United Lincolnshire Teaching Hospitals NHS Trust

Suspected Tongue-Tie in Babies

Information and advice for parents and carers

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What is a tongue-tie?

As babies develop in the womb, the tongue separates from the floor of the mouth but remains connected by a piece of skin called the “lingual frenulum”. This is normal.

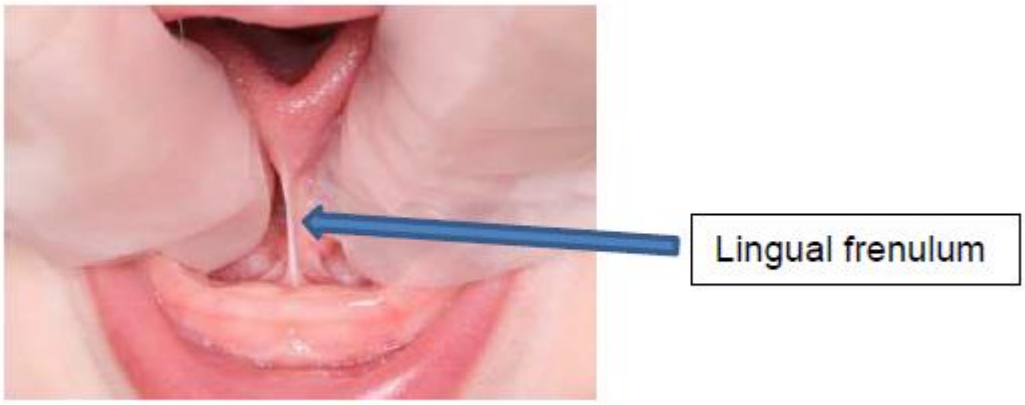

*Image courtesy of Alder Hey Children’s NHS Foundation Trust

Between 5 and 10% of babies may have a “tongue-tie”, where this normal piece of skin is tighter or shorter than usual and restricts how the tongue moves. While a tongue-tie may be suspected from the appearance of the lingual frenulum, an assessment of how the tongue moves and not how the tongue looks is required for diagnosis.

You may have heard the terms “posterior” or “sub-mucosal” tongue-tie. It used to be believed that there could be restriction underneath the tongue, which would not be visible. Based on new knowledge and research of the tongue’s anatomy, these diagnoses are now outdated and not supported by current evidence.

What possible problems can a tongue-tie cause?

It is important to note that these issues can all occur both with and without a tongue-tie being present. Please seek extra support with feeding first to rule out other possible causes and potentially avoid an unnecessary surgical procedure for your baby.

Possible problems for the breastfeeding mother:

- Sore/cracked nipples
- Breast engorgement or mastitis (inflammation of breast tissue)
- Low milk supply

Possible problems in newborn babies:

- Difficulty latching
- “clicking” sounds when feeding
- Excessive milk spillage from corners of mouth
- Excessive colic symptoms
- Frequent, short feeds
- Very long feeds
- Poor weight gain

Possible problems in later life:

There is not enough evidence to say that babies with a tongue-tie will go on to have other problems in later life, such as difficulties with their speech. It is not possible to predict which babies will or will not go on to have future issues. Unless you or your baby are currently experiencing problems, such as those listed above, your baby will not be offered a tongue-tie division on the NHS. Your health visitor or GP can advise you at any time if you have concerns about your child and may refer your child at a later time if problems do arise. You can also self-refer your child at any point for support with their speech and language through the Lincolnshire Children’s Therapy Service NHS website.

How is it diagnosed?

Tongue-tie is a possible cause of feeding problems in the early days, but it is not the most common. Most early feeding problems can be completely fixed just with extra support on how to hold and latch your baby deeply. If your baby is less than 28 days of age, the hospital’s Specialist Infant Feeding Team can support you. Ask your midwife or health visitor for a referral. After 28 days, you can contact your health visitor for additional support.

Tongue-ties are not routinely checked for as staff need special training to diagnose them but you should receive support to establish feeding. Tongue-ties are usually suspected if you are having ongoing difficulties despite receiving support.

What is the referral process?

If a health professional suspects a tongue-tie may be present, they will refer the baby to the ENT (Ear Nose and Throat) specialist team for a skilled assessment and proper diagnosis. This referral is done by e-Referral or letter to the ENT department. You will be offered an outpatient appointment in the ENT clinic as soon as possible, usually within a few weeks.

At your ENT appointment

A detailed history will be taken at your appointment then your baby's tongue movement will be assessed. If surgical division of the tongue-tie is recommended, all your options will be discussed with you and you will have the opportunity to ask any questions.

You may choose to wait and see how feeding goes with extra support. Some tongue-ties naturally divide, stretch, or tear on the lower teeth over time. This is not dangerous for your baby.

If you choose to have the tongue-tie surgically divided, the procedure will be discussed and written consent obtained. The medical term for division of a tongue-tie is "frenotomy".

If your baby is younger than 6 months, frenotomy is performed in the ENT outpatients' clinic by a trained clinician. Unless you want more time to consider your options, this is usually performed at your initial appointment. There is no need for any anaesthesia. If your baby is older than 6 months, a general anaesthetic is required.

Feeding difficulties in infants can be related to a number of causes, only one of which is tongue-tie. It is important to be aware that frenotomy alone is not guaranteed to improve feeding. Please be reassured that we will continue to work with you to achieve the best outcome for you and your baby.

What are the risks of frenotomy?

Frenotomy is a simple procedure and is usually straightforward, however all operations can carry some risks.

The following complications have a less than 3% chance of occurring (3 out of every 100 people):

- Bleeding
- Wound infection
- Damage to the tongue
- Damage to the area under the tongue that makes saliva (salivary duct)
- The tongue-tie returning

There is no evidence that tongue exercises after frenotomy reduce these risks and they can be painful for your baby.

Due to these potential risks, we would not advise that frenotomy is performed by a private clinician outside of the hospital.

What to expect during the procedure

You will be given the option to stay with your baby or leave the room. You will not be expected to hold your baby for the procedure.

Baby will be gently held by a member of staff to keep their head still. It may also be helpful to wrap baby in a blanket to keep their arms securely out of the way. While some babies do not like this, it does not hurt them.

The lingual frenulum is snipped using sterile scissors. Pressure is then applied using a piece of sterile gauze under the tongue. Usually there are only a few drops of blood. The procedure is not painful but most babies will still cry for a few seconds.

As soon as the bleeding has stopped, baby will be given back to you and you will be encouraged to feed them as soon as possible. This comforts baby and helps stop the bleeding. It also encourages baby's tongue to move.

Healing after a frenotomy

After frenotomy, baby should feed in their usual routine. Improvements with feeding are sometimes instant or may improve slowly over time. If you have continued problems with feeding, please seek ongoing support.

The day after the procedure, a small white blister may appear under the tongue. This takes 24 to 48 hours to heal and does not require any treatment.

Advice after a frenotomy

What if there is any bleeding from the wound?

- **If your baby will feed**, feed them for at least 15 minutes. If the bleeding has not stopped after feeding for 15 minutes, apply continuous pressure directly to the wound with a clean muslin/bib for 5 minutes.
- **If your baby will not feed**, let your baby suck on a clean finger or a dummy if they use one for at least 5 minutes. This will help put pressure on the wound through the tongue. If there is still any bleeding after this, repeat for a further 5 minutes. Repeat a third time if needed.

If the bleeding does not stop, call 999 or attend your nearest Accident and Emergency Department.

What if my baby is unsettled?

Evidence suggests that babies do not feel much pain or soreness after the procedure. If your baby does cry more than normal this usually settles within 24 hours. During this time, it helps to feed and cuddle your baby regularly. It is rare for a baby to require any pain relief but there are pain relief options available.

For babies under 8 weeks of age:

- Paracetamol can be prescribed by your GP.

For babies over 8 weeks:

- Paracetamol (e.g. Calpol) can be given without a prescription. Follow the instructions on the packaging.

What if my baby is reluctant to feed or there is a change in the way my baby feeds?

Some babies may feed differently after the procedure as the tongue is able to move more freely. If you are breastfeeding, skin to skin contact and laid-back feeding positions can help. You can also try giving some of your expressed breast milk from a sterilised plastic medicine spoon or syringe to calm your baby before offering the breast.

If you are bottle feeding your baby and they will not take the teat, try giving some milk from a sterilised plastic medicine spoon or syringe. Never force the teat into your baby's mouth as this can be stressful for them.

Contact details

If you have any questions or queries, please do not hesitate to contact us:

- Outpatients ENT department, Pilgrim Hospital, Boston: 01205 446055
- Boston ENT secretaries: 01205 446490
- Lincoln County Hospital, Lincoln: 01522 512512 (ask for ENT department)
- Lincoln ENT secretaries: 01522 573256

Feeding Help and Support:

- ULTH Specialist Infant Feeding Team (for breast and bottle fed babies up to 28 days of age) – ask your midwife or health visitor for a referral
- Health Visiting Service: 01522 843000
- National Breastfeeding Helpline: 0300 1000212
- Breastfeeding Network: 08444 120995
- Association of Breastfeeding Mothers: 0300 3305453

General statements that are made in this patient information do not apply in every case, as each patient is an individual. Your consultant will advise you on any specific after-care.

We accept that in time, experience and more research may change opinion/recommendations and will continue to review the literature and adapt our practice according to best available evidence.

United Lincolnshire Teaching Hospitals NHS Trust has worked with AccessAble to create detailed Access Guides to facilities, wards and departments at our sites.
www.accessable.co.uk/united-lincolnshire-hospitals-nhs-trust

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