Specialist Midwife Led Oral Assessment and Management of Ankyloglossia and Frenulotomy Guideline

Guideline information

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Summary of document:
This guideline is to support Hywel Dda maternity staff and Health visitors to follow the appropriate pathways when they suspect the presence of a tongue tie, which is adversely affecting the way a baby is feeding.

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 for appropriate referral by maternity, paediatric doctors and Health Visitors.
This policy uses the term “women” to reflect that maternity and reproductive care are sex-based health needs. It applies equally to all people who are pregnant or have recently given birth, including trans men and non-binary people. Care must be delivered in an inclusive, respectful, and responsive way.

To be read in conjunction with: N/A

Patient information: https://www.tongue-tie.org.uk/information -(opens in a new tab)

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1.0 – New Guideline
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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, after appropriate feeding assessments, the relevant referral pathway for midwifery led management of frenulotomy.

Contents

Scope

This guideline is applicable to newborn infants up to the age of 12 weeks where a tongue tie (Ankyloglossia) is suspected, with associated infant feeding difficulties, 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 Health Visitors 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.

Note. It is important to also understand that a visible frenulum does not always indicate that a tongue tie is present.

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 Oral Assessment Clinic

- Specialist Midwives who are trained in frenulotomy are only to separate a tongue tie for feeding problems.
- 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 Oral Assessment Clinic for assessment is appropriate.

IMPORTANT. Concerns raised by health professionals /parents about potential speech impairment is **not a** criteria for a frenulotomy for any child under a year and therefore not appropriate for referral to Midwife led clinic .

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

T**he 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. many attending appointments do not require the procedure or specialist support (Hogan, Westcott, and Griffiths, 2005) (NICE, 2005).**

Feeding 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 (See Appendix 2 and Appendix 3). The Assessment Tool for Lingual Frenulum Function (ATLFF)™ (See Appendix 6) scoring is to be used by the appropriately trained Tongue Tie practitioner **only**

Referral Pathway

Referral for specialist assessment is required where there are suspicions that:

- a tongue tie is present AND
- despite adequate and sustained feeding support is affecting the baby's ability to successfully establish feeding.

Specialist oral 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

Responsibility of referring clinician:

- Ensure that adequate and feeding support has been undertaken prior to referral
- Ensure that Parents made fully aware that they are attending a Tongue tie Assessment appointment and a division will not be offered if tongue function is not restricted.

Note Following discharge of baby to care of the health visitor

Once the baby has been discharged from maternity services to the care of the health visitor any suspicion of a tongue tie (see signs and symptoms of breast-feeding issues in section 3) by other health professionals should be routed via the Health Visitor, for feeding assessment and possible referral to Midwife Led Oral Assessment .

When to refer to the ENT doctor on call?

Babies that are **still an in-patient** 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 can be referred to ENT (Ear Nose Throat) on call (bleep 560) to discuss and for consideration of further management.

Note: The Specialist Midwife practitioners have set clinic days (as they are dual role) and therefore attending outside clinic hours to assess baby/perform a frenulotomy is **not** to be expected and will be at the specialist midwife practitioners' discretion only.

NIPE Discharge should not be delayed.

Criteria for referral to Midwife Led Oral 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 (See 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 discussed with ENT Department.

- Family history of blood clotting disorders/low platelets/haemophilia/ Von Willebrand's.
- Cleft palate.
- Pierre Robins syndrome.
- Babies receiving SCBU care with known complex medical diagnosis.
- Frenulum is vascular in appearance.

Procedure for Oral Assessment with assessment for 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 Assessment Tool for Lingual Frenulum Function (ATLFF)™(See Appendix) or alternatively the Bristol Tongue Assessment Tool (BTAT) (See Appendix 2) and its associated pictorial Tongue Tie and Breastfed Baby (TABBY) assessment tool, (See Appendix 3) can be a useful addition to assessing the severity of a tongue tie.

Note: The ATLFF scoring is to be used **only** by the appropriately trained Tongue Tie practitioner

- Complete the Tongue Tie Assessment tool (See 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 (See 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 (See Appendix 5) • Provide letter for GP (See Appendix 7).

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 (bleep 560) 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

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Appendix 1 Midwife Led Tongue Tie Assessment Referral Form

Referral Date…….

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

MOTHER DETAILS	BABY DETAILS
Hospital number	Hospital Number
Full Name	Full Name
Address	
	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

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?				

 Design and Illustration: Hanna Oakes | oakshed.co.uk

Appendix 4. Specialist Midwife Tongue Tie Practitioner Assessment Form

Midwife Led Tongue Tie Practitioner Assessment Form

Hospital No: Name: DOB:	Date: Birth mother/Guardian name: Telephone number: Email: Place of Birth: Age of Baby:

Feeding Assessment *please tick (√)*

Breast		Combi		Bottle	

Sore / mishappen nipples at feed		Dribbling	
Difficulty attaching/ fussiness		Poor seal on teat	
Clicking nose at the breast		Windy	
Dissatisfied after feed		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= Assessment Tool for Lingual Frenulum Function (ATLFF)™ score=

Confirm Vitamin K has been given	
Confirm that no history of bleeding disorders	
Palate visualised and intact	
Procedure explained	
Consent form completed with risk factors explained	
Post division leaflet wound care leaflet given.	

Comments:

Signature:

Administration/ Audit *(please tick (√))*							
Eido Leaflet given via:	Email				RE-DIVISION		
	Paper copy in person				Initial division performed by:	Same practitioner	
Entered onto WPAS	Yes		No			Other	
6-8 week follow up email sent	Yes		No		Frenulum NOT separated		

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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 - opens in new tab

Appendix 6 Assessment Tool for Lingual Frenulum Function (ATLFF)™

Assessment Tool for Lingual Frenulum Function (ATLFF)™

Function Item score: _____

Appearance Item score: _____

Combined Score: _____ / _____

Mothers Name: _____

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

Date of assessment: _____

FUNCTION ITEMS

Lateralization
- 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 **OR** moderate cup
- 0 Poor **OR** no cup

Peristalsis
- 2 Complete anterior to posterior
- 1 Partial **OR** 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 1 cm **OR** absent frenulum
- 1 1 cm
- 0 Less than 1 cm

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

Attachment of lingual frenulum to tongue
- 2 Occupies less than 50% of the tongue underside in the midline
- 1 Occupies 50-75% of the tongue underside in the midline
- 0 Occupies 75-100% of the tongue underside in the midline

ASSESSMENT

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

11 = Acceptable Function score only if Appearance Item score is ≥8.

<11 = Function Score indicates function impaired. Frenotomy should be considered if management fails. Function score of 9-10 **with** an appearance score of 8-9 is considered borderline, all other management strategies should be exhausted before revision. Bodywork is indicated. Frenotomy necessary if Appearance Item score is < 8 **AND** Function Score is <8.

ASSESSMENT TOOL FOR LINGUAL FRENULUM FUNCTION ™

Appendix 7.Letter for General Practitioner

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