ☐	UNSURE ☐	**Family history of bleeding problems**	YES ☐	NO ☐	UNSURE ☐

Reason for referral: (place a cross in box to all relevant)

Not Latching ☐ Latching but slips off breast frequently ☐ Latches but incorrect suck/swallow☐

Associated problems: (place a cross in box to all relevant)

Nipple pain ☐ Nipple soreness ☐ Nipple trauma / cracked ☐ Other Click here to enter text.

Weight loss at 72 hrs Above 10% ☐ Above 12% ☐

Jaundice noted? Normal physiological ☐ Any other Click here to enter text.

BRISTOL TONGUE TIE ASESSMENT TOOL

	0	1	2	Score
Tongue tip appearance	Heart shaped	Slight cleft /notched	Rounded	Click here to enter text.
Attachment of frenulum to lower gum ridge	Attachment at top of gum ridge	Attached to inner aspect of gum	Attached to floor of mouth	Click here to enter text.
Lift of tongue with mouth wide (crying)	Minimal tongue lift	Edges only to mid-mouth	Full tongue lift to mid-mouth	Click here to enter text.
Extension of tongue	Tip stays behind gum	Tip over gum	Tip can extend over lower lip	Click here to enter text.
SCORE TOTAL Click here to enter text.				

Actions taken pre referral: (place a cross in box to all relevant actions taken) (50% of babies with tongue tie will breastfeed ok if breastfeeding technique is good)

Reluctant feeder pathway 24hrs ☐ 48hrs ☐ 72hrs ☐

If latches Exaggerated latch ☐ Biological nurturing ☐ Chin firmly placed to breast ☐

Confirm: CHIN leads---Close ☐ Head ☐ Inline ☐ Nose to Nipple ☐

Interim measures Expressing ☐ Breast compression ☐ Use of nipple shields ☐