



# **Tongue Tie & Oral Dysfunction**

We know that feeding can be a tricky topic, but don't panic. We are here to answer any questions you might have and support you on your infant feeding journey. This service is led by our infant feeding consultant, who specialises in infant oral dysfunction.

## **What is a tongue tie?**

The term 'tongue tie' is used to describe the lingual frenulum underneath the tongue, when it anchors the tongue to the floor of the mouth, resulting in a restriction of normal tongue movement.

Before birth, this piece of tissue is prominent in all babies. Fortunately, in most cases, the tissue naturally recedes before birth. It is estimated that for 1-2 in 20 babies, this tissue remains prominent and restricting, which can cause it to be difficult for these babies to use their tongues.

True tongue ties are more than just the presence of tissue under the tongue; the diagnosis of a tongue tie is based mainly on the function of the tongue. A suitably trained professional can carry out a tongue tie assessment which usually involves using a gloved finger to trigger specific tongue movements from the baby.

## **Could my infant be tongue-tied?**

Tongue ties cannot be diagnosed nor ruled out based on appearance alone; this is only half of the diagnosis tool. There are, however, some common signs and symptoms that may lead you to access an assessment.

**For the breastfeeding or chestfeeding parent:**

- Nipple Pain and trauma
- blanching nipples (white- or purple-coloured nipples)
- lipstick-shaped nipples after feeds
- milk blebs
- chronic blocked ducts or mastitis
- low milk supply
- engorgement
- anxiety and/or postnatal depression

**For the infant:**

- pushing away breast or bottle
- biting or chomping whilst feeding
- colic and reflux
- unsettled baby
- feeding constantly
- long pauses in between sucks
- guzzling and choking
- low or static weight gain
- weight loss
- milk leaking from the mouth
- clicking
- arching of the back during or after feeds

- open mouth when at rest
- sucking blister
- frequent night waking

It is important to seek support from practitioners that are skilled in tongue ties and infant feeding, due to many of these signs and symptoms mimicking other feeding challenges. The treatment will only be effective with the correct diagnosis.

## **What is oral dysfunction?**

Evidence suggests that many unnecessary procedures are conducted due to practitioners' inability to diagnose and resolve alternative causes of oral dysfunction. There may be numerous reasons for oral dysfunction, such as a receding jaw, low tone, high tone, muscle tension, torticollis, plagiocephaly or tension within the fascial system. Jumping straight to a tongue tie release is not only unethical, but it may delay the correct treatment. For many, this delay could mean the end of a breastfeeding journey.

At The Natal Network, we look at the whole picture and work towards resolving the feeding issue's through conservative functional intraoral exercises and bodywork before considering if a tongue tie division is necessary.

## **What is a frenulotomy and is it safe?**

A frenulotomy is a simple and safe procedure, usually carried out in a community clinic or your own home. It involves swaddling your baby before using a pair of blunt-end scissors to release the tissue under the tongue. This is a quick procedure, and you will be encouraged to remain with your baby.

As with any surgical procedure, you will be asked to review and sign a written consent form. This will be confirmed verbally before performing the tongue tie release. You can withdraw consent at any point.

By consenting to the procedure, you are acknowledging the potential risks outlined within the form.

### **Risks of the frenulotomy procedure:**

- severe bleeding
- infection
- damage to surrounding structures
- ulceration
- pain
- adapting to new mobility of the tongue
- reoccurrence
- no improvement or worse feeding outcomes

The chance of experiencing any of these risks is slight, and frenulotomies are considered a safe procedure with infrequent complications.

## **How likely am I to experience complications?**

### **Severe bleeding**

It is expected that there will be little to no bleeding after your infant's division. You will be asked to feed your baby immediately after the procedure, which usually applies enough pressure to the wound to stem any bleeding that may have occurred.

In a small number of patients (estimated 1 in 400), it is also required to apply pressure using a sterile gauze for approximately 20 minutes. It is extremely rare for a patient to need any further intervention than this.

### **Infection**

If there is an active infection in your baby's mouth, then the procedure will be delayed until the underlying infection has been treated. Further to this, there is added protection for breastfed babies, as breastmilk is known to be protective against infection. Signs of an infection would be if your baby seems sleepy, unsettled, refusing feeds, fever. In this instance please contact your local healthcare provider and inform them of the recent procedure.

### **Damage to surrounding tissue**

There are no cases reported (within literature) of damage to the surrounding structure. It is, however, standard to include this risk with any surgical procedure.

### **Ulceration**

Approximately 48 hours following the procedure, there will be a white or yellow diamond-shaped wound under the tongue. This resembles an ulcer, as the moisture within the mouth prevents a scab from forming, taking approximately 14 days to heal. It can be easy to mistake this wound for an infection, especially if yellow patches become

visible. Be reassured that these yellow patches are usually bilirubin and common in the healing process. It is not an indication of infection.

## **Pain**

It is irresponsible to imply that this procedure is pain-free. However, the degree of pain experienced by babies appears to be like other postnatal procedures such as immunisations or heel-prick tests.

Interestingly, one study reported that 18% of babies slept through the procedure. This can be accounted for by the lack of nerve endings within the frenulum. Anaesthetic is not recommended, as even local anaesthetic may impact feeding post-procedure. Babies over 3 months can be given liquid paracetamol; those younger than 3 months can consult with their GP before the appointment and obtain a prescription for pain relief. Medical pain relief, however, is not generally necessary.

## **Reoccurrence of tongue tie**

In rare cases (estimated 1 in 100 procedures), reoccurrence of a restricted frenulum may happen. To limit the risk of reoccurrence, the tongue must be encouraged to move through feeding and non-invasive oral exercises and games.

While many parents see improvements immediately, some babies require more support to use their newly-found tongue. There are 8 muscles in your baby's mouth; some will have been working hard to compensate for the original restriction, which may have caused tension. Others muscles that have been restricted, will require time to build strength and tone. Ultimately it may take time and practice for your baby to learn the most effective way to feed. This is usually done before birth, but in the case of a tongue-tied baby, this needs to be learned post tongue tie release.

We will only perform the procedure if you can commit to continuing recommended aftercare at home; this involves a mixture of oral exercises, bodywork, and massage. This is crucial to optimise wound healing and reduce the risk of reattachment. Aftercare will also help to correct dysfunctional suckling skills that your infant may be displaying, due to their potential restriction.

### **No improvement or worse feeding outcomes**

Unfortunately, we cannot guarantee positive outcomes, as releasing a tongue tie is only the beginning of the solution. It may take time for improvements to be seen, which may be disappointing for parents.

The evidence is clear that the most favourable outcomes are seen when a release is performed alongside skilled infant feeding support. Packages at The Natal Network are designed to offer comprehensive follow-up with IBCLC support for this reason.

### **What are the benefits of frenulotomy (tongue tie division)**

Following an accurate diagnosis of a restricted frenulum, a tongue tie division is an effective treatment for many infant feeding-related problems.

#### **What does the evidence say?**

95% of parents saw an improvement in infant feeding within 48 hours post-procedure.

80% of parents reported improvements in infant feeding 24 hours post-procedure.

100% of babies had normal tongue function, 3 months post-procedure.

52.6% of babies saw improvements in reflux symptoms 1-week post-procedure and were able

to reduce or stop prescribed reflux medication.

88.6% of breastfeeding parents reported an increase in comfort whilst feeding

83% of babies who were not growing as expected continued to breastfeed and achieved normal growth rates by 5 days post-procedure.

60.7% of infants continued to receive breastmilk 6 months after treatment.

## **Do lip ties need releasing?**

Understandably, lip ties are a concern for many parents. They are easily visible and frequently mentioned on parenting forums. Within the UK, we do not currently support the division on lip ties to improve breastfeeding symptoms.

The rationale is that, unlike the bottom lip, the top lip remains in a neutral position during feeds. When a baby's top lip flanges (often described as fish lips), they may be attempting to cling to the breast, indicating a shallow latch. You may also notice sucking blisters along the top lip as a sign your baby compensates for a shallow latch.

If we release the frenulum along the top lip, your baby would be able to compensate for a shallow latch better with the ability to cling to the breast rather than treating the primary cause of the shallow latch.

## **Do tongue ties cause speech and dental problems?**

A tongue tie division is not recommended by The National Institute of Clinical Excellence (NICE) to prevent speech and dental problems in later life. Although there is evidence to suggest that tongue ties may impact some children's speech development and dental health, it is impossible to predict who will be affected. For this reason, it is not recommended as a preventative measure to avoid many unnecessary procedures.

If your child's speech has been affected, a frenulotomy can be performed on older children. This is usually carried out by a surgeon under anesthetic. Your child should also have received support and interventions from a speech and language therapist before being referred. The criteria for release under these circumstances will depend on your hospital's policies and guidelines; generally, the procedure is not considered for any child under 5 years.

For some infants with a tongue tie, the tongue is unable to sit in its natural resting position on the roof of their mouth. This may form a narrow or bubble palate, narrowing the space for teeth to erupt and leading to overcrowding and dental decay due to stuck food debris. Dental check-ups are an essential part of preventative child health; if you are concerned a tongue tie is impacting your child's dental health, this can be reviewed at routine dental appointments and referred if required.

## **Will my baby's tongue tie impact introducing solids?**

Restricted tongue movements (caused by a tongue tie) may impair a child's ability to move food around their mouth, swallow, and chew. This may become evident once a child has started solids at 6 months of age. Symptoms may include gagging and food refusal.

## **Why has feeding become difficult again after seeing initial improvements?**

Some families may experience a recurrence of symptoms between weeks 1 and 3 post-procedure. Fibrous tissue will start to form in the wound around this time as a natural part of the healing process, but because this tissue is not as flexible, there may be a relapse in symptoms. Encouraging your baby to lift their tongue through gentle post-procedural exercises, games, and regular feeding will encourage the wound to heal vertically. This is the optimal position to maximise tongue function. Over time this tissue will become smoother and softer.

Another common reason for relapse in symptoms is oral muscle fatigue. As with all muscles, we must regularly move them to build strength and tone. For babies with muscle movements restricted by a tongue tie, it will take time for this to happen. Like going to the gym, the more you commit, the stronger you become. This fatigue should resolve as the muscles build strength and the movement becomes more straightforward.

It can take time to re-educate a muscles, your baby's oral muscles have learned compensatory methods of suckling, and despite having had a tongue tie release, they will not yet have the muscle memory of how to use the tongue without the restriction. Regular feeding and engagement with post-procedural exercises will help re-educate your baby's suckling skills.

These skills are useful throughout your feeding journey, as any changes within your baby's mouth, such as teething and colds, may prompt them to use old compensatory methods of suckling.

## **Why don't you recommend disruptive wound massage?**

Disruptive wound massage entails massaging the open wound and stretching it into the optimal healing position numerous times a day. This post-procedural aftercare is not widely used in the UK. It is, however, more common in the USA.

We do not advocate or recommend disruptive wound massage, as many parents find this intolerable and will increase the risk of poor adherence to postoperative care. There is also a risk of increasing the amount of inflammation, which would increase fibrous tissue, further restricting tongue function. Alongside this, parental reports have often shown subsequent feeding aversions.

The bottom line is if babies are in distress, parents are also in distress. Without evidence of disruptive wound massage's benefits, we cannot ethically ask families to undertake this process, nor would we wish to.

## **How do we get our baby to move their tongue?**

We advocate using regular feeding and gentle oral exercises or games, alongside bodywork and fascial massage.

This is based on scientific knowledge of muscle rehabilitation, fascial tension release, and wound care.

We aim to use your baby's natural reflexes to encourage tongue movement to build tone, strength and to re-educate their neuromuscular pathways.

We encourage parents to be led by their baby and only continue if their baby enjoys the exercises. We work to resolve tension within the muscular or fascial systems before performing a tongue tie

division, which gives us the best opportunity to maximise positive outcomes and optimise wound healing.

It may be necessary to rebook an appointment for a tongue tie release at a later date to allow time for any tension to resolve. Whilst we understand this could be disappointing, it is necessary in some cases - as releasing the tongue tie will not improve function if the muscles are constricted.

## **Will a tongue tie resolve on its own?**

Every tongue tie is anatomically different. We use an assessment tool that will give us information on whether to offer a surgical division (if a resolution cannot be reached through conservative methods, such as positioning and attachment support and oral exercises).

This is often seen in tongue ties that are made of the same tissue as the webbing between your fingers and as such, do not 'stretch' over time.

As your baby grows (and there is more space within their mouth), you may experience different symptoms of a tongue tie. Likewise, your baby may learn other ways of using their oral muscles to compensate for the restriction.

## **What if my baby hasn't received vitamin K?**

We can still perform a frenulotomy if your baby hasn't received vitamin K, as long as you fully understand and accept the increased risk of uncontrolled bleeding.

Although the risk of Vitamin K Deficiency Bleeding (VKDB) is low, it cannot be

predicted in infants who have not received vitamin K. VKDB can occur in three forms:

- Early VKDB (within 24 hours) affects around 1 in 250 to 1,000
- Classical VKDB (between 2–7 days old) affects about 1 in 10,000 to 25,000 infants
- Late VKDB (between 2 weeks to 6 months) occurs in approximately 1 in 50,000 to 150,000 infants.

Without supplementation, there's a chance your baby could bleed more heavily than expected after the procedure, and in very rare cases, this could be life-threatening.

If your baby hasn't received vitamin K, you will be asked to give informed consent before proceeding with the frenulotomy. The clinician will clearly explain the potential risks, answer any questions you may have, and ensure you feel comfortable and confident in your decision.

If you prefer, you also have the option to delay the procedure until your baby has received vitamin K. If you're still unsure or have any concerns about vitamin K, VKDB, or the frenulotomy itself, please speak with your midwife, GP, or one of

our clinicians — we're here to support you in making the safest and most informed choice for your baby.

## **Conservative feeding strategies for tongue-tied babies**

Some strategies that may help while you are waiting for a tongue tie release, or if you have decided against a tongue tie release, can include:

Breast shaping.

'Flipple' technique.

Laid-back breastfeeding positioning

Paced bottle feeding.

Frequent smaller feeds for bottle-fed infants.

Sitting babies upright following feeds

Access, reliable advice and support to optimise positioning and attachment.

Soften breasts through hand expressing if engorged, before attempting to latch baby

Encourage tongue movement through exercises and games.

If unable to breastfeed directly, maintain your milk supply by expressing at least 8 times in 24 hours, including during the night.

**If you notice the wound bleeding or oozing once discharged, follow the below advice:**

1. Feed your infant.
2. If the wound continues to bleed, apply constant pressure to the tongue, pressing it on top of the wound using 2 fingers and a clean muslin cloth for 10 minutes.
3. If the bleeding continues after this intervention, is soaking through the muslin cloth, or you are concerned, please call 999 for support and present at your local A&E.

**Please take a copy of the bleeding guidelines found in the confirmation email to assist with the continuation of treatment in the hospital.**

Inform The Natal Network by emailing [hello@natal.network](mailto:hello@natal.network), following discharge from the hospital so we can report the incident via our national reporting system.

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## **Where can I access further support and information?**

[Infant Tongue Tie UK Support Group for Parents & Health Professionals | Facebook](#)

[Home - Association of Tongue-tie Practitioners](#)

[Lactation Consultants of Great Britain - Charity \(lcgb.org\)](#)

[Breastfeeding Helplines - The Breastfeeding Network](#)

[Telephone helpline - La Leche League GB](#)

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