Patient information

Suspected restrictive lingual frenulum (RLF) or 'tongue-tie': Information for parents

Dear parent/carer

Your baby has been referred for assessment of tongue mobility and possible division (frenulotomy) of a RLF (tongue tie). This leaflet will help you prepare yourself for this consultation and procedure (if required) and answer some of the questions you may have.

Why has my baby been referred to a specialist?

The piece of tissue joining the underside of the tongue to the floor of the mouth is called the lingual frenulum. When this is short, thick or extends right to the end of the tongue, it may be described as tongue-tie or ankyloglossia.

Whilst a visible lingual frenulum does not necessarily impede breastfeeding, and many babies feed successfully, in some cases it can **restrict** a baby's tongue movements to an extent that it prevents them from achieving deep and effective attachment at the breast. This can lead to ineffective feeding and/or swallowing of excessive amount of air. Therefore, your nipples may be painful and/or damaged.

Your referrer will have observed feeding and discussed optimum positioning for your baby and signs of effective attachment at the breast. **If there are no breastfeeding issues, please discuss with the health care professional who has referred your baby to the specialist, as the referral may be unnecessary.**

Occasionally, a RLF can affect bottle fed babies causing dribbling of large volumes of milk, excessive clicking on the teat, severe colic or reflux that may need a referral to our service.

Do I need to restrict the feeding prior to the appointment?

Yes, we need your baby to be hungry to assist in assessment of tongue movements and encourage interest in feeding after the procedure. **We ask that you do not provide a feed for approximately two hours prior to the appointment time**. Whilst every effort will be made to run to time a delay is possible, and your baby may feel very hungry before the appointment. This may be distressing for you and a member of staff will be available for support and guidance.

Immediately after the division procedure, you will be asked to put your baby to your breast or give a bottle if you are bottle feeding. If you have been using a nipple shield to assist with attaching your baby to the breast, please bring it along. If your baby has been unable to breastfeed and you have been expressing your milk and giving by bottle, may we ask that you consider bringing a nipple shield to try to transition your baby back to the breast? If your baby is receiving formula milk, please bring a prepared feed with you to give after the assessment.

We ask that you come to the clinic **accompanied by another adult**. The reason for this is to ensure that they can support you and your baby during the consultation and procedure. If a frenulotomy is performed, you can safely drive / be driven home without being distracted.

Why is vitamin K important prior to the procedure?

Vitamin K helps blood to clot and prevent serious bleeding. In newborns, giving vitamin K can prevent a rare but significant bleeding condition called “Vitamin K deficiency bleeding” or “Haemorrhagic disease of the newborn”. If your baby **has not** received intramuscular (IM) injection of vitamin K or alternatively, at least two doses of oral vitamin K, we would not proceed with the frenulotomy procedure without the confirmation of a normal blood clotting screen. This clotting screen is a blood test which can be arranged by your GP. Your baby would need to have blood taken and analysed and only when the results are confirmed to be normal, can we proceed with an appointment at our clinic.
It is therefore important that you bring your baby’s ‘red book’ as proof of vitamin

K administration.

What will happen at the consultation?

The practitioner will ask you about the difficulties with feeding being observed. With your permission, an assessment of the tongue movements and the position of the frenulum will be carried out. The outcome of the assessment will be discussed with you prior to any further action. A division will not be offered if it is judged that an RLF is not present or is present but not causing feeding difficulties. If a division of the RLF is felt to be the best option, the rationale for this will be discussed and written consent obtained.

A second health care professional, usually a midwifery support worker, will be available to support the procedure and feeding after the division of the frenulum.

What does the procedure involve?

Your baby will be wrapped in a towel and the frenulum below the tongue will be divided using sterile scissors. We expect your baby to cry during the assessment and division. Following the division, the crying may become a little louder but usually settles quickly when a feed is given.

You will be asked to feed your baby, by breast or bottle, immediately after the procedure to help any bleeding to stop. It is believed that breastmilk soothes the cut under the tongue whilst the action of breastfeeding promotes pain relief and is calming. Most babies feed normally after the procedure; however, some may continue to be upset. If your baby remains distressed and does not want to feed straightaway, we offer pain relief with drops (1-2ml) of sucrose and paracetamol. If baby is 8 weeks or over, please bring baby paracetamol with you, that you can administer if required.

Will my baby be given an anaesthetic or sedation?

No, as most babies tolerate this procedure well and many parents report the distress to their baby is minimal, in fact less than that seen with immunisation injections. Use of a general anaesthetic has the potential for complications, whilst injecting a local anaesthetic or using sedation has not been shown to be beneficial. It is therefore considered appropriate to perform this procedure without anaesthesia or sedation in young infants.

What will happen following the procedure?

Feeding will be interrupted after a couple of minutes to check for any bleeding. If

bleeding is seen the doctor may take the baby back to the examination table and put pressure with a piece of gauze at the site of the cut for 5 minutes at a time (sometimes more than once). Very rarely it may be necessary to use a dental roll soaked with medicinal solution placed over the cut to help stop the bleed.

Once the practitioner is satisfied that bleeding has stopped, you will be shown to a waiting area to continue breastfeeding until a final check is made 20-30 minutes later at which point an explanation of what to expect in the next few days will be given. **If you live more than 30 minutes away from the hospital, we recommend a longer period of stay on the hospital site of 45 minutes following the procedure.**

What should I do once I get home?

Care for your baby as normal offering feeds promptly in response to **early feeding cues**. If your baby is crying it is more probable that you may catch the wound area under their tongue with your nipple or the teat of a bottle. This can make the wound start to ooze some blood (see below for further advice).

Most parents do not note any significant changes in their baby's behaviour. If your baby does cry more than normal or appears more irritable this usually settles within 24 hours in response to regular feeding and frequent cuddles. You may want to consider skin to skin and baby wearing using a sling. A small proportion of babies who have had this procedure may be a bit upset and irritable and in very rare cases mothers have reported a short duration of breast refusal. It is not usually expected for a baby to require analgesic pain relief but if you are concerned, please seek advice from your GP/111.

How will the wound look and how long will it take to heal?

Healing starts very quickly at the site of the division. In the first few days, you will notice a diamond shaped whitish / grey colour at the site of the cut. This will change to a yellow colour in approximately a week's time and finally heal leaving a small string like appearance. **This is normal and not a recurrence.** Very rarely a small yellow blister may be noted at the site of the cut. This heals up quickly. If you remain concerned, please discuss with a health care professional. We recommend that for the first 48 hours after division you cover your baby's hands with mittens / their babygro to prevent them touching the wound with their fingers and making it bleed.

What if there is a slight ooze of blood from the wound?

If this happens feed your baby immediately to stop the oozing. After five minutes of feeding check to see that the slight ooze has stopped and if so continue to feed as your

baby needs. If the oozing has **not** stopped, apply continuous pressure with a clean cloth for five minutes, then re-check. **If bleeding persists, or you are concerned, call 999 or go to your local emergency department.**

What follow up care will my baby receive?

The health professional that referred your baby can provide feeding support. You will be contacted by phone two weeks following your baby's frenulum release to ask if the procedure has improved the feeding experience and discuss any concerns. Please could we ask that you provide a phone number on which you will be contactable? If you think you have missed this call, contact the community midwives hub via telephone 01284 713755.

Lip tie

There is no current published evidence supporting a link between breastfeeding problems and lip tie. Although the lip provides a good seal around the nipple, the process of sucking is mainly between the tongue and the palate. The National Institute for Health and Care Excellence (NICE) have not issued any guidance on this issue. **The only indication to do any intervention would be dentition issues in the future, after the eruption of permanent canines**. If you require further information, please seek a referral to a dentist.

Feedback and comments

Feedback enables us to determine to what extent the procedure was of help to you and your baby and follow up on any concerns you may have. It will help us to improve our service and enhance the quality of support given to parents in a similar situation to you.

Feedback will be sought two weeks after the procedure.

Directions to the clinic

The postcode for the West Suffolk Hospital is IP33 2QZ. Details of on-site car parking can be found here: https://www.wsh.nhs.uk/Patients-and-visitors/Information-for-visitors/Car-parking.aspx Once you have parked in car park A in front of the hospital, follow the directions for paediatric outpatient clinic (Rainbow clinic) from the main entrance.

Register your arrival with the staff at the clinic (with your appointment letter). Should you have any queries please talk to one of our receptionists.

For completion by the practitioner:

Baby …… NHS Number…….

Assessed for RLF on ……..

Release of RLF discussed with parent(s) Not required □

Performed with consent □

Practitioner

Printed name..... Signature …….

Please take this form with you should you need to consult your GP or attend your local emergency department following division of RLF.

This leaflet has been adapted and reproduced with kind permission from original material published by Mr A Minocha, consultant paediatric and neonatal surgeon. Luisa Lyons RM IBCLC of Norfolk and Norwich University Hospitals NHS Foundation Trust.

Clinical research

West Suffolk NHS Foundation Trust is actively involved in clinical research. Your doctor, clinical team or the research and development department may contact you regarding specific clinical research studies that you might be interested in participating in. If you do not wish to be contacted for these purposes, please email info.gov@wsh.nsh.uk. This will in no way affect the care or treatment you receive.

If you would like any information regarding access to the West Suffolk Hospital and its facilities, please visit the website for AccessAble (the new name for DisabledGo) https://www.accessable.co.uk/organisations/west-suffolk-nhs-foundation-trust

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