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Trust Guideline For Neonates with a Restrictive Lingual Frenulum (Tongue Tie) Causing Difficulty in Feeding

For Use in:	Maternity Services
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For:	Neonates
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6	07/12/2021	Revised and updated, hyperlinks added	Luisa Lyons

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Trust Guideline for Neonates with a Restrictive Lingual Frenulum (Tongue Tie) Causing Difficulty in Feeding

Objective

To clarify the Trust's support of frenulotomy [release procedure], where a restrictive lingual frenulum (RLF, tongue-tie) is having a negative impact on a neonate's feeding, particularly breastfeeding.

This guideline provides a clear pathway for midwives' support, advice and referral of babies under their care, where a restrictive frenulum is causing feeding difficulties.

Rationale

Breastfeeding has many advantages for both mother and baby. Support of breastfeeding is integral to health improvement programmes. Evidence available suggests that around 10.7% of babies may have the appearance of a tongue-tie (obvious lingual frenulum) and about half of those will have difficulty breastfeeding (1). Surgical release of a restrictive lingual frenulum has been shown to enable effective breastfeeding in babies who are experiencing difficulties with attachment at the breast and milk transfer. (1, 2, 3, 4, 5, 6, 7, 8, 9).

Where a feeding problem is assessed as being due to the baby's restrictive frenulum and where there is parental agreement, this Trust supports referral of the baby to the neonatal surgical team for the release procedure.

Broad recommendations

Referral of such babies for assessment of whether the release procedure is required, should be carried out by appropriately skilled midwives/nurses/MCA's known as RLF link midwives/nurses/MCA's. They should also provide skilled aftercare and follow up all mothers and babies referred to the RLF service.

Release of a restrictive frenulum to assist effective feeding, should only be performed by registered healthcare professionals who are appropriately trained.

Guideline

Suspected restrictive lingual frenulum (tongue-tie) in the neonate

In any mother who is experiencing difficulty in breastfeeding her baby, positioning and attachment at the breast and milk transfer, should be reviewed using Baby Friendly Initiative [BFI] standards. If there are signs of sub-optimal/ineffective attachment, despite positioning at the breast being sound, a careful inspection of the oral cavity should be done to identify if a restrictive lingual frenulum is affecting normal tongue movement. A check for issues such as bubble palate, high arched palate and submucosal cleft should also be performed.

Similarly, if a formula fed or expressed breastmilk fed neonate is experiencing persistent difficulty in feeding, despite trying different bottles, teats and flow rates and using a paced feeding technique, a thorough inspection of the oral cavity should be performed.

If the lingual frenulum gives the appearance of restricting the tongue, its impact on tongue movements and sucking should be documented in the baby's health record. Further advice should be sought from a trained RLF link midwife / nurse who has

completed the NNUHFT RLF competency for Assessment and Referral . They can assess the baby's tongue mobility and make a differential diagnosis to rule out other causes of feeding difficulties. If indicated, the link midwife / nurse can then refer the baby to the RLF team. Please ensure parents are aware the referral is for an **opinion** of whether a division is needed, not for a frenulotomy. For our referral criteria, please see Appendix 7.

This guidance is summarised in the Flow Chart (Appendix 1). If the baby is admitted under Neonatal / Paediatric teams for reason other than feeding difficulties (e.g. is resident on the Neonatal Unit), the respective teams should be aware of the referral **and should confirm that there are no ongoing medical issues** such as sepsis, respiratory, cardiac or metabolic conditions which require attention before frenulotomy. Referrals should be avoided in preterm babies under 37 weeks gestational age except where the individual case has been discussed with the RLF team.

Early breastfeeding problems where restrictive lingual frenulum is present

This guideline recognises that breastfeeding is a complex interaction between mother and baby and that many factors can affect the ability to feed. Skilled breastfeeding support is an integral part of the care of a baby with a restrictive lingual frenulum.

Caution is advised with raising the issue of frenulotomy with parents prior to day 3, when positioning and attachment is being learned and tongue movements and sucking skills are developing (10). See guidance sheet for parents in Appendix 2 (Trust Docs ID: 11904) regarding why all babies are not "checked at birth" for Restrictive Lingual Frenulum (RLF). If a baby has a very short and very restrictive anterior lingual frenulum and is unable to effectively feed before 3 days old, please discuss these individual cases with the RLF team.

The midwife/MCA caring for mother and baby should offer support and advice regarding the individual's feeding problem, to ensure the mother has understood and assimilated advice on effective positioning and attachment. In the first instance, carers should assess a breastfeed using the Breastfeeding Assessment Tool Trust Docs ID: 14528) and where indicated, refer to a RLF Link Midwife/Nurse/MCA, (Trust Docs ID 12598) who should endeavour to see the mother and baby within 24-48 hours of being requested.

Some neonates will feed effectively, despite the appearance of the frenulum, depending on factors such as, the elasticity of the frenulum and the mother's breast tissue. If the neonate is unable to effectively attach at the breast, breast milk will need to be hand expressed and given to the baby as an interim measure. See relevant section of: 'Trust Guideline for the management of healthy babies over 37 weeks gestation who are reluctant to feed' (Trust Docs ID: 8334). If a bottle-fed baby is unable to transfer milk from a bottle effectively despite trying different teats and bottle flow rates, they should be referred to the RLF link midwives/nurses in the first instance for a bottle feeding assessment.

Review by link midwife within 24-48 hours of referral (where possible)

Using the Assessment form (Appendix 3, Trust Docs ID: 9283) the link midwife will make an evaluation of:

- Diagnosis of lingual frenulum that restricts normal tongue extension (anterior protrusion), elevation and right and left sided lateralisation

- Feeding difficulties (include assessment of positioning and attachment and milk transfer)
- Maternal symptoms and signs in baby (history and direct observation)

Where a referral to the neonatal surgical team is indicated, they will then complete and send a Referral form (Appendix 4, Trustdocs ID 9284) to the RLF Team via email (nnu-tr.rlfreferrals@nhs.net). Do not send by post.

This guideline **only** supports referral, if a restrictive frenulum is the possible cause of feeding difficulties. **Where parents of a neonate are requesting the release procedure, for any other reason (i.e. potential future speech issues, cosmetic appearance), in the absence of feeding difficulties, the midwife must inform them that the frenulum will not be released for this reason (if there is no feeding issue), and direct them to consult their General Practitioner if they have further queries.**

Please ensure parents are aware the referral is for *an opinion of whether a frenulum release is needed, not for a frenulotomy necessarily.* The decision of whether to perform a freulotomy will rest with the RLF specialist midwife/nurse or surgeon who is performing the division.

The referrer must provide the parents with the Parent Information Leaflet in Appendix 5 (Trust Docs ID 9863) regarding the procedure and parental agreement form in Appendix 6 (Trustdocs Id: 15485) prior to the referral being made. They must indicate on the referral form that this has been given to parents for the referral to be accepted (it is crucial that Vitamin K is given, IM or at least two doses of oral vitamin K, or if declined, that clotting studies have been arranged and confirmed as normal before completing a referral).In cases where clotting studies are required the referrer will need to liase with the GP for these to be taken and results attached to the referral form.

In addition, the referrer **must identify and specify any other known clinical condition** the baby might have e.g. antenatal ultrasound issues, neonatal alerts, birth injury, any inpatient NICU stay, any known or suspected cardiac issues, metabolic or growth issues and any oxygen dependence and medications If a baby has previously been on the Neonatal Unit, a discharge summary needs to be included with the RLF referral to ensure it is safe to offer the procedure.

It is also extremely important to inform the RLF team about any safeguarding issues, e.g. foster parents. If the parents do not have consenting rights, please ensure whoever has parental responsibility signs the consent form and/or whoever has the legal authority to do so.

Direct referral to the Neonatal and Paediatric Surgical Team without the involvement of a link midwife/nurse should only be made in exceptional circumstances.

If a practitioner other than a registered health care professional (e.g. a Senior Maternity Care Assistant, Assistant Practitioner or Breastfeeding Practitioner) completes a referral, they need to have completed the RLF assessment and referral competency and been signed off by a member of the RLF team.

Table 1 Problems that may be seen in association with a restrictive frenulum

Breastfeeding difficulties	Bottle feeding difficulties
•—'Lipstick' shaped nipple seen upon detachment •—Nipple pain, vasospasm •—Nipple trauma (ulcerated, bleeding, cracked) •—Mastitis (associated with incomplete drainage or cracked nipples) •—Difficulty of the baby attaching to the breast (signs of frustration) •—Frequent feeding, lengthy feeds, feeding •—Excessive early weight loss and/or poor weight gain •—Prolonged jaundice •—Clicking sounds audible on the breast	•—Uncoordinated feeding leading to 'messy' feeder •—Dribbling large amounts of milk out of the sides of mouth •—Protracted feeding •—Poor suction on the teat leading to clicking sounds •—Aerophagia •—Excessive early weight loss •—Poor weight gain or static weight

RLF Information Leaflets

Please see the NNUHFT RLF Parent Information Leaflet in Appendix 5 (Trust Docs ID: 9863). This is a comprehensive information leaflet we have produced for parents. When referring a baby into the RLF service for an appointment, please ensure parents have this.

Other leaflets are available from The Lactation Consultants of Great Britain (LCGB) which is obtainable from their web site www.lcgb.org or the NICE leaflet can be downloaded from www.nice.org.uk. *Division of ankyloglossia (tongue-tie) for breastfeeding – information for the public* IPG149. In addition, further information is available at the Association of Tongue Tie Practitioners website http://www.tongue-tie.org.uk/tongue-tie-information.html .

Referral to Paediatric Surgical Team by link Midwife/Nurse/Health visitor

On receipt of a referral, an appointment will be arranged, and the parents notified in a timely manner. Clinically urgent referrals will aim to be seen within 1-2 weeks and non-urgent referrals within 2-4 weeks. Referrals are prioritised on clinical urgency of need (e.g. infant weight loss and/or jaundice as a priority, mastitis, severe nipple trauma, at-risk babies seen first). A frenulotomy will only be performed if the procedure is likely to resolve the feeding problem. In the interim whilst awaiting the appointment, specialist infant feeding support should be offered and consideration given to referring the mother and baby to the specialist infant feeding clinic (Trust Docs ID: 14719).

After-care

The link midwife/nurse should arrange for a Community Midwife or Senior Maternity Care Assistant to review the neonate and re-evaluate feeding, ideally the day after their appointment at the RLF clinic. This could be a virtual contact by phone if clinically appropriate. They will determine ongoing care as necessary. **As an aspect of good practice, all link midwives/nurses referring babies for the release procedure should follow up the mother and baby by phone/face to face contact.** This follow up will enable the mother to debrief from the experience with the person that made the referral and will advance the referrer's understanding of the effects a restrictive frenulum on feeding and outcomes following the release procedure.

There is no clear current evidence to support the recommendation any post-operative digital stretches or any other exercises as the RLF team at NNUHFT achieve a complete division (achieving a diamond wound). By undertaking stretching exercises, there is a risk of potential harm, infection, increased scarring and oral aversion with any manipulation of the wound.

Auditing and Monitoring Compliance

The process for audit, multidisciplinary review of results and subsequent monitoring of action plans is detailed in the monitoring compliance table Appendix 7.

Summary of Development and Consultation process undertaken before registration and dissemination

This guideline was updated by the RLF team, Mr Ashish Minocha was consulted prior to this guideline being assessed and approved by the Maternity Services Guidelines Committee.

It was reviewed and amended to new national guidance. The guideline is approved by the Head of Maternity Services and the Clinical Director for Paediatrics.

Distribution List:
Head of Midwifery and all clinical maternity areas
Community team leaders (midwifery) and Outreach team (NICU)
Trust Intranet
Neonatal Unit
Paediatric Department
Maternity Units in the East of England, via their Infant Feeding Leads
Health Visiting services in the East of England, via their Infant Feeding Leads.

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Further Reading

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National Institute for Health and Clinical Excellence (2006) CG 37 Postnatal Care: routine postnatal care of women and their babies **NICE.**

Source documents

Assessment for Restrictive Lingual Frenulum (Tongue Tie)
Trustdocs Id: 9283

Bottle Feeding Assessment Trust Docs Id: 14556

Breastfeeding Assessment Tool Trust Docs ID: 14528

Checking for Tongue Tie (Restrictive Lingual Frenulum) Trustdocs Id: 11904

Healthy Babies over 37 weeks gestation who are Reluctant to Feed (Management of)
Trustdocs ID: 8334

Infant Feeding Keyworkers Trust Docs Id: 12598

Information for parents/carers of a baby referred with a diagnosis of Restrictive Lingual Frenulum (tongue tie) Trustdocs Id: 9863

Parental Agreement for Assessment and Treatment of Restrictive Lingual Frenulum (Tongue–Tie) in Outpatient Clinics Trustdocs Id: 15485

Referral form for Division of Restrictive Lingual Frenulum (Tongue Tie) Trustdocs Id: 9284

Specialist Infant Feeding Clinic (Trust Docs ID: 14719

Trust Guideline for Neonates with a Restrictive Lingual Frenulum (Tongue Tie) Causing Difficulty in Feeding

Appendix 1

Flow chart for use when caring for a mother and baby where a restrictive lingual frenulum (tongue tie) appears to be causing feeding problems

Observe a full feed and complete a breastfeeding assessment (Trust Docs ID: 14528) or bottle feeding assessment (Trust Docs ID: 14556) form. N.B. Anyone can, and should, do this. It is not exclusively the role of the link midwife/nurse.

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If there are signs of sub-optimal/ineffective attachment despite effective positioning, ask a link midwife/nurse to assess (For a list of assessors, see Trust Docs ID: 12598). She/he will refer the baby to the restrictive lingual frenulum service if appropriate, using a Referral Form (Trust Docs ID: 9284) having made a differential diagnosis and checked for any relevant known clinical conditions. She/he will include the assessment form (Trustdocs Id: 9283) with the referral and give the parents the information sheet (Trustdocs Id: 9863) and parental agreement form (Trustdocs Id: 15485)

N.B. If the baby is admitted under neonatal / paediatric teams for reasons other than feeding difficulties, the respective teams should be aware of the referral **and should confirm that there are no ongoing medical issues** such as sepsis, respiratory, cardiac or metabolic conditions which require attention before frenulotomy.

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If required, in addition whilst waiting for the RLF clinic appointment, a referral could be made to the Specialist Infant Feeding Clinic (Trust Docs ID: 14719) where a breastfeeding specialist can review the mother and baby at the next available clinic appointment.

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Formula fed babies should only be referred if there is a clinical indication (e.g. significant weight loss or excessively lengthy feeds, aerophagia on medications for reflux / colic) after trying different teats, bottles and flow rates. It is less common for a frenulotomy to be required for a formula fed baby.

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Senior Maternity Care Assistants (SMCAs) and Assistant Practitioners / Nursery nurses may only refer if they have had the appropriate training, attended the RLF clinic and have completed the NNUH competency document. MCA's who have not completed the competency can perform feeding assessments.

Appendix 2

Checking for Tongue Tie (Restrictive Lingual Frenulum)
Trustdocs Id: 11904

Appendix 3

Assessment for Restrictive Lingual Frenulum (Tongue Tie)
Trustdocs Id: 9283

Appendix 4

Referral form for Division of Restrictive Lingual Frenulum (Tongue Tie)
Trustdocs Id: 9284

Appendix 5

Information for parents/carers of a baby referred with a diagnosis of Restrictive Lingual Frenulum (tongue tie)
Trustdocs Id: 9863

Appendix 6

Parental Agreement for Assessment and Treatment of Restrictive Lingual Frenulum (Tongue–Tie) in Outpatient Clinics
Trustdocs Id: 15485

Appendix 7

Referral Criteria

All babies must have a face to face oral assessment (or if this is not possible due to COVID19, a video assessment -but this is not idea) to be referred to our service in order to confirm the presence of a RLF. We are able to accept referrals where there is:

1. An inability to gain weight normally, (at least 25g per day, and back to birthweight by 2 weeks old). Please consider maternal milk supply issues and seek to remedy these as far as possible if this is a contributing factor.

2. Jaundice requiring phototherapy, or prolonged jaundice over 14 days (along with a referral to yellow alert clinic for term babies).

3. Significant maternal mental health difficulties exacerbated by feeding issues which are thought to be due to a RLF.

4. Significant breast or nipple trauma (including mastitis, breast abscess, infection of the nipple/breast, cracked or bleeding nipples)

5. In term babies, an inability to breastfeed effectively due to a RLF necessitating expressing and bottle feeding or a nasogastric tube.

We will not see babies who have an obvious lingual frenulum but where there are no feeding issues mentioned above.

Appendix 8

Document Name: Neonates with a restrictive frenulum (tongue tie) causing difficulty in feeding.
NHSLA / CNST Criteria No 5 (Newborn feeding – Level 1.5.5 (c) -problem)

Element to be monitored	*Lead Responsible for monitoring*	*Monitoring Tool / Method of monitoring*	*Frequency of monitoring*	*Lead Responsible for developing action plan and acting on recommendations*	*Reporting arrangements*	*Sharing and disseminating lessons learned and recommended changes in practice as a result of monitoring compliance with this document*
List of all link midwives/nurses within maternity wards of the NNUH (to include NICU, Buxton and CAU)	RLF specialist midwife/nurse	A formalised audit with reference to CNST requirements	3 yearly audit or when clinical risk identified regarding failure to follow guideline	Clinical lead for RLF service and	Department Clinical Governance Meeting and Audit Meeting	The Lead responsible for developing the action plans will disseminate lessons learned via the most appropriate committee e.g. Clinical Effectiveness; Clinical Governance, Patient Safety and where appropriate, the Compliance Assurance Group.
Baby and mother referred to a link midwife/nurse are seen within 48 hours of referral	RLF specialist midwife/nurse	A formalised audit with reference to CNST requirements	3 yearly audit or when clinical risk identified regarding failure to follow guideline	Clinical lead for RLF service and	Department Clinical Governance Meeting and Audit Meeting	
Parents of a baby referred to Neonatal Paediatric Surgical Team by link midwife/nurse receive an appointment within 2 weeks of receiving the referral	RLF specialist midwife/nurse	A formalised audit with reference to CNST requirements	3 yearly audit or when clinical risk identified regarding failure to follow guideline	Clinical lead for RLF service	Department Clinical Governance Meeting and Audit Meeting	