

Tongue Tie Assessment.

Management of Ankyloglossia and Midwife led Frenulotomy Guideline

Guideline information

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Summary of document:

This gives guidance to Hywel Dda maternity staff and specialist public community health nurses when they suspect the presence of a tongue tie, which is adversely affecting the way a baby is feeding, and the appropriate referral pathway.

Scope:

This guideline is applicable to newborn infants up to the age of 12 weeks where a tongue tie (Ankyloglossia) is suspected and should be used by maternity, paediatric and specialist community public health nurses

To be read in conjunction with:

NA

Patient information:

Include links to [Patient Information Library](#)

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Keywords

Tongue Tie, ankyloglossia, Frenulotomy

Glossary of terms

Ankyloglossia (tongue tie)

Frenulotomy (separation of a tongue tie)

Key points:

Guidance on the management of infants up to the age of 12 weeks where a tongue tie (ankyloglossia) is suspected and the relevant referral pathway for midwifery led management of frenulotomy

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Scope

This guideline is applicable to newborn infants up to the age of 12 weeks where a tongue tie (Ankyloglossia) is suspected and should be used by maternity, paediatric and specialist community public health nurses

Aim

The aim of this document is to:

- Support midwives, paediatricians and specialist community public health nurses to identify those babies suspected to have a tongue tie which is causing feeding difficulties.
- Provide guidance on the appropriate referral pathway

Objectives

The aim of this document will be achieved by the following objectives:

- Provide consistent guidance on the identification of ankyloglossia in newborn infants up to 12 weeks of age
- Provide Health Board staff with clear guidance on the referral pathway and inclusion criteria

Introduction

Tongue-tie, also known as ankyloglossia, is characterised by an abnormally short or tight lingual frenulum; which can cause restriction to tongue movement. It varies in degree, from a mild form in which the tongue is bound only by a thin mucous membrane to a severe form in which the tongue is completely fused to the floor of the mouth.

Infant feeding difficulties may arise as a result of the inability to suck effectively, possibly causing sore nipples, engorgement/mastitis, and poor infant weight gain in breastfeeding. Bottle feeding babies may experience excessive dribbling or increased colic from a tongue tie.

Hywel Dda University Health Board has given its commitment to achieving the UNICEF Baby Friendly Initiative standards for the Health Visiting service. Furthermore it has pledged to double the numbers of mother's breastfeeding their babies from birth up to 6 months of age.

NICE (2005) suggest that the evidence is adequate to support the use of frenulotomy to separate a tongue tie, provided that normal arrangements are in place for consent, audit and clinical governance.

Role of the Midwife Led Tongue-Tie Assessment Clinic

Midwives trained in frenulotomy are only registered to separate a tongue tie for feeding problems.

Concerns by parents/health professionals about potential speech impairment is **not** criteria for Midwife-led frenulotomy

Although ankyloglossia is thought to be present in about 9% of neonates (de Oliveira et al) many tongue-ties are asymptomatic and cause no feeding problems. But for those where a feeding problem does arise and there a tongue tie is suspected to be the cause then referral to the Midwifery Led Tongue Tie Clinic for assessment is appropriate.

Assessment and confirmation of tongue tie will be made by the appropriately trained Midwife in the specialist clinic.

The Specialist Midwife will then be able to advise parent/s as to whether frenulotomy is appropriate or required as not all tongue ties will affect the baby's ability to establish feeding i.e. may not need division or specialist support (Hogan, Westcott and Griffiths, 2005) (NICE, 2005)

Issues arising from a Tongue-Tie

A tongue tie is caused by a short, restrictive lingual frenulum which can restrict tongue mobility. This may cause feeding problems for both the mother and baby.

Signs and Symptoms

Mother

- Sore, damaged or bruised nipples
- Misshapen or discoloured nipples after feeding
- Engorgement/ mastitis (from poor drainage)
- Reduced milk supply
- Exhaustion from frequent feeding
- Distress from failure to establish breastfeeding

Baby

- Restricted tongue and jaw mobility
- Restless and unsettled feeds
- Difficulty achieving and sustaining a deep attachment
- Difficulty staying attached to breast or bottle
- Premature end of feed due to exhaustion
- Frequent and / or very long feeds
- Excessive early weight loss / failure to gain weight
- Difficulty controlling milk flow, choking easily

- Clicking noises while feeding , dribbling
- Colic, wind, hiccoughs or flatulence

(Association of Tongue Tie Practitioners 2014)

The Bristol TABBY Tongue Assessment Tool can be used to grade the tongue tie. ([Appendix 2](#) and [appendix 3v](#))

Considerations for Referral

Referral for specialist assessment is required where there are suspicions that a tongue tie is present AND despite adequate and sustained feeding support (conservative measures taken) is affecting the baby's ability to successfully establish feeding

Specialist assessment needs to be undertaken by a competent member of staff familiar with tongue tie division.

Who can refer to the Midwife Led Tongue-Tie assessment Clinic

- Midwives
- Paediatricians
- Health professionals including Health Visitors, SCBU

When to refer to the ENT on call?

Babies that are **still an in-patient** should be referred firstly to ENT (Ear Nose Throat) to perform assessment prior to discharge.

Note: The Specialist Midwife practitioner has set clinic day and therefore attending outside clinic hours to assess baby/perform a frenulotomy will be at the midwife practitioners' discretion only.

NIPE Discharge should not be delayed.

Criteria for referral to Midwife Led Tongue-Tie Assessment Clinic.

- Baby is equal to or less than 12 weeks of age
- Baby was over_37 weeks gestation at birth (or age adjusted)
- Baby has received Vitamin K at birth (IM or at least one dose of oral)
- A full feeding assessment including positioning and attachment has been performed, on the ward or community, and documented with reasoning for referring to Tongue Tie Clinic via the referral form ([Appendix 1](#)).

The Bristol TABBY Tongue Assessment Tool can be used as a visual aid to support reasoning for referral for assessment ..

Contraindications for Midwife Led Frenulotomy

The following are contraindicated for midwife led frenulotomy and should be referred to the ENT Department for assessment.

- Family history of blood clotting disorders/low platelets/haemophilia/ Von Willebrands.
- Cleft palate.
- Pierre Robins syndrome.
- Babies receiving SCBU care with known complex medical diagnosis.
- Frenulum is vascular in appearance.
- No feeding issues

Procedure for Assessment of Tongue-Tie

- Explain to parents what the examination involves and obtain verbal consent.
- Wash Hands thoroughly and dry them.
- Non-sterile gloves may be used for initial assessment.
- Ensure good lighting.
- Using index finger on bottom lip to encourage baby to stick tongue out. Assess the range that baby is able to extend their tongue beyond their bottom lip.
- Gently sweep index finger across lower gum. The baby should have free movement of tongue from left to right.
- Test the ability of the baby to suck on the examiners' finger with the pad of the little finger facing upwards. If tongue movement is impeded, the examiner will feel 'bunching' of the tongue and the lower gum ridge against their finger. A normal peristaltic 'wave' of the tongue will NOT be felt.
- Sweep index finger gently across underside of tongue, feeling for a band of tissue that may be rigid if a tongue tie is present. Pressing gently with both index fingers, either side of the frenulum, sometimes helps to visualise a posterior tongue tie.
- Using the Bristol Tongue Assessment Tool (BTAT) ([Appendix 2](#)) and its associated pictorial Tongue Tie and Breastfed Baby (TABBY) assessment tool, ([Appendix 3](#)) can be a useful addition to assessing the severity of a tongue tie.
- Complete the Tongue Tie Assessment tool ([Appendix 4](#))

Procedure of Tongue-Tie Division (Frenulotomies)

- Explain to parents the procedure for a tongue tie division and provide an 'information for parents' leaflet ([Appendix 5](#))
- Discuss potential risks and complications (all reported as rare)

- Excessive bleeding
 - Wound infection
 - Scarring at site of wound
 - No improvement to feeding
 - Reattachment of frenulum
 - Damaged to Tongue and Salivary glands
- Gain written Parental consent.
 - Division should be performed using a sterile procedure with curved, blunt end tongue tie scissors.
 - Provide pressure to the wound using a sterile gauze swab before promptly returning baby to mother to offer comfort and a feed.
 - Assess bleeding
 - Assess feed.
 - Provide parents with post frenulotomy wound care information leaflet. ([appendix 5](#))
 - Provide letter for GP ([Appendix 6](#)).

Bleeding Post Tongue-Tie Division

There is usually very little blood loss following the procedure and excessive or prolonged bleeding is reported as rare. Any minor amount of bleeding can be controlled with localized pressure.

The infant is allowed to feed immediately following the procedure.

If bleeding appears excessive and is prolonged apply pressure with gauze (moistened) to wound for ten minutes. If blood seeping around the gauze apply pressure with two fingers. Maintain airway and keep baby warm and calm.

At ten minutes should bleeding persists bleep ENT call and request that they attend to review whilst continuing to apply a further 10 minutes of pressure with gauze. If there is significant or excessive bleeding put out urgent bleep for both ENT and Paediatricians. If concerns are serious a paediatric crash call can be placed by 2222.

Auditable standards

- Follow-up with the mother should be offered via a telephone conversation within three weeks of the procedure.
- Information should be obtained for audit purposes:
 - Amount of referrals to Tongue Tie Clinic
 - Number of frenulotomies performed

- Number of babies with significant bleeding lasting more than 10 minutes post-frenulotomy
- Number of parents reporting improvement to feeding post-frenulotomy.

References

de Oliveira, A. J., Duarte, D. A., & Diniz, M. B. (2019). Oral Anomalies In Newborns: An Observational Cross-Sectional Study. *Journal of dentistry for children* (Chicago, Ill.), 86(2), 75–80.

National Institute for Health and Care Excellence (NICE). 2005.Division of ankyloglossia (tongue tie) for breastfeeding

Ingram, J., Copeland, M., Johnson, D., & Emond, A. (2019). The development and evaluation of a picture tongue assessment tool for tongue-tie in breastfed babies (TABBY). *International breastfeeding journal*, 14, 31. <http://doi.org/10.1186/s13006-019-0224-y> **Open access** under the terms of the Creative Commons Attribution <http://creativecommons.org/publicdomain/zero/1.0/>

Association of tongue-tie practitioners 2014 <https://www.tongue-tie.org.uk/>

J.E O'Shea, J P Foster, C PF O'Donnell, D Breathnach, S E Jacobs, D A Todd, P G Davis
Frenotomy for Tongue Tie in newborn infants.Cochrane Database Syst Rev 2017 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6464654>

Hoganm M., Westcott, C., and Griffiths, D.M. (2005) A randomised, controlled trial of division of tongue-tie infants with feeding problems. *Journal of Paediatrics and Child Health*, 41 (5-6):246-50

Appendix 1 Midwife Led Tongue Tie Assessment Referral Form



Referral Date.....

Date of Appointment for Midwife Led Tongue Tie Assessment Clinic
.....

MOTHER DETAILS

Hospital number
Full Name
Address

BABY DETAILS

Hospital Number
Full Name

Date of Birth

Age at time of referral

Vitamin K at birth? IM

Oral

Contact Number.....Confirm that there is No FH of blood clotting disorders

Feeding problem(s) including action taken and details of TT assessment. Any relevant birth details or family history

Feeding at referral

Exclusive BF	
Exclusive expressing	
Mixed feeding	
Formula feeding	

Referred by NAME:

SIGNED:

CONTACT NUMBER:

Please ensure the Mother brings this form with her to the appointment along with the Child Health Record (Red Book)













Midwife Led Tongue-Tie Assessment Clinic, Midwifery Led Unit , Glangwili .

Appendix 2 Bristol Tongue Assessment Tool (BTAT)

Bristol Tongue Assessment Tool (BTAT)			
Elements	0	1	2
Tongue tip appearance	Heart shaped	Slight cleft / notched	Rounded
Attachment of frenulum to lower gum ridge	Attached 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
Protrusion of tongue	Tip stays behind gum	Tip over gum	Tip can ascend over lower lip

Appendix 3 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 4 Midwife Led Assessment Form

Name:
Hospital No
DOB



Date

Birth Mother /Guardian Name

Telephone Number

Place of birth

Feeding assessment

Breast		Mixed		Bottle	
--------	--	-------	--	--------	--

Sore nipples		Dribbling	
Difficulty latching/ fussiness		Poor seal on teat	
Clicking noises at the breast		Windy	
Dissatisfied after feeds		Frequent feeds	
Taking a long time to feed		Sleep problems	
Poor weight gain		Other	

Frenulum	
Thick	100%
Medium	75%
Diaphanous	50%
Posterior	25%

Bristol Assessment Tool score =

Confirm vitamin K has been given	
Confirm no family history of clotting disorders	
Palate visualised and intact	
Procedure explained	
Consent form completed with risk factors explained	
Post division wound care leaflet given	

<p>Comments:</p> <p>Signature</p>
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Appendix 5 – Patient information leaflets

Free patient information leaflets available from Association of Tongue-Tie Practitioners (see link below)

- Tongue-tie and Infant feeding
- Care after Tongue-Tie Release

<https://www.tongue-tie.org.uk/information> -open in new tab

Appendix 6 - letter



Midwife Led Tongue Tie
Assessment Clinic
Glangwili General Hospital
Dolgwilli Road.
Carmarthen
SA31 2AF

Telephone

Date

Reference:

Dear Dr

The above patient has been seen as an outpatient in the Midwife Led Tongue Tie Clinic for assessment of the lingual frenulum, following referral for feeding difficulties.

Tongue tie was confirmed and with parental/guardian consent was then divided.

There were no difficulties with the division and advice was given regarding wound care, tongue exercises post division and a feeding assessment was made.

A small white or yellow ulcer under the tongue , lasting 1-2 weeks, is normal following the procedure and not an indication of infection in the absent of inflammation. The parents/guardians are aware of this.

Yours faithfully

Midwife and Tongue Tie Practitioner

<https://www.tongue-tie.org.uk/information> for public information and leaflet: Care after Tongue Tie release

