Frimley Health
NHS Foundation Trust

Care of the infant with tongue tie

Key Points

- To ensure staff are supported in knowing how to provide early identification and assessment of feeding problems linked to tongue tie
- To help staff provide skilled intervention to safeguard breastfeeding and or the establishment of lactation, whether or not surgical frenulotomy is performed.

Version:	3.0
Date Issued:	17 December 2024
Review Date:	December 2027
Key words:	Tongue tie, breast feeding, bottle feeding

This is a controlled document. If you are using a printed copy, check it against the guidelines site to ensure you are using the latest edition. Print copies must be destroyed after use.

Abbreviations

BFT	Breast Feeding Team
CACOU	Children's Ambulatory Care Outpatient Unit
CMW	Community Midwife
HV	Health Visitor
IFT	Infant Feeding Team

Contents

1. Introduction - What is a Tongue tie?

A tongue tie (also known as Ankyloglossia) is caused by a short or tight membrane under the tongue (the lingual frenulum).

Where the membrane is attached at, or close to the tongue tip, the tongue tip may look blunt, forked or have a heart shaped appearance. However, where the membrane is attached further back the tongue may look normal in appearance.

Research suggests that approximately 1 in 10 babies may be born with some restrictive membrane under the tongue. But only about half of those babies display significantly reduced tongue function, making breast or bottle feeding difficult.

These babies may benefit from treatment to release the restriction that the membrane is having on the tongue and enable a baby to feed effectively.

2. Problems which may be due to a restrictive tongue tie

Mother

- Sore/damaged nipples
- Nipples which look misshapen or blanched after feeds
- Mastitis
- Low milk supply or fast, quick let down
- Exhaustion from frequent/constant feeding
- Distress from failing to establish breastfeeding

Baby

- Restricted tongue movement
- Small gape resulting in biting/grinding behaviour
- Unsettled behaviour during feeds
- Difficulty staying attached to the breast or bottle
- Frequent or very long feeds
- Excessive early weight loss/poor weight gain/faltering growth
- Clicking noises and /or dribbling during feeds
- Colic wind, hiccoughs
- Reflux (vomiting after feeds)

3. Diagnosis

- A breastfeeding/bottle feeding assessment should be completed at 24 hours old, day 5 or at each postnatal check. If concerns are identified, a feed should be observed with skilled assistance for the mother to position and attach her baby. Initiate Appendix 1 for the clinical care pathway for tongue tie.
- A feeding plan will be developed in partnership with the mother and reviewed within an agreed timeframe to evaluate if improvements to breastfeeding have been made. Following the reluctant feeding pathway if baby reluctant to feed.
- If problems persist despite skilled support and a short/tight lingual frenulum is identified, then tongue tie may be considered.

- The midwife caring for the baby should then carefully assess feeding to confirm whether the tongue tie appears to be problematic for effective feeding and milk transfer. This assessment must include observing a full feed for signs of effective attachment and milk transfer.
- To avoid an unnecessary frenulotomy, the midwife should offer the mother skilled assistance to improve the positioning of her baby at the breast, which may be enough to help the baby achieve effective attachment. Different positions suit different babies, but whatever position is used, 'C.H.I.N.' principles always apply (Close, Head free, In line, Nose to nipple). If the breastfeeding problem resolves with improved positioning, continued support with the successful technique should be offered at every feed until the mother is confident herself. Repeated practice may be needed initially by new mothers.
- During any period when a baby is not breastfeeding effectively the mother will be supported to initiate and maintain her milk supply. Appropriately trained staff should teach the mother how to express her milk comfortably and effectively and support her to express at least 8 times in 24 hours, including once at night.
- Tongue tie leaflet (Appendix 3) to be given to parents.

4. Referral Process

Up to 28 days for feeding support and up to 6 weeks for tongue tie clinic.

If the baby is still in hospital, then an inpatient consult to Infant feeding team should be made on Epic.

If the baby is at home, then the CMW/HV can refer to IFT by emailing the BFC referral form (Appendix 2).

FPH IFT fhft.infantfeedingfph@nhs.net
WPH IFT fhft.infantfeedingteam@nhs.net

The parents can self-refer to IFT by email.

Following tongue tie assessment in the BFC, the IFT midwife will order and book a tongue tie (t.tie) clinic appointment on Epic.

If there is decreased service availability, or delay in referral, an appropriate plan should be initiated to support the maintenance of lactation with the mother.

5. The Procedure

Frimley - The t.tie clinic is held in CACOU. The division is performed by the ENT surgeon.
Wexham - The t.tie clinic is held in Children's outpatients. The division is performed by a General Surgeon.

The baby will be assessed by the ENT/General surgeon and a frenulotomy will **only** be performed with the parent's consent if a restriction is diagnosed and is clinically indicated.

The surgeon/IFT will discuss risk of bleeding and check that the baby has received Vitamin K following birth prior to the procedure.

6. Bleeding Post Frenulotomy

A small amount of bleeding post division is common. Allowing the baby to feed on the breast/bottle following division will help to compress the floor of the mouth and stop the bleeding.

1:400 babies will require pressure to settle the bleeding
1:7000 will require application of adrenaline
1:77000 will require cautery or suturing

7. Management of Excessive Bleeding

If there is an unusual amount of bleeding after division, it is likely to be dark venous bleeding. Bright red arterial bleeding is very rare.

1. Hold baby upright, put some gauze on the raw diamond wound under the tongue and hold in place firmly with one finger, taking care not to place any pressure under the baby's chin, as this can obstruct the airway. Moistening the gauze with sterile water, sterile normal saline or breastmilk will help prevent the clot sticking to the gauze and being removed when the gauze is removed. Continue to press for at least 10 timed minutes. Ensure that the airway is maintained. Keep baby warm and calm.
2. If the gauze becomes soaked while you are pressing, replace the gauze and check you are pressing under the tongue on the raw diamond, but now press with 2 fingers, side by side, to ensure you are pressing on the outer edges as well as the centre. Continue pressure for at least 10 timed minutes. **Do not continuously remove the gauze to see if the bleeding has stopped: wait for at least 10 minutes and then look.**
3. If bleeding persists apply pressure for a further 10 minutes using gauze or Kaltostat,
4. If bleeding persists soak gauze in Tranexamic acid and apply for 5 minutes.
5. If bleeding persists ENT/ Maxillofacial surgeon to consider electrocautery.

8. Auditable standards

- All formula supplements should be clinically indicated with optimum care given and/or with fully informed maternal choice.
- 80% of women to be shown hand expressing.
- All babies who are reluctant to breastfeed to be offered skin-to-skin contact.

9. Monitoring

This guideline will be subject to a minimum of yearly audit and results presented to the Baby Friendly Initiative (BFI) working party, ward and unit meetings. Action plans will be monitored under the BFI implementation strategy.

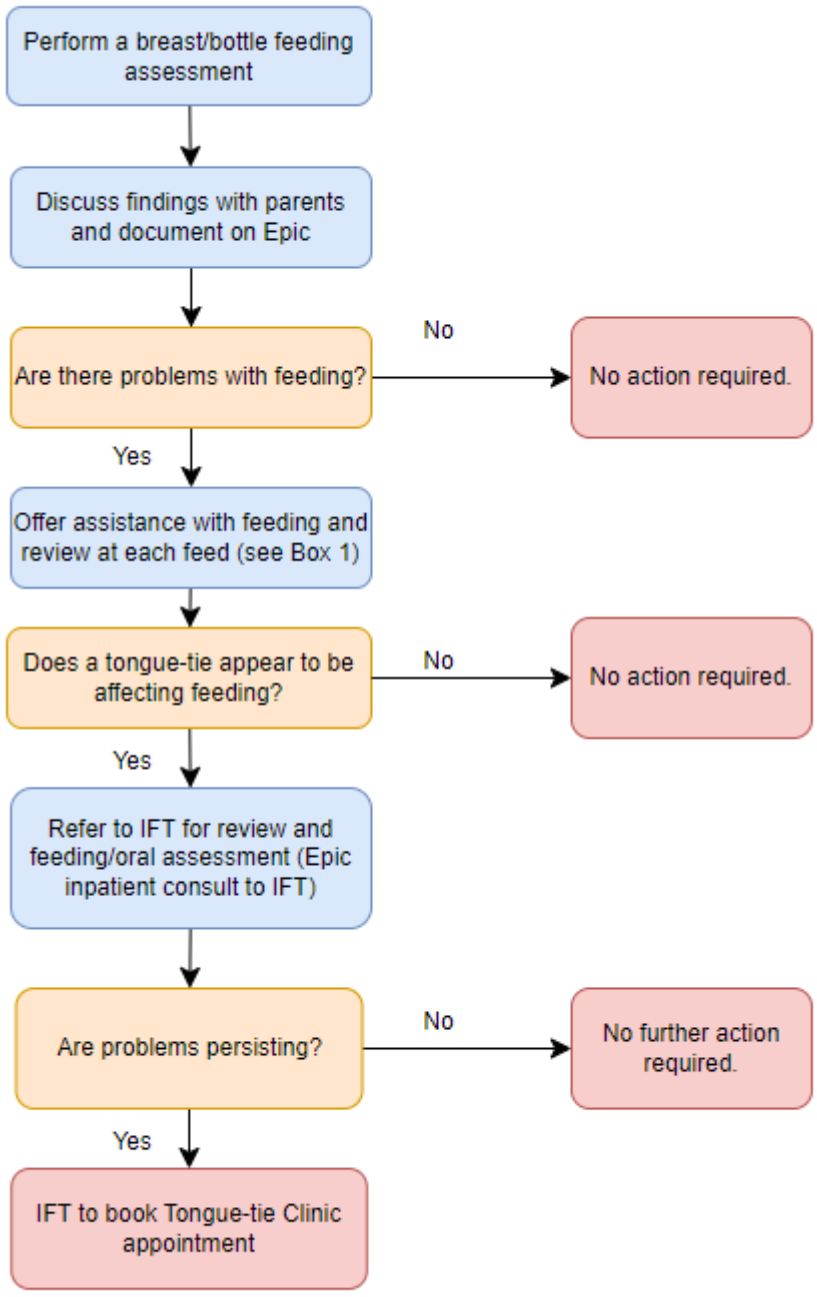
10. Communication

If there are communication issues (e.g., English as a second language, learning difficulties, blindness/partial sightedness, deafness) staff will take appropriate measures to ensure the patient (and her partner, if appropriate) understand the actions and rationale behind them.

References

1. Jones, W. (2018) *Breastfeeding and medication.* 2nd edn. London: Routledge
2. Watson Genna, C. and Rabin, J. (2022) 'Breastfeeding: normal sucking and swallowing', in Watson Genna, C. (ed.) *Supporting sucking skills in breastfeeding infants.* 4th edn. Burlington, MA: Jones and Bartlett Learning
5. National Institute for Health and Care Excellence [NICE] (2005) *Division of* ankyloglossia *(tongue-tie) for breastfeeding*. IPG149. Available at: https://www.nice.org.uk/guidance/ipg149 (Accessed: 04 April 2024)
6. Hogan, M., Westcott, C. and Griffiths, M. (2005) 'Randomized, controlled trial of division of tongue-tie in infants with feeding problems', *Journal of Paediatrics and Child Health*, 41(5-6), pp. 246-250. Available at: https://doi.org/10.1111/j.1440-1754.2005.00604.x
7. Power, R.F. and Murphy, J.F. (2015) 'Tongue-tie and frenotomy in infants with breastfeeding difficulties: achieving a balance', *Archives of Disease in Childhood*, 100(5), pp. 489-494. Available at: https://doi.org/10.1136/archdischild-2014-306211
8. Ridgers, I., McCombe, K. and McCombe, A. (2009) 'A tongue-tie clinic and service', *BJM*, 17(4), pp. 230-233. Available at: https://doi.org/10.12968/bjom.2009.17.4.41671

Appendix 1: Clinical Care Pathway for Infant with Tongue tie
(Up to 6 weeks of age)



Box 1 – Assistance with feeding

- Offer assistance with feeding/ positioning and attachment
- Ensure hand expressing or pumping to initiate lactation
- Review at each feed

If problems persist,

- Refer to IFT- Inpatient consult to IFT

Post division: follow-up in Breastfeeding Clinic if under 28 days or HV if over 28 days.

Appendix 2 (a): Community Referral Form to Frimley Park Hospital Infant Feeding Team

Mother's Details	Baby's Details
Name: Tel No: MRN/NHS Number: Email: Address: Postcode: GP:	Name: DOB: MRN/NHS No: Age of baby: Method of feeding: - BF □ EBM □ AF □ (Tick all that apply)

Please advise what care has already been provided. Tick all that apply.
Note – an appt with IFT clinic will only be made if feeding has been observed and support provided with P&A by Midwife/Health Visitor

- Feeding assessed using BF tool? Y □ N □
- Positioning & Attachment observed and adjusted accordingly? □
- Advised to safeguard milk supply by expressing? □
- Supplements given if required? - EBM □ AF □
- Care plan documented in notes/EPIC Y □ N □
- GP referral/treatment if appropriate? Y □ N □

Problem identified – please mark all that apply

All babies with feeding issues must be under 6 weeks to refer

- Persistent short and excessively frequent feeds □
- Prolonged feeding at the breast or bottle feeds taking longer than 40 mins □
- Painful feeding □
- Mothers with nipple damage/engorgement/blocked ducts/mastitis/breast abscess – Positioning and attachment optimum □
- Low/inadequate supply □

Relevant Family History or Weight loss issues in the first 28 days

Date time	Age of Baby	Additional notes.	Print Signature

Outcome: Appointment made with IFT ☐ Continue community support ☐

Referrer Name & Role: **Referrer contact details:**

Infant Feeding Team Name:

Date received:

Referral forms to be emailed to fhft.infantfeedingfph@nhs.net

Advisor Name & signature **Date:**

Appendix 2 (b): Community Referral Form to Wexham Park Hospital Infant Feeding Team

Mother's Details	Baby's Details
Name: Tel No: MRN/NHS Number: Email: Address: Postcode: GP:	Name: DOB: MRN/NHS No: Age of baby: Method of feeding: - BF □ EBM □ AF □ (Tick all that apply)

Please advise what care has already been provided. Tick all that apply.
Note – an appt with IFT clinic will only be made if feeding has been observed and support provided with P&A by Midwife/Health Visitor

- Feeding assessed using BF tool? Y □ N □
- Positioning & Attachment observed and adjusted accordingly? □
- Advised to safeguard milk supply by expressing? □
- Supplements given if required? - EBM □ AF □
- Care plan documented in notes/EPIC Y □ N □
- GP referral/treatment if appropriate? Y □ N □

Problem identified – please mark all that apply

All babies with feeding issues must be under 28 days to refer

- Persistent short and excessively frequent feeds □
- Prolonged feeding at the breast or bottle feeds taking longer than 40 mins □
- Painful feeding □
- Mothers with nipple damage/engorgement/blocked ducts/mastitis/breast abscess – Positioning and attachment optimum □
- Low/inadequate supply □

Relevant Family History or Weight loss issues in the first 28 days

Date time	Age of Baby	Additional notes.	Print Signature

Outcome: Appointment made with IFT ☐ Continue community support ☐

Referrer Name & Role: **Referrer contact details:**

Infant Feeding Team Name:

Date received:

Referral forms to be emailed to fhft.infantfeedingteam@nhs.net

Advisor Name & Signature: **Date:**

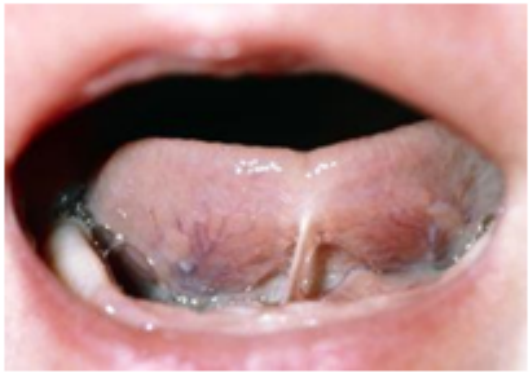
Advisor Name & signature **Date:**

Appendix 3: Parent information leaflet

Maternity / Infant Feeding Team

NHS
Frimley Health
NHS Foundation Trust

Tongue-tie



What is a tongue-tie?

This is where the frenulum, a thin membrane underneath the tongue, is unusually short or tight, restricting the tongue movement.

How can it affect feeding?

All babies are different: some may be affected and others may not. Often, this depends on the mobility of their tongue. When babies are breastfeeding, they need to draw the nipple to the back of the mouth and keep it there. If the tongue movement is restricted, they may not be able to attach effectively at the breast. Occasionally, babies may find it difficult to bottle feed.

Breastfed babies

- may have difficulty latching on to the breast and/or staying attached, sometimes making 'clicking' sounds
- may feed frequently, and/or feed very slowly
- may have poor weight gain
- have colic, wind, hiccoughs
- have reflux (vomiting after feeds)
- small gape resulting in biting/grinding behaviour

Bottle fed babies

- may find it difficult to bottle feed
- may take a long time to feed
- drink only small amounts
- dribble a lot of milk during feeds
- make clicking noises during feeding
- have colic, wind, hiccoughs
- have reflux (vomiting after feeds)

Breastfeeding mothers

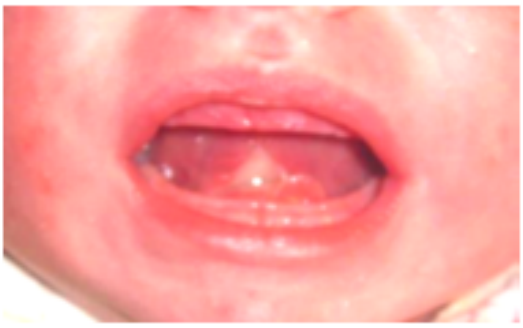
- may find feeding very painful because of sore, damaged nipples
- may develop mastitis from poor drainage and nipple trauma
- may find their milk supply reduces over time
- may become exhausted from frequent/constant feeding
- may become distressed from failing to establish breastfeeding

How is it diagnosed?

You will receive support with feeding whilst in the hospital and, once you return home, by your community midwife and Health Visitor. If, following support with feeding/positioning and attachment, you and your baby are still experiencing difficulties with feeding and a tongue tie is suspected or diagnosed, then you will be referred to our infant feeding team. There you will be offered an appointment in one of our breastfeeding clinics where we can support you with feeding and assess whether the tongue tie appears to be affecting feeding. You will then be referred to our tongue tie clinic where an ENT surgeon (FPH) or general surgeon (WPH) will assess and divide the tongue tie if appropriate.

What happens during the tongue-tie clinic?

Our ENT/General surgeon will assess the tongue-tie and advise you whether the tongue-tie would benefit from being divided. If so, you can hold your baby to comfort him/her. The infant feeding specialist midwife will support your baby's head, whilst the surgeon performs a small cut with blunt ended curved scissors to divide the tongue-tie. This is a relatively painless procedure as there are few nerve endings in the frenulum of a newborn baby. There are normally a few drops of blood and your baby may feed straight away. A small white patch will appear under your baby's tongue resembling an 'ulcer' which may last a week or two. This is the normal healing process and your baby should continue to feed at least 8 times in 24 hours.



Community feeding support

Our breastfeeding clinics are currently appointment only. Please contact:

FPH fhft.infantfeedingfph@.nhs.net

WPH fhft.infantfeedingteam@nhs.net

to book into one of these clinics.

How can I find out more?

- Association of Tongue-tie Practitioners www.tongue-tie.org.uk
- UNICEF http://www.unicef.org.uk/Babyfriendly/ (search for tongue-tie)
- La Leche League GB http://www.laleche.org.uk/
- Breastfeeding Network http://www.breastfeedingnetwork.org.uk
- NHS choices http://www.nhs.uk/Conditions/tongue-tie/Pages/Introduction.aspx

Reference

National Institute for health and clinical Excellence 2005. Division of ankyloglossia (tongue-tie) for breastfeeding. Available at www.nice.org.uk/IPG149publicinfo.

For a translation of this leaflet or for accessing this information in another format:

Please contact (PALS) the Patient Advice and Liaison Service on:

Frimley Park Hospital
Telephone: 0300 613 6530
Email: fhft.palsfrimleypark@nhs.net

Wexham Park & Heatherwood Hospitals
Telephone: 0300 615 3365
Email: fhft.palswexhampark@nhs.net

Frimley Park Hospital	**Heatherwood Hospital**	**Wexham Park Hospital**
Portsmouth Road, Frimley, Surrey, GU16 7UJ	Brook Avenue, Ascot, Berkshire, SL5 7GB	Wexham Street, Slough, Berkshire, SL2 4HL
Hospital switchboard: 0300 614 5000		**Website:** www.fhft.nhs.uk

Title of Leaflet	Tongue-tie				
Author	Fiona Lewis, Lead Infant Feeding Midwife		Department	Maternity	
Ref. No	L/126/2	Issue Date		Review Date	

Full version control record

Version:	3.0
Guidelines Lead(s):	Fiona Lewis, Joint Lead Infant Feeding Midwife, FPH
Contributor(s):	
Lead Director / Chief of Service:	Miss Anne Deans, Chief of Service for Obstetrics & Gynaecology
Library check completed:	4 April 2024
Ratified at:	Cross Site Obstetric Clinical Governance meeting, 16 December 2024
Date Issued:	17 December 2024
Review Date:	December 2027
Pharmaceutical dosing advice and formulary compliance checked by:	N/A
Key words:	Tongue tie, breast feeding, bottle feeding

This guideline has been registered with the Trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health NHS Foundation Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Guideline Lead(s)	Status	Comment
1.0	May 2017	Lead Midwife for Infant Feeding	Final	
2.0	June 2020	Joint Infant Feeding Leads FPH/WPH	Final	
3.0	Oct 2024	Fiona Lewis, Joint Lead Infant Feeding Midwife, FPH	Final	

Related Documents

Document Type	Document Name
FH Parent Leaflet	Tongue Tie