TONGUE-TIE (ANKYLOGLOSSIA) – ASSESSMENT AND MANAGEMENT cont'd

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM

- Assessment and management of a neonate suspected with tongue-tie and breastfeeding problems
- Appropriate support of parents whose neonate is identified with tongue-tie

2. PATIENT

- Neonate presenting with breastfeeding difficulties where tongue-tie is suspected

3. STAFF

- Medical, midwifery, and nursing staff
- Lactation Consultant (IBCLC)

4. EQUIPMENT

- Small sharp blunt-tipped scissors
- Sterile gloves
- Sterile gauze swab
- Oral sucrose

5. CLINICAL PRACTICE

- Refer to flowchart (Appendix 1)
- Ensure full breastfeeding assessment has excluded other causes of breastfeeding problems
- File completed Hazelbaker Assessment Tool for Lingual Frenulum Function (HATLFF) (Appendix 2) in integrated clinical notes.
- Discuss findings with parents and provide written information (Appendix 3)
- Discuss possible complications of the procedure with parents (bleeding, haematoma, ulceration, possibility of repeat procedure)
- Minimise complications by:
    - Performing neonatal examination including oral assessment
    - Ensuring vitamin K has been administered to neonate
    - Investigating family with any history of bleeding disorders
    - Determining Hepatitis C status of mother and following management guidelines
- Complete written consent with parent(s) for procedure if performed at RHW and file in the integrated clinical notes
- Refer to private paediatrician or Westmead Tongue-tie Clinic, as alternatives, if requested by parent(s)
- Perform frenotomy (by experienced paediatric medical officer) with the following technique:
    - Perform hand hygiene
    - Wrap neonate securely
    - Stabilise neonate's head (assistant required)
    - Administer analgesia in the form of oral sucrose
    - Put on sterile gloves
    - Use your thumb to stabilize the jaw whilst placing your index finger under the neonate's tongue to gain clear access to the frenulum

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TONGUE-TIE (ANKYLOGLOSSIA) – ASSESSMENT AND MANAGEMENT cont'd

- Divide the frenulum with a small pair of sharp, blunt-tipped scissors
- Apply pressure to the floor of the mouth with a sterile gauze swab to stop any bleeding
- Return neonate to mother
- Encourage mother to breastfeed neonate as soon as practicable
- Assess for bleeding after 15 minutes
- Document procedure and outcome in integrated clinical notes

6. DOCUMENTATION

- Hazelbaker Assessment Tool for Lingual Frenulum Function (HATLFF)
- Breastfeeding Assessment Tool
- Integrated clinical notes
- ObstetriX
- Breastfeeding Support Unit (BSU) referral form
- Request/Consent for medical procedure treatment (For parents/guardians of patients less than 16 years of age)

7. EDUCATIONAL NOTES

- Ankyloglossia (tongue-tie) is a congenital anomaly occurring in approximately 2-10% of neonates with a male to female ratio of 3:1
- Tongue-tie is characterised by an abnormally short and possibly thickened lingual frenulum which may restrict mobility of the tongue.
- Variations are:
  - Type 1- Attachment of the frenulum to the tip of the tongue, usually in front of the alveolar ridge in the lower lip sulcus
  - Type 2 - Attachment of frenulum is 2-4 millimetres behind the tongue tip and attaches on or just behind the alveolar ridge
  - Type 3 - Attachment of the frenulum to the mid-tongue and the middle of the floor of the mouth and is usually tighter and less elastic
  - Type 4 - Is essentially against the base of the tongue and is thick, shiny and very inelastic
- Associated breastfeeding difficulties are well documented and include neonatal problems with latching, maintaining latch, poor milk transfer, poor weight gain, and sore nipples in the mother
- Despite the evidence on the positive effects of frenotomy on breastfeeding, there is a lack of consensus regarding tongue-tie management. Careful assessment is required as it is important to determine whether the frenulum is interfering with breastfeeding and division is appropriate. The HATLFF has been designed for this purpose. This tool has been validated by research for face and content validity and comprehensiveness
- There are various terms in the literature to describe tongue-tie division. For example, frenotomy, frenectomy, frenulotomy, frenuloplasty, tongue-tie division, or snip
- Post frenotomy, an immediate improvement in maternal nipple pain and breastfeeding efficacy may be demonstrated
- Complications following frenotomies are uncommon, but, may include:
  - Excessive bleeding
  - Haematoma
  - Ulceration
  - Infection
  - Repeat procedure
- Contraindications to frenotomy include:
  - neonate who has not been given intramuscular (IM) vitamin K, or has not been administered the second dose of oral vitamin K
  - family history of bleeding disorder that has not been investigated

TONGUE-TIE (ANKYLOGLOSSIA) – ASSESSMENT AND MANAGEMENT cont'd

- If the mother is Hepatitis C positive, breastfeeding post frenotomy should be delayed until any neonatal bleeding has ceased
- A tongue-tie may not have an initial effect on breastfeeding efficacy, however, problems may occur once the neonate's demands increase and the mother is not able to successfully establish lactation
- Follow up for all neonates who have had a frenotomy is recommended to assess healing of frenotomy, progress of breastfeeding and to provide further support if required as it may take extra time for breastfeeding to become established. There may be other issues besides the tongue-tie that are not resolved by frenotomy. Routine referral to the Breastfeeding Support Unit (BSU) is recommended

8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP

- Breastfeeding – Protection Promotion and Support
- Supplementary Feeding of Breastfed Infants in the Postnatal Period
- Breastfeeding Support Unit (BSU)
- Vitamin K (Phytomenadione) Prophylaxis In Newborns
- NSW Health PD2010_058. Hand Hygiene Policy

9. RISK RATING

- Low

10. NATIONAL STANDARD

- CC – Comprehensive Care

11. REFERENCES

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REVISION & APPROVAL HISTORY
Reviewed and endorsed Maternity Services LOPs 25/10/16
Approved Quality & Patient Safety Committee 15/8/13
Endorsed Maternity Services LOPs 13/8/13

FOR REVIEW : NOVEMBER 2021

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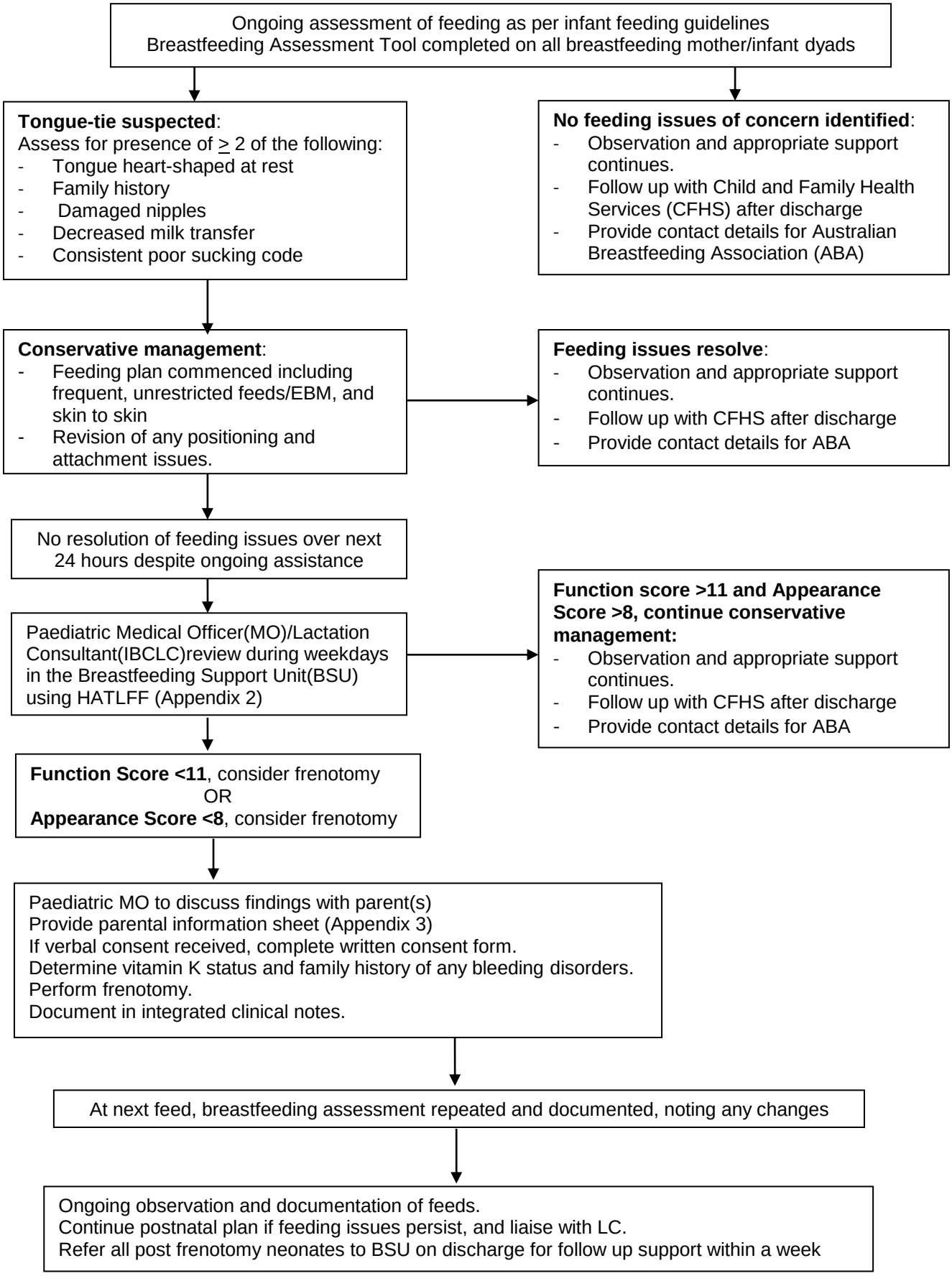
APPENDIX 1

Flowchart for Tongue-tie Identification, Assessment and Management



APPENDIX 2

HAZELBAKER ASSESSMENT TOOL for Lingual Frenulum Function

Health
South Eastern Sydney
Local Health District

Facility:

HAZELBAKER ASSESSMENT TOOL FOR LINGUAL FRENULUM FUNCTION

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SES060465

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

Appearance Items	Function Items
Appearance of tongue when lifted ☐ 2: Round or square ☐ 1: Slight cleft in tip apparent ☐ 0: Heart-shaped or V-shaped	Lateralization ☐ 2: Complete ☐ 1: Body of tongue but not tongue tip ☐ 0: None
Elasticity of frenulum ☐ 2: Very elastic (excellent) ☐ 1: Moderately elastic ☐ 0: Little OR no elasticity	Lift of tongue ☐ 2: Tip to mid mouth ☐ 1: Only edges to mid-mouth ☐ 0: Tip stays at alveolar ridge or rises to mid-mouth only with jaw closure
Length of lingual frenulum when tongue lifted ☐ 2: More than 1cm OR embedded in tongue (75-100%) ☐ 1: 1cm (50%) ☐ 0: Less than 1cm (25%)	Extension of tongue ☐ 2: Tip over lower lip ☐ 1: Tip over lower gum only ☐ 0: Neither of above, OR anterior or mid-tongue humps
Attachment of lingual frenulum to tongue ☐ 2: Tip over lower lip ☐ 1: At tip ☐ 0: Notched tip	Spread of anterior tongue ☐ 2: Complete ☐ 1: Moderate or partial ☐ 0: Little OR none
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 at ridge	Cupping ☐ 2: Entire edge, firm cup ☐ 1: Side edges only, moderate cup ☐ 0: Poor OR no cup
	Peristalsis ☐ 2: Complete, anterior to posterior (originates at the tip) ☐ 1: Partial: originating posterior to tip ☐ 0: None OR reverse peristalsis
	Snapback ☐ 2: None ☐ 1: Periodic ☐ 0: Frequent OR with each suck
Appearance Total Score: _____	Function Total Score: _____

Appearance Score: 10 =Normal tongue
<8 =Consider frenotomy

Function Score: 14=Perfect function (regardless of appearance score)
11=Acceptable function (if appearance score=10)
<11=Impaired function (consider frenotomy)

Medical Officer/ Lactation Consultant: Print full name: _____

Signature: _____ Date: ____/____/____

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FRENULUM FUNCTION

SES060465

NO WRITING

APPENDIX 3

TONGUE-TIE: Information for parents

Health
South Eastern Sydney
Local Health District

Facility:

HAZELBAKER ASSESSMENT TOOL FOR LINGUAL FRENULUM FUNCTION

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

TONGUE-TIE
Information for parents

What is a Tongue-Tie?

A Tongue-Tie (TT) or ankyloglossia is a condition in which the thin piece of skin (frenulum) sitting underneath baby's tongue is short and restricts tongue movement. It occurs in about 2-10 in a 100 of babies and may range from mild to severe. Babies with a TT may feed perfectly, although almost half experience difficulties.

Signs and symptoms to indicate the Tongue-Tie may be causing a problem

1. Poor attachment, baby unable to maintain effective attachment, mother experiencing discomfort
2. Sore nipples – misshapen after feeds
3. Poor breastmilk transfer and intake/poor weight gain
4. Decrease breastmilk supply

Assessment of Tongue-Tie

The recommendations for treatment will be made following an assessment process by a Lactation Consultant or experienced clinician. The assessment includes baby's mouth and tongue movement, a breastfeed, maternal discomfort and exclusion of other causes of poor feeding. The size of the TT is not important as even a small TT may cause problems.

Release/snip of Tongue-Tie (Frenotomy)

Sometimes a release/snip of the TT will be recommended if you consent a consent form must be signed. Your baby will be securely wrapped and his/her head gently held still. Your baby will be given a sugar drops for pain relief. The doctor places a finger under the baby's tongue to gain clear access to the TT. The TT is released with sterile scissors. Your baby will be returned to you immediately following the procedure so that you can feed and comfort him/her.

Complications

Rare complications of the procedure include bleeding and infection. If your baby has not had Vitamin K at birth or there is a family history of bleeding please discuss this with the doctor assessing your baby before the procedure. If you are Hepatitis C positive please discuss this with the doctor before the procedure.

Does releasing a Tongue-Tie hurt?

Logically, releasing a TT may hurt. However, a significant number of small babies (about 1 in 6) are asleep when their TT is released and remain asleep during the procedure. The milk from the first breastfeed after the snip will also act as a pain killer. If possible feed your baby/provide a breast milk feed before the procedure.

Wound and Aftercare

There is no specific aftercare required. A few drops of blood may be visible but the bleeding stops when pressure is applied under the tongue with sterile gauze. The bleeding rarely causes a problem. There may be a small white patch under the tongue (a healing ulcer). It heals quickly and doesn't cause baby any discomfort.

Tongue mobility following snip

In some circumstances the TT snip does not resolve the feeding issues. If you have any concerns following the procedure, please talk to the midwife caring for you and your baby. Contact details for follow up with Child and Family, a Lactation Consultant, Paediatrician or G.P will be arranged.

Where can I find more information?

Australian Breastfeeding Association 'Tongue tie and Breastfeeding January 2015

http://www.breastfeeding.asn.au/bf-info/tongue-tie

NO WRITING