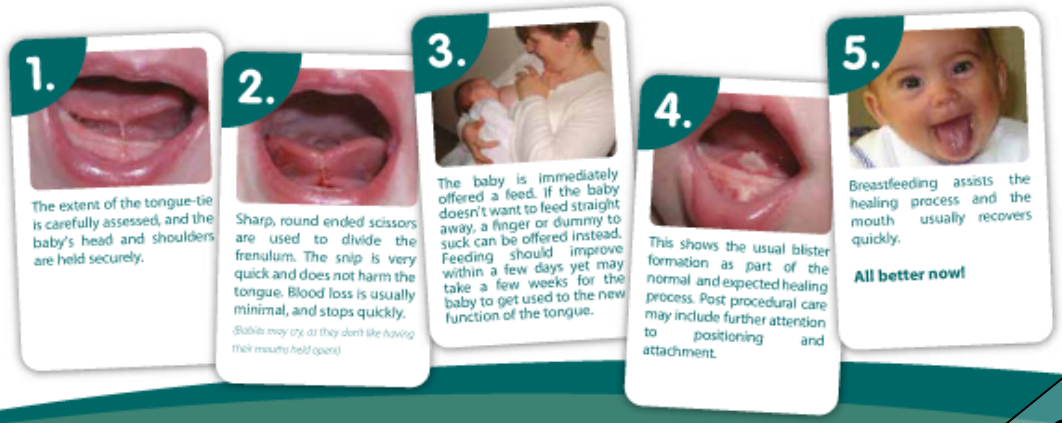
LACTATION CONSULTANTS of GREAT BRITAIN

Tongue-tie & Infant Feeding

Information for parents and health professionals

How is the tongue-tie divided? *(Procedures may vary between treatment centres)*



1. The extent of the tongue-tie is carefully assessed, and the baby's head and shoulders are held securely.

2. Sharp, round ended scissors are used to divide the frenulum. The snip is very quick and does not harm the tongue. Blood loss is usually minimal, and stops quickly.

(Babies may cry, as they don't like having their mouths held open)

3. The baby is immediately offered a feed. If the baby doesn't want to feed straight away, a finger or dummy to suck can be offered instead. Feeding should improve within a few days yet may take a few weeks for the baby to get used to the new function of the tongue.

4. This shows the usual blister formation as part of the normal and expected healing process. Post procedural care may include further attention to positioning and attachment.

5. Breastfeeding assists the healing process and the mouth usually recovers quickly.

All better now!

Research

Hogan M, Westcott C, Griffiths M, 2005. Randomized, controlled trial of division of tongue-tie in infants with feeding problems. *Journal of Paediatrics and Child Health, 41 Issue 5-6: 246-250*

Conclusions: This randomized, controlled trial has clearly shown that tongue-ties can affect both breast and bottle-feeding, and that division is safe and successful. Treatment improved feeding for mother and baby significantly better than the intensive skilled support of a lactation consultant.

Geddes D et al 2008. Frenulotomy for breastfeeding infants with ankyloglossia: effect on milk removal and sucking mechanism as imaged by ultrasound. *Pediatrics vol 122 no1: e188-e194*

Conclusions: Infants with ankyloglossia and persistent breastfeeding difficulties showed less compression of the nipple by the tongue post frenulotomy, improved breastfeeding, increased milk transfer, and less maternal pain.

Websites

Association of Tongue-tie Practitioners:
www.tongue-tie.org.uk

Carmen Fernando, speech-language pathologist:
www.tonguetie.net

International Affiliation of Tongue-tie Professionals:
www.tongue-tie

Lactation Consultants of Great Britain:
www.lcgb.org

NICE guidelines:
www.nice.org.uk/ipg149

UK Baby Friendly Initiative:
www.babyfriendly.org.uk

Where to get treatment

If local treatment is not available, please go to the UK Baby Friendly Initiative website at **www.babyfriendly.org.uk** for a list of centres to which referrals may be made. Please also visit the Association of Tongue-tie Practitioners **www.tongue-tie.org.uk.**

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What is a tongue-tie?

Tongue-tie (also known as ankyloglossia) is caused by a tight or short membrane under the tongue (the lingual frenulum). The tongue-tip may appear blunt or forked, or have a heart-shaped appearance. The membrane may be attached at the tongue-tip or further back. Recent research suggests that as many as one in ten babies may appear to be tongue-tied with most of them likely to have feeding problems. There is often a family history of tongue-tie.

Tongue-tie and infant feeding

The medical literature up to the 1990s makes little if any reference to tongue-tie and its impact on breastfeeding. This may be because bottle-feeding can be easier than breastfeeding for a tongue-tied baby. There is now evidence that tongue-tie can cause problems with both breast and bottle-feeding.

For pain-free and effective breastfeeding, free movement of the tongue is vital. The baby needs to advance the tongue beyond the lower gum and take in a portion of the mother's breast tissue behind the nipple. This places the nipple near the back of the mouth.

In contrast, a tongue-tied infant cannot move the tongue freely. The baby may not be able to attach easily to the breast or bottle, and swallowing may also be difficult. The mother's nipples may get damaged, and blocked ducts and mastitis may result. The pain can make it very hard to continue with breastfeeding.

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Possible signs of problems due to tongue-tie

Please note that you and your baby may not show all of these signs and that there may be other reasons for the symptoms you are experiencing. It is therefore really important that you are assessed by a practitioner who is skilled in lactation issues.

Mother

- Sore, damaged or bruised nipples; painful feeding
- Misshapen or discoloured nipples post feed
- Mastitis/breast infections (from poor drainage)
- Reduced milk supply
- Exhaustion from frequent feeding
- Distress from failure to establish breastfeeding

Baby

- Restricted tongue movement
- Small gape leading to biting/ grinding behaviour
- Restless and unsettled feedings
- Difficulty in staying attached to breast or bottle
- Premature end of breastfeed due to exhaustion
- Frequent and/or very long feeds
- Excessive early weight loss/failure to gain weight
- Clicking noises while feeding, dribbling
- Colic, wind, hiccough or flatulence due to poor attachment

Treating a tongue-tie by frenulotomy

A simple surgical technique is used to treat the baby as an outpatient. The frenulum is carefully snipped with sharp, round ended scissors to free the tongue. No anaesthetic or stitching is needed, and there is little if any pain or bleeding. The baby can feed straight after the snip.

NB Not all babies with a tongue-tie need treatment. Early diagnosis and extra support from an infant feeding specialist may prevent or solve problems as positional strategies may assist in achieving an optimal latch to improve breastfeeding. If problems persist, the baby should be referred for assessment and treatment as soon as possible, to avoid interruption of breastfeeding.

You may want to consider the support of a trained practitioner, many of whom have specialist knowledge in supporting breastfeeding babies who have a tongue-tie, or visit the Association of Tongue-tie Practitioners website for further information **www.tongue-tie.org.uk/find-a-tongue-tie-divider.html**

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This leaflet is based on the LCGB publication Breastfeeding & Tongue Tie 2001 by Mary O'Shea IBCLC, revised by the author and the LCGB Committee.