Common misconceptions about tongue tie

Tongue tie has been a topic of increasing debate recently and opinions differ on diagnosis and treatment. This article will discuss some of the uncertainties that contribute to the concerns of both practitioners and parents.

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Key points

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1. Tongue tie (ankyloglossia) is a congenital oral anomaly in which an unusually short, thick lingual frenulum tethers the underside of the tongue to the floor of the mouth.
2. It can restrict the tongue's movement, preventing the baby from feeding properly.
3. Cutting the tie – frenulotomy – may improve difficulties with breastfeeding.
4. Recommendations for standardised assessment, diagnosis and treatment are presented.

During over 20 years' experience as an International Board Certified Lactation Consultant (IBCLC), both in the NHS and in private practice, I have observed and noted three common misconceptions about tongue tie that contribute to late diagnosis and treatment. As team lead in a large NHS tongue tie service that treats almost 1,000 infants a year, I have experienced a wide range of issues. In addition, I have treated a further 250 infants within my role as a lactation consultant and tongue tie practitioner in private practice.

I will explore the main areas of uncertainty that can cause delays in referral and treatment. In both of my practices we assess and treat frenulotomy-ready babies aged from day 8 up to 26 weeks; it is not unusual for dyads to have been experiencing significant difficulties with breastfeeding and often parents are pushed to the edge of their physical and emotional resources before presenting for treatment.

Identification of tongue tie

Parents often report that they may have had tongue tie identified at the newborn examination, or in the early postnatal period (**FIGURES 1 and 2**). Others may have received a great deal of support with breastfeeding and lactation management in the community setting, but not had an oral examination. Alternatively they may have been advised that the tongue tie is 'mild' and it will not present a problem with feeding.

With this experience in mind I have identified three major and common misconceptions:

Latch

'They said the latch looked fine, but I still had pain and damage to the nipples, I dreaded every feed' (Becky, mother of Hugo, seven weeks).

Very often the latch will look absolutely perfect, but the mother will report that she is in a great deal of pain; that is the enigma of tongue tie.

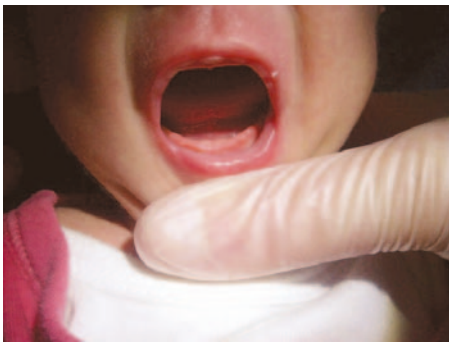

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FIGURE 1 Posterior tongue tie.

It is important to observe an entire feed and enquire how the mother feels her baby's tongue is moving in relation to her nipples; enquire about specific areas of compression, does she feel the tongue persistently/intermittently or never cushioning her baby's gums, or is the suckle disorganised with aerophagia (excessive swallowing of air) and an audible persistent clicking sound. Observe the nipples immediately post feed for compression or devascularisation.

Restriction in the tongue mobility may include lateralisation. This can be detected by stimulating the baby's gums with a clean adult index finger and noting whether the baby is able to move the tongue readily or sluggishly from left to right. The tongue-tied baby's tongue may not be able to move, and will perhaps distort and stand on its side, or movements will be accompanied by squaring and notching of the tip of the tongue.

The tongue-tied baby will not be able to fully elevate the tongue to the hard palate; instead it may be able to elevate only partially, often asymetrically and again with distortion, sometimes humping on the surface, or with the tip only or the sides raising higher than the centre – appearing similar to a whale's tail.

For effective organised suckle and secure latch the tongue needs to cushion the lower gums and protrude approximately 16mm over the gums.

The suckle may be an ineffective 1:1 suck swallow ratio, and be disorganised in other ways, sliding from side-to-side or protruding with just the tip immediately retracting behind the gum, causing loss of suction and as a consequence aerophagia accompanied by an audible clicking sound. Hypersalivation may be present due to the tongue-tied baby not being able to effectively clear fluids from the mouth. Gag reflex may also be guarded and hypersensitive.

The practitioner should enquire and note whether the mother can feel the nipple being abraded or rasped by the tongue, or feel a frank biting, clamping sensation on the nipple or at the nipple/areola junction. Specific patterns of trauma/loss of tissue will provide important clues as to exactly how the baby's tongue is moving within the buccal cavity.

If the mother continues to report all of the above pain, despite amendments to position and latch, further investigations should be carried out, including an oral examination to confirm or exclude oral restrictions or other pathology.

Furthermore, it is also of significance to examine the mother's breasts and take a pain history to exclude or confirm the presence of fungal/bacterial infection, vasoconstriction, eczema or dermatitis etc.

Weight fluctuations

'As my baby was gaining weight well, my health visitor told me that my baby didn't need a tongue-tie procedure, I tried to tell her that she was feeding sometimes hourly and I could hardly put her down, I was exhausted' (Smita, mother of Anya, 11 weeks).

The weight acceleration of the babies I see swings wildly from one extreme to the other; some will have remained static for several weeks while others will have fallen through two plus centiles or accelerated through two plus centiles.

The disorganised way that the tongue-tied baby suckles can either down-regulate or up-regulate maternal milk supply, or they simply need to feed very frequently in order to transfer the required volumes to gain weight or just tick over. Feeds may be protracted, sometimes for hours with poor hunger and satiety cues, or very short and minutes apart.

Practitioners need to look beyond weight gain and consider the extraordinary efforts mothers make to feed their tongue-tied babies, particularly if the baby is experiencing gastro-oesophageal reflux-like symptoms, often sequential to disorganised suckle and aerophagia.

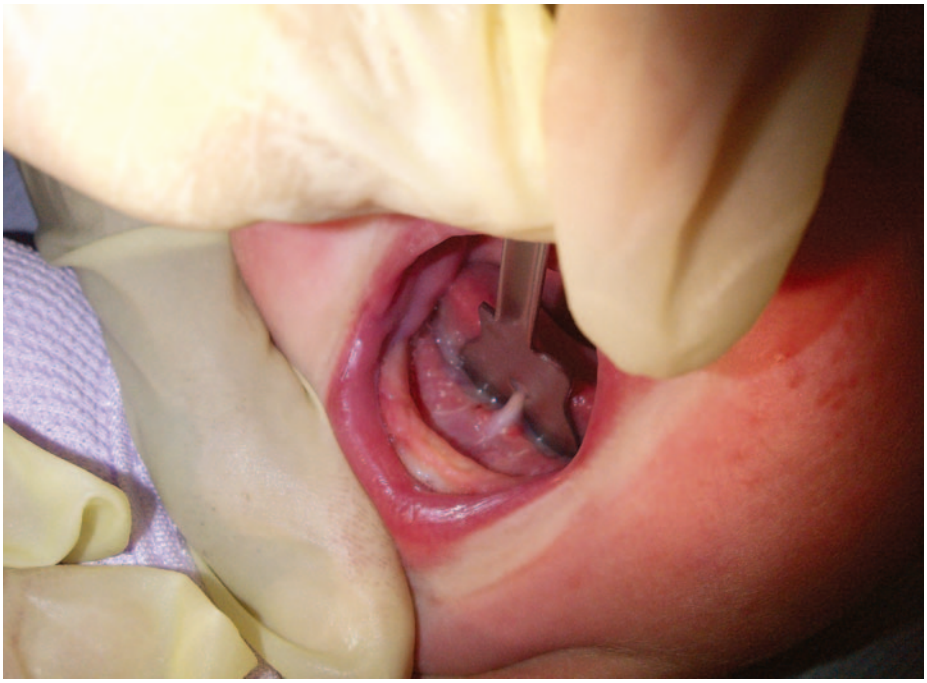

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FIGURE 2 Isolation of posterior tongue tie.

Auditing my practice areas reveals that feed duration, frequency, milk transfer, adverse feeding behaviours and weight gain improve significantly following frenulotomy.

Reflux

'At the eight-week check, my GP said that although my baby had a visible tongue-tie, as he could stick his tongue out it was not a problem and he didn't need it treated. He did, however, give me a prescription for Gaviscon for baby for the awful pain, posseting, back arching, coughing and gagging she was having' (Ana, mother of Lili, 12 weeks).

I have observed in both practice areas the resolution of reflux symptoms post-frenulotomy, including aerophagia and excessive wind, back arching, not being able to finish a feed even though hungry, coughing, posseting/vomiting, stridor and prolonged crying.

It is easy to understand how a baby may aquire the above symptoms if they are tongue-tied; suckle may be disorganised, resulting in disruption of peristalsis and aerophagia, causing pain, discomfort and fracturing of feeds.

Recommendations

- Encourage access to early assessment, diagnosis and treatment of tongue tie to improve breastfeeding and adverse feeding behaviours.
- Assess the frenal lingual tissue and tongue mobilisations in the examination of the newborn check.
- Revise the National Institute for Health and Clinical Excellence (NICE 2005)[1] guidance to be more specific about assessment of tongue mobility and feeding issues.
- Increase the visibility of tongue tie and the behavioural feeding difficulties associated with it among all healthcare professionals.
- Examine babies presenting with reflux or colic symptoms for tongue tie to confirm or exclude the possibility of its presence, and prevent unnecessary medication and investigations.
- Standardise assessment, referral and treatment pathways.

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Further reading

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