Aneurin Bevan University Health Board

Identification and Management of Babies with Ankyloglossia (Tongue Tie)

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Policy on a Page: Key Messages

Aim:

This guideline aims to standardise the identification and management of tongue tie in babies, ensuring evidence-based and consistent care.

Summary of key changes (for revised documents only)

- Alignment with contemporary practice.
- Confirmation of referral process via electronic maternity system, Badgernet.
- Transition to new ABUHB guideline template.
- Update to *Tongue Tie Information for Parents* leaflet to include incidence of infection associated with ankyloglossia.
- Strengthening of statements with regards to equality, diversity and inclusion.

Key Requirements:

- Frenulotomy only for feeding difficulties
- Not for speech or weaning concerns
- Assessment does not guarantee treatment

Baby must be:

- ≤ 12 weeks, ≥ 37 weeks gestation
- Vitamin K given
- Feeding difficulties despite support

Referral

- Via Badgernet/email
- TABBY score required

Safety

- Written consent
- Two staff present
- Urgent escalation for bleeding

Target Audience:

This guideline applies to clinicians working within maternity services.

Training:

Staff are expected to access appropriate training where provided. Training needs will be identified through appraisal and clinical/ educational supervision.

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1. Introduction/Overview

Breastmilk is identified as the optimal source of nutrition for babies and children up to the age of two and beyond. The benefits of breastfeeding for both the mother/parent and infant are well documented (UNICEF, 2022). To enable continued breastfeeding, it is important to provide robust support which includes identifying and managing potential issues.

Ankyloglossia, also known as tongue tie, is a relatively common condition which is thought to be present in approximately 8% of babies (Hill et al 2021), and can be defined as an abnormally short or thickened frenulum, resulting in restricted tongue movement (NICE, 2005).

Feeding difficulties have been reported in babies with tongue restriction, as the tip of the tongue may be restricted from protruding beyond the lower gum ridge and the baby's ability to extend, elevate, cup and lateralise the tongue is impeded. This causes difficulties with breastfeeding and bottle feeding in some babies which can lead to hospital readmission and cessation of breastfeeding.

2. Scope

This document will provide guidance to staff within Aneurin Bevan University Health Board who undertake tongue tie assessment, referral and frenulotomy.

3. Statement/Background

As part of a recognised Marmot region (Gwent PSB 2022), Aneurin Bevan University Health Board aims to reduce inequalities and contribute to giving every child the best start in life by supporting continued breastfeeding up

to two years and beyond, as per WHO and UNICEF recommendations (2022).

If you have difficulty understanding any part of this guideline- including due to learning, sensory, or communication needs- please speak with your Line Manager or contact the authors of this guideline for support or clarification.

Staff must take a proactive approach to identifying and meeting the accessibility and communication needs of people with disabilities and/or language barriers, including offering information in alternative formats, arranging interpretation or communication support as required, and not relying solely on individuals to request adjustments.

The term "woman/ women" will be used throughout this document however, it is recognised that this refers to all pregnant, birthing and postnatal people regardless of gender identification.

Staff must take a proactive approach to identifying and meeting the accessibility and communication needs of people with disabilities and/or language barriers, including offering information in alternative formats, arranging interpretation or communication support as required, and not relying solely on individuals to request adjustments.

4. Aim

This guideline will ensure that families seeking assessment and treatment for ankyloglossia are able to access a service in a timely manner, so as to reduce the potential barriers for continued breastfeeding.

5. Main Body

Midwife/ Nurse-Led Tongue Tie Assessment Clinic

The assessment clinic is led by registered health care professionals who have been trained in tongue tie assessment and management, and frenulotomy will only be performed for feeding problems thought to be caused by a tongue tie.

Evidence supporting frenulotomy for potential speech and weaning issues is weak, and these are therefore not indications for frenulotomy within the Midwife/ Nurse-Led Tongue Tie Clinic.

Frenulotomy will be performed based on the tongue tie practitioner's assessment, and parents should be informed that a referral to the clinic will not necessarily result in treatment.

Referral Process

Referral should be considered when there are suspicions that a tongue tie is present and, despite adequate feeding support, is affecting the baby's ability to feed efficiently. All staff should be aware of the possible symptoms of tongue tie (Appendix 1), but note that babies with a tongue tie do not necessarily have every symptom.

The assessor can refer to the clinic using the Infant Feeding referral form via Badgernet (Figure 1 and 2). If there is no access to Badgernet, an email can be sent to abb.infantfeeding@wales.nhs.uk, ensuring there is documentation of feeding assessment and tongue tie assessment. With both referral methods, a TABBY score should be documented (Appendix 2).

The tongue tie practitioner will contact the parents via telephone to arrange a clinic appointment, and send the Parent Information Leaflet (Appendix 3).

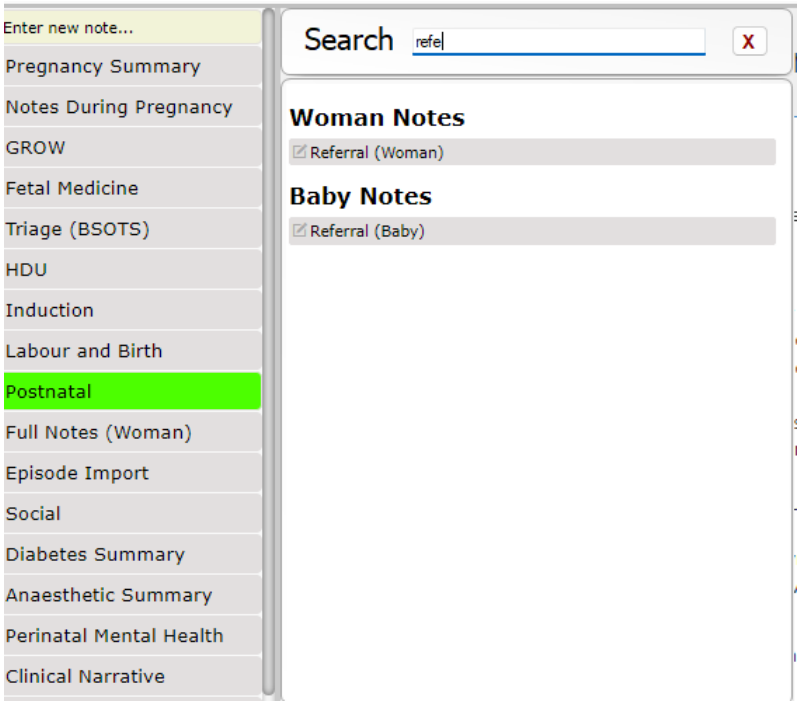

Figure 1 Badgernet Postnatal Referrals

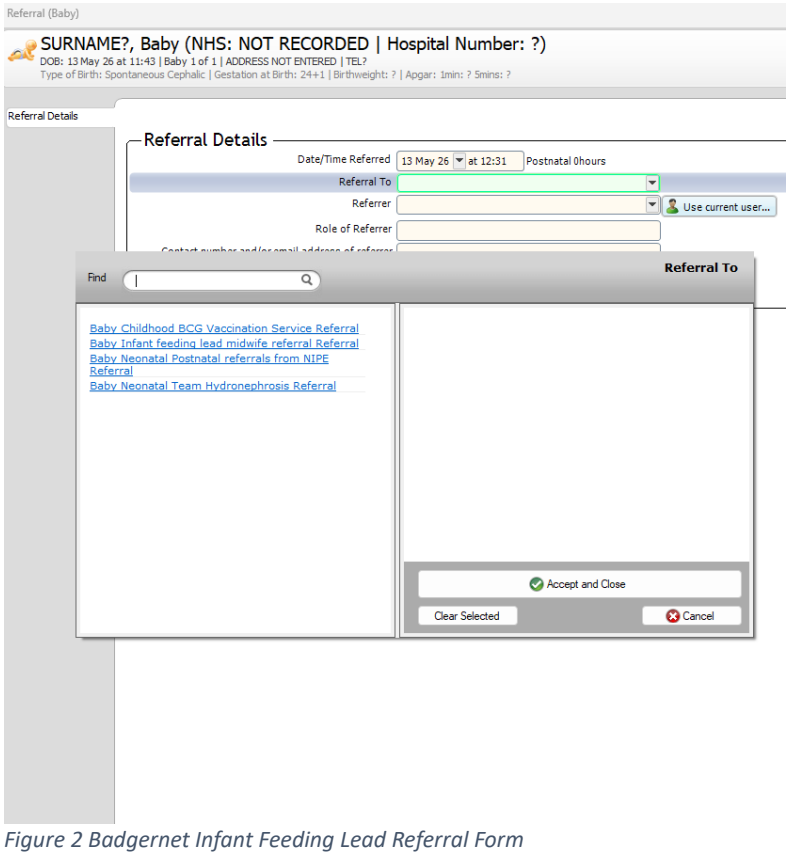

Figure 2 Badgernet Infant Feeding Lead Referral Form

Referral Criteria

- Baby is equal to or less than 12 weeks of age,
- Baby is greater than 37 weeks' gestation at birth (or age adjusted),

- Baby has received vitamin K (by intramuscular injection or at least two oral doses) *,
- A full feeding assessment has been completed and, despite adequate feeding support, feeding difficulties continue.

*Vitamin K must have been administered more than 24 hours before frenulotomy. If parents decline vitamin K, a full clotting screen should be arranged with paediatrics before attending the Midwife/ Nurse-led Tongue Tie Assessment Clinic.

Exclusion Criteria

The following babies are not suitable for frenulotomy;

- Family history of blood clotting disorders (following investigations),
- Cleft palate,
- Pierre Robin sequence,
- Frenulum is particularly vascular on examination,
- Absence of feeding issues.

In the event that a baby is under the care of a paediatrician or has any medical history, frenulotomy will not be performed unless there is written confirmation from the baby's paediatrician or GP that frenulotomy is safe and appropriate.

Procedure

Prior to the procedure, ensure the pre-procedure checklist is completed, written consent has been sought and an opportunity given for the parents to ask any questions.

Prepare the equipment and environment

The following equipment/ environmental factors are required;

- Sterile gloves,

- Sterile blunt end scissors,
- Small sterile gauze pad,
- Clean towel and blanket,
- Neonatal and paediatric resuscitation equipment (for emergencies only),
- Two members of staff are required for the procedure (a trained practitioner and a support worker),
- Good lighting,
- Flat area/ surface.

Preform frenulotomy procedure

- Fully visualise the palate before proceeding,
- Use a double or single finger to elevate the tongue and stretch the frenulum,
- Using sterile blunt ended scissors, snip the frenulum,
- Check for symmetry and make sure lateral edges are symmetrical by a single or double finger tongue elevation,
- Compress the floor of the mouth with the sterile gauze pad and return baby to the parent/guardian for immediate feeding,
- Encourage the baby to feed,
- Observe the feed,
- Observe the baby's wellbeing and post-procedure blood loss,
- If the baby is particularly unsettled and reluctant to feed, consider oral sucrose.

After Care

- Give post procedure information leaflet *"Aftercare Advice Following Tongue Tie Release"* (Appendix 4),
- Ensure letter to GP is sent,
- Provide information for Personal Child Health Record ("red book"),

- Record the outcome for the appointment on Tongue Tie Database for audit purposes,
- Ensure parents are aware of local feeding support groups for ongoing support.

Adverse Outcomes

In the unlikely event of continued bleeding following the procedure, refer and follow the bleeding protocol (Appendix 5). Contact '999' and transfer the baby to the Grange University Hospital for ongoing management.

Complete a DATIX incident report following any bleeding event which requires intervention.

6. Roles and Responsibilities

- It is the responsibility of the Infant Feeding Lead Midwife to ensure this guideline is circulated to all appropriate staff members upon ratification.
- It is the responsibility of both the Infant Feeding Lead Midwife and Infant Feeding Lead Health Visitor to ensure that appropriate staff have adequate training in order to complete assessments and referrals.
- It is the responsibility of the tongue tie practitioners within the health board to refer to this document to ensure high quality standardised levels of care.

7. Consultation

All new or significantly revised policies will be subject to consultation within the division via the Clinical Effectiveness Forum (CEF) and with relevant professional groups and/ or individuals present.

Individuals with expertise in obstetrics and midwifery have been consulted with in the development of this policy.

8. Equality Impact Assessment

An equality impact assessment has been carried out and approved as this guideline prioritises care based on standardised assessment and clinical need.

9. Training Requirements

Midwifery staff are required to complete the mandatory breastfeeding study day on an annual basis.

Frenulotomy is to be performed by appropriately trained clinicians only.

Staff are expected to access appropriate training where provided. Training needs will be identified through appraisal and clinical/ educational supervision.

10. Audit and Review

This policy will be reviewed on a 3-yearly basis, unless significant changes to clinical practice/ national policy arise.

Referrals, procedures and outcomes will be recorded by the tongue tie practitioners leading the service, and audited by the Infant Feeding Lead Midwife.

An email will be sent to parents 4 to 6 weeks following their appointment to gather feedback to monitor outcomes.

11. References

UNICEF, 2022 Breastfeeding leaflet (unicef.org.uk)

Hill, R.R., Lee, C.S. & Pados, B.F., 2021, The prevalence of ankyloglossia in children aged <1 year: a systematic review and meta-analysis. *Pediatric Research* **90**, 259–266

NICE, 2005 Division of ankyloglossia (tongue-tie) for breastfeeding | Guidance | NICE

Gwent PSB, 2022. Microsoft Word - 03 - Proposal - Gwent Becoming A Marmot Region.docx (gwentpsb.org)

12. Appendices

Appendix 1: Common symptoms of ankyloglossia (tongue tie)

Breast feeding	**Bottle feeding**
Flattening of nipple	Excessive dribbling of milk
Nipple trauma	Poor seal on bottle
Mastitis	Audible clicking sounds due to poor suction
Excessive early weight loss	Aerophagia
Poor weight gain (see weight loss pathway)	Poor weight gain (see weight loss pathway)
Difficulty attaching to the breast	Excessive early weight loss
Clicking sounds	Reflux symptoms
Low milk supply	Coughing/choking episodes during feeds
Prolonged feeds	
Short, very frequent feeds	

Coughing/choking episodes during feeds	
Reflux symptoms	

Appendix 2: TABBY Tongue Assessment Tool

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?				

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Appendix 3: Tongue Tie Information for Parents

Tongue Tie Information for Parents

What is tongue tie?

'Tongue tie' describes a restriction of the tongue caused by a short or inelastic frenulum. A frenulum is the skirt-like structure which forms across the floor of the mouth and attaches to the underside of the tongue (the 'string' beneath the tongue).

Most babies have a visible frenulum but only a small number of babies have restricted tongue movement caused by a short, tight frenulum.

Some frenula are easy to see whereas others are further back in the mouth and not so obvious.

It is important to note that not all babies with a tongue tie require frenulotomy (procedure that divides or 'snips' the frenulum). If there are no feeding issues you will not require an appointment for frenulotomy. If there are feeding issues that can be resolved with good lactation support, a frenulotomy may not be necessary.

Tongue tie symptoms

Tongue tie can cause feeding issues for both parents and babies. You may have only some of these symptoms.

Mother/parent	**Baby**
Nipple trauma	Coughing/choking during feeds
Mastitis	Very frequent feeds
Low milk supply	Very long feeds
Over supply of milk	Colic/wind
	Reflux
	Difficulty staying attached to the breast
	Weight loss/faltering growth
	Excessive dribbling of milk during feed

What will happen at the appointment?

A referral to the clinic does not mean your baby will definitely be offered a frenulotomy. The decision for frenulotomy will be made following assessment by the practitioner at the clinic.

During your appointment you will be asked to feed your baby as part of the assessment. Your baby will then have a physical assessment by the tongue tie practitioner where the oral function will be 'scored' using the ATLFF (Assessment Tool for Lingual Frenulum Function). This will include the practitioner observing your baby's ability to lift, extend and move their tongue from side to side. The practitioner will also place their finger in your baby's mouth and assess how well they suck. Following this assessment, the findings will be shared with you and a full discussion will take place regarding your options. This may include some feeding adjustments and returning to clinic at a later date if issues continue.

If your baby's tongue function is restricted and following discussion you decide you would like to proceed with the frenulotomy procedure, you will first be asked to sign a consent form. Following this, your baby will be swaddled and someone will

hold your baby's head in a fixed position to reduce movement. Babies often start to cry at this, but it is for a very short time. The practitioner will hold your baby's mouth open and lift his or her tongue and make an incision with scissors. Sometimes when the frenulum is very short and tight, a second incision may be necessary once more of the underside of the tongue is visible. It is common for the wound to bleed minimally, and gauze is placed on the wound to absorb any blood. The baby will then be handed back to you for a feed. Feeding immediately after frenulotomy helps comfort your baby and encourages tongue movement.

Things to consider before making a decision

Although a frenulotomy is a minor procedure which is usually low risk, there are risks involved:

Bleeding

Bleeding is usually minimal and stops very quickly after the procedure.
If bleeding is more than expected, the practitioner may need to apply pressure to the wound with a piece of gauze (1 in 400). The risk of the baby needing medication to stop the bleeding is approximately 1 in 7000. The risk of the baby requiring surgical intervention to stop the bleeding is 1 in 70,000.

Infection

Breast milk is very good at aiding the healing of the incision, however there is a small risk of infection (1 in 6000). The wound may become red, inflamed and baby may be unwell with a temperature and lethargy. If this happens your baby will need antibiotics.

Damage to surrounding structures

There is a very small risk of damage to salivary glands and nerves in the tongue. Sometimes this will heal itself, however any damage to surrounding structures may result in abnormal healing and may require a further surgical procedure to correct.

Reformation

In some babies the frenulum may reform. You may notice changes in your feeding following a period of improvement. If this happens you should contact a frenulotomy practitioner via the email address you will be provided with for re assessment. Sometimes a second procedure is necessary.

Frenulotomy Aftercare

Immediately after the procedure, your baby will be handed back to you and you will be asked to feed your baby. You may find an improvement of symptoms instantly, however this is not always the case as your baby may need to learn how their new tongue moves. The improvement in feeding may be gradual, and can take 3 to 4 weeks before you notice whether or not the frenulotomy has been effective. You will be given an aftercare leaflet detailing some exercises to do, and details of feeding support groups and clinics if further lactation support is required.
Sometimes the wound can start to bleed again once you are home. If this happens, you should apply pressure to the wound with your finger for 10 minutes. If this does not stop the bleeding, then you should present to A+E.
You will be emailed 4-6 weeks post procedure, asking for feedback to help us collect important data around tongue tie, infant feeding, and the efficacy of offering frenulotomy as a service.

For any **non urgent** queries, email abb.infantfeeding@wales.nhs.uk

Appendix 4: Aftercare Advice Following Surgical Tongue-tie Release Leaflet

Aftercare Advice Following Surgical Tongue-tie Release

Association of Tongue-tie Practitioners

Educate • Support • Care

This factsheet has been provided by the Association of Tongue-tie Practitioners to support the discussions you have had with your tongue-tie practitioner regarding what to expect and the care of your baby following tongue-tie release.

Wound healing

Following tongue-tie release there MAY be a diamond-shaped wound healing under the tongue. This will heal by itself and be pink in colour to begin with. Over the first few days it is normal for the wound to look white or yellow and, if your baby is premature, it MAY even look a bright yellow / orange colour. The size of the wound will reduce and then disappear over the next 7-14 days.
Further examples of what this can look like can be found on the ATP website.

It is advisable to take extra care to thoroughly sterilise any feeding equipment being used to reduce the chance of infection.
All formula feeds should be made up in accordance with the manufacturer's instructions on the packaging.

When to be concerned?

If your baby's wound looks swollen, red and inflamed or if your baby develops a high temperature, refuses to feed, is sleepy or irritable please make an urgent appointment with your general practitioner (GP) or speak with your out of hours service on 111 as, although very unlikely, your baby may require antibiotics. If you have any questions about the wound healing please contact your practitioner to discuss and / or email them an image of the wound.

Further bleeding

Your practitioner will check your baby's wound after the first feed to ensure all bleeding has stopped. If your baby vomits after the procedure you may notice some streaks in the milk / vomit. Similarly, you may notice a small streak of blackness in your baby's stool later on due to a small amount of blood that has been swallowed with the first feed after the procedure.

What to do if bleeding starts again later when you are on your own:

- Step 1: Offer the baby the breast or bottle and feed them. This will usually stop the bleeding within a few minutes just as it did immediately after the procedure. If the baby refuses to feed then sucking on a dummy/soother or your clean finger will have a similar effect.
- Step 2: If the bleeding is very heavy or it does not reduce with feeding and stop within 15 minutes, then apply pressure to the wound under the tongue with one finger using a clean piece of gauze or muslin for 20 minutes. Do not apply pressure under the baby's chin which can affect breathing.
- Step 3: If bleeding continues after this time and you are concerned, continue to apply pressure to the wound and please call 999 as it will be advisable to get your baby checked in hospital.

For more information see https://www.tongue-tie.org.uk/bleeding-guidelines

First published by the Association of Tongue-tie Practitioners 2017. Updated 2021.
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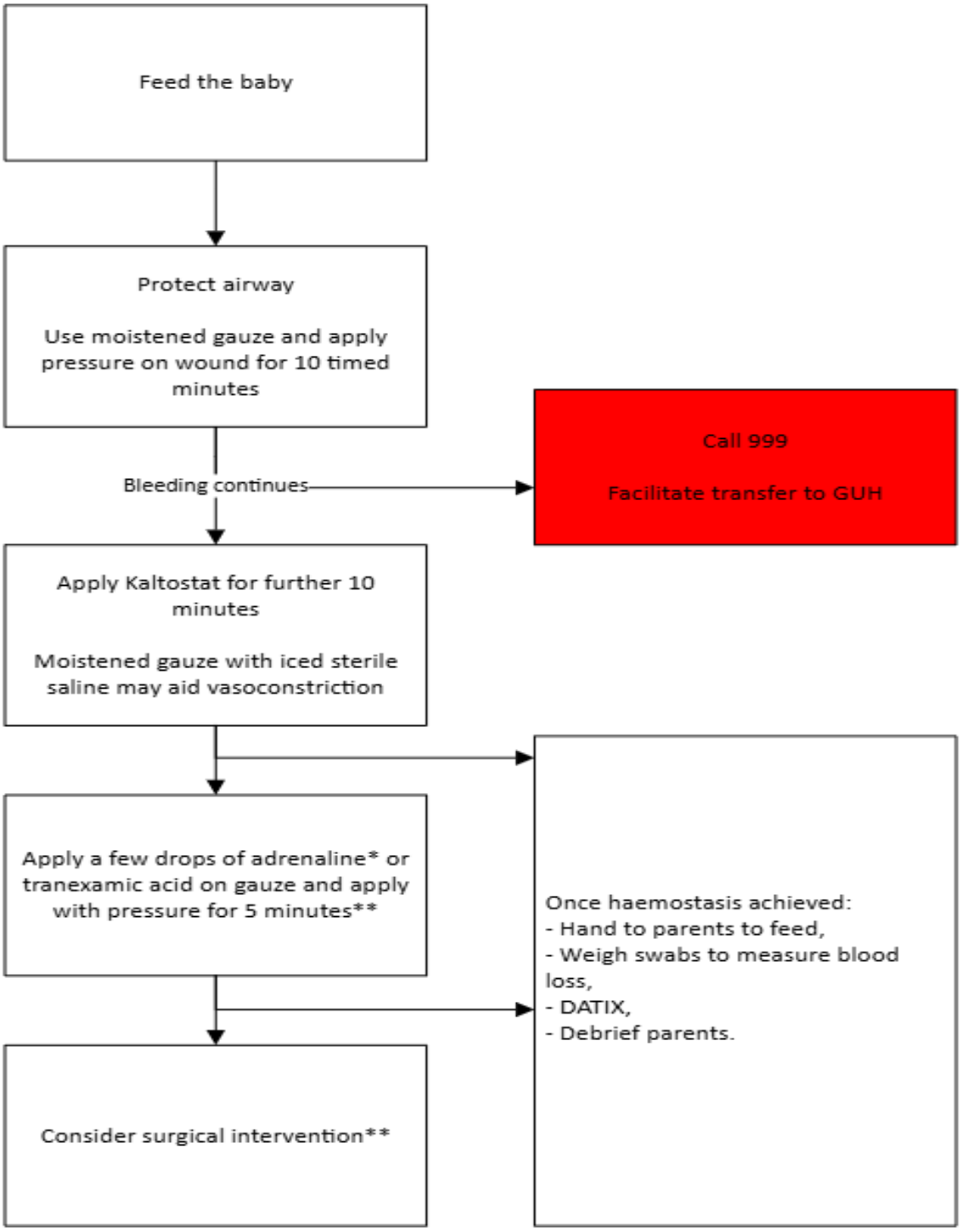
Appendix 5: Prolonged bleeding management following frenulotomy



*Adrenaline to be administered in a controlled hospital environment with suitable monitoring. Consider effect of systemic absorption, choose smaller concentration of 1:10,000 or 1:100,000

**To be administered by medical team

Guidelines based on www.tongue-tie.org.uk/bleeding-guidelines