Dr. Brown's Medical Webinar 1.21.25

Ankyloglossia and Other Ties

(PK=Dr. Peggy Kelley; SH=Shanna Harris)

Question and Answer Addendum

Q: What are your thoughts on the inability to attain tongue tip to the roof of the mouth at rest with a tight frenulum that is required for optimal pituitary gland function? Also even if feeding is deemed functional, what is your thought on long term speech difficulties when not releasing the tight frenulum when it's such an easy and non-invasive procedure when the baby is a newborn?

PK: I am not aware of information regarding tongue tip and pituitary function. I would be very interested in your references regarding that connection. I do release tongues for possible speech difficulties when the anterior tie is within a centimeter of the tongue tie and extends onto the mandible.

Q: Do you know Martinelli tongue test?

PK: I do not know that tongue test.

SH: I have looked into the Martinelli test. This again is only partially validated. The other concern I have regarding this test and the Tabby is that it scores the tongue on appearance but does not take breastfeeding or tongue FUNCTION into account.

Q: If there is no pain in breastfeeding, but reflux is an issue, is a tie something that should be considered?

PK: I would consider reflux treatment not a tie. But if in my evaluation of the infant's airway, I found a tongue tie I would discuss how it could be contributing.

SH: I agree. I would not consider tongue tie release a first line treatment for reflux.

Q: What are the rates of reattachment post release and the common reasons of reattachment?

PK: I do not know of any published reattachment rates. Commonly it is from deep injury preventing good continued tongue movement or age at release when child cannot follow tongue sticking out directions and is weaned from breast or bottle feeding.

SH: I don't know of any recorded data regarding reattachment but at my practice, it is very rare.

Q: Is there a connection with the increase of microplastics in our environment and fascia restrictions?

PK: I am not aware of any.

Q: to clarify, you are stating that s/p tie clip, you should not complete stretches to prevent aversion?

PK: Correct.

Q: So, why is there such an increase in over recognizing of this--are we just not doing enough homework to really assess it?

PK: That is quite possible. Not assessing the whole dyad and anchoring on the baby's tongue as the cause in all cases of difficulty.

SH: I also think some of the confusion comes from the amount of "information" circulating that is not data/research based. There are numerous rating scales, assessment tools, etc available online as well as anecdotal reports making it very difficult to weed out what is evidence-based. And I agree that we have not always been putting the assessment of the DYAD first.

Q: With increasing focus on therapists/professionals seeking myofunctional certification, is this contributing to some of the controversy and confusion?

PK: It may. It is an advantage in a multidisciplinary approach that there is room for conversation to be sure that we are speaking about the same thing when we use the same words. For example that my posterior tongue is your posterior tongue.

SH: I agree that this is an area where collaboration would be most beneficial.

Q: If you cannot have resting tongue posture in sleep due to tongue restriction, Wouldn't that lead to apnea ?

SH: There is some misunderstanding about tongue position and apnea. In all cases, the tongue must be forward to prevent airway obstruction in awake, sleep or general anesthesia. When the "real" posterior tongue can fall back, the airway occludes. A tight frenulum prevents that.

Q: We have been having some pushback from pediatricians regarding ENT referrals for kids with suspected tongue ties after the AAP article. Any advice to advocate for at least an ENT evaluation?

PK: I think that the pediatrician needs to be comfortable that the ENT will not cut a tongue just because they have a tongue and that the ENT will assess and decline to do a procedure more often than do it. In my practice, only about 25-30% of the referrals for "tongue-tie" have a tongue tie. More often the feeding issue or in the older child, the

speech issue is not from a tongue tie. It is an uncommon surgeon who is happy to have non-surgical patients "clogging" up their clinic slots that could otherwise be for patients who will need a surgery or procedure.

SH: At my institution, we have a Breastfeeding Medicine clinic. All babies referred for a tongue tie have a breastfeeding assessment BEFORE being referred to ENT which has reduced the over-whelming number of referrals we were being sent that did not have a tongue tie. I think that establishing a working relationship with a research-driven lactation professional would be very helpful to encourage the PCP to refer appropriate patients.

Q: Would you recommend waiting until infant is term prior to a frenectomy if one is suspected and limiting function?

PK: I would wait until they are at least reliably trying to eat and at least 35 or 36 weeks gestation. My concern would be possible reattachment if the tongue is not elevating and moving a lot.

Q: Shanna, you talked about not needing to manipulate the breast for breastfeeding. I've always been taught to "sandwich" the breast. Can you talk more about this? Only using u hold if there are issues?

SH: Research has shown that the more manipulation to the breast, the harder it is for mothers to replicate that same position when not being observed and the increased risk of breast tissue trauma/nipple pain. The least amount of manipulation is easiest to replicate for ongoing nursing and allows the baby's mouth to more easily latch on the breast. However, some breasts require more support, shaping due to size, shape, etc. In those cases, I recommend a U-hold because it supports the weight of the breast but does not significantly change the shape of the nipple. You're correct that in the past we were taught to "sandwich" or "squeeze" the breast, but we're realizing that less manipulation is better for pain-free latching.

Q: Has anyone studied objective measurements (Hazelbaker, etc.) after a release and how it compares to the objective measurement before the release? Or have you taken note in clinical practice?

PK: There have been studies with the Hazelbaker pre and post-release which show improvement in grading. The Hazelbaker gives an appearance AND a function score which is why it's so highly regarded. I have independently used it on babies pre-and post-release, and (I haven't analyzed this data but anecdotally) there is noted improvement after release. The difficulty in pre and post-release studies is that it would be best to assess on a different day than the actual procedure. The first feeding after release is usually either great due to placebo effect OR is terrible due to baby's response to procedure so we would want to re-assess on a different "normal" day. It would require scheduling dyads back on a

different day to assess breastfeeding and most new-moms and babies and surgeons do not have time to come for this.

Q: Do you have insights on spontaneous lingual frenotomy? Is surgical intervention recommended afterwards?

PK: my understanding of embryology is that there is a certain amount of apoptosis that occurs to release the tip of the tongue from the floor of the mouth. This is completed by the time the palate closes in utero so by about 8 weeks of fetal life so not too likely post 40 weeks. I am not aware of any spontaneous frenotomy without trauma and then would only surgically intervene if bleeding did not stop on its own.

Q: If no post-surgical stretching, then there is no evidence of reattachment as long as infant engages in the functional activity of breast feeding?

PK: No evidence that I am aware of with a non-thermal release.

SH: Agree. No evidence I am aware of.

Q: Regarding posterior tongue tie- I find that is more concerning than anterior only- as the entire tongue is not able to compress the nipple fully- because it can't elevate- what's your take on that?

PK: I usually find that there is a reason for the inability of the tongue to elevate, pain, neurologic immaturity or difficulty, etc. I agree that the diagnosis and treatment of a poorly functioning tongue that is not tongue tied anteriorly is a challenge. I would certainly focus on bottle feeding such a baby with expressed breast milk -if possible.

Q: How can we support better tongue positioning within the oral cavity? If the infant has a high arch palate and tongue resting on the bottom of the mouth from birth.

PK: Some palates are super high and cannot create a latch or suction or compression - particularly with a large nipple. One way valves and bottle feeding expressed milk may be a good option.

SH: If the concern is tongue position with breastfeeding, I would recommend trying different nursing positions as well. The different nursing positions can help Mom not experience nipple pain during breast feeding if their baby's palate is high.

Q: What are your thoughts on open mouth posture in infants? I have a lot of parents mention concern.

PK: I find a lot of nasal obstruction as the cause in the older baby. If it is a newborn, I would be wanting a neurologic evaluation for tone.

Q: Do you have handouts or recommendations as far as oral motor exercises for post release?

PK: I do not.

Q: What is your opinion on myofunctional therapy with speech therapy after frenectomy?

PK: If the release if in an older child for speech then continuing speech therapy will be necessary.

Q: Does ' tongue tie ' in older kids affect dental hygiene?

PK: It can. Movement of saliva and ability to use the tongue to find and remove food particles from both sides of the teeth can lead to dental problems. Great brushing and rinsing can mitigate that even for people with tongue tie - And maybe a good mirror to double check the fronts!

Q: Would it be right to assume that if a child is able to produce alveolar (ex: t) and velar sounds (ex: k) that a tongue tie surgery would not be recommended?

PK: Perhaps for routine speech. I have released tongues for rapid speech in a debate team participant and in musicians who need to tongue quickly.

Q: What are your thoughts on the risk of "reattachment" after a release? Many who advocate for post-surgical stretches suggest that not doing the stretches would result in a reattachment, but I know that you mentioned stretches are not actually recommended in the clinical practice guidelines.

PK: I agree that tongue movement makes sense but would caution against anything that is perceived by the baby as negative - to prevent a hunger strike or oral aversion.

SH: I have asked some professionals who suggest post-release stretching for their data and no one has been able to provide me with any. I have seen privately created hand-outs with stretching recommendations but again, these have no research to support them. It concerns me that some people will charge for "stretching sessions" or handouts with stretches but have no research to support these. Personally, I have never had a reattachment occur after a release and find that having the child use their tongue appropriately...breastfeeding, continue with speech therapy, sticking out tongue games, etc to be the best recommendation for post-release care.

Q: Not a question just a mention. My granddaughter had tongue tie. At the hospital it was dismissed. She had a very hard time with latch. So we went to a private lactation consultant and advocated for a release. Done by ent is office and it was an immediate relief. My point is opinions differ so need to advocate for moms and babies for direct breastfeeding.

PK: agreed. It is my favorite thing to do for a struggling mother/baby dyad when it is the right thing to do.

SH: Absolutely; especially since nipple pain peaks around day 2 after birth. This is when babies are now home and the LC in the hospital is no longer evaluating the dyad which is why later lactation support is so important.

Q: As an SLP, I have seen many infants have greatly improved breastfeeding and bottle feeding after a laser frenectomy. It can help them overall in many ways, including tension and ability to coordinate breathing and swallowing.

PK: I would ask if you have seen the same thing with scissor frenotomy. The laser release is not special as far as the anatomic release is concerned. Even Dr. Ghaheri found scissor frenotomy effective when he could not laser at the beginning of COVID.

Q: Do you have any family friendly resources or suggestions for when a parent has been previously provided misinformation from a different provider? At times, this information has been previously provided convincingly and it is difficult to get parents to buy in to what is actually fact/evidence based.

PK: https://www.healthychildren.org/English/news/Pages/AAP-report-addresses-rise-in-tongue-tie-diagnoses-for-breastfeeding-concerns.aspx

Q: How soon should exercises for tongue mobility be practiced after surgery?

PK: Immediately.

Q: I think it's difficult because there are providers completing releases that are recommending stretches afterwards.

PK: Yes that is difficult.

SH: I agree. In those cases, I always request they send me their data/research that supports what they are recommending, telling patients.

Q: And how long should exercises be targeted after surgery?

PK: In general, I advocate for 2 weeks for an older child. Fun licking games and tongue sticking out contests, etc. For babies just feeding and fun imitation as they grow.

Q: Have these speakers talked to a dentist who is trained in tongue-ties or gone through research from a dental standpoint?

PK: I have participated in multidisciplinary panels with dentists.

SH: Same. I have spoken on numerous multidisciplinary panels with pediatric dentists and one of the ENT surgeons at my practice is also a DDS.

Q: I have had a few children (3-4yo) with CP and tongue (either confirmed on ENT assessment and divided, or suspected but no treatment yet) who are unable to progress to taking foods containing soft lumps, as unable to mash them between the tongue and the

hard palate. Might there be something to do with limited range/limited control over tongue movement due to the CP that increases impact of tongue tie that might otherwise have not been an issue?

PK: There could be. There is a balance and there is a concern that the lack of control of the tongue could result in more airway obstruction if the tongue can fall back further. The jaw of a non-chewer does not grow or keep up with the maxilla so the airway obstruction worsens over time.

Q: Lactation at our hospital often comments about high palate being the issue for breast feeding issue. What can I tell her?

PK: She is correct. But not all lactation specialists are experts in palate shape and variability that is normal vs problematic. It also matters how big the mom's nipple is, etc.

SH: I agree. Not all babies with a high palate will have breastfeeding issues. Research indicates that MOST breastfeeding difficulties can be corrected with appropriate fit and hold, so finding the best positions for that dyad would be my first thought.

Q: I was always taught that laser prevents scar tissues build up and is less bloody. But also have clinically seen more attachments with scissor release. Any thoughts?

PK: I was taught that heat induces inflammation and scar. It is less bloody. Pressure and platelet adhesion clots vessels in a short time.

SH: I have seen more post-release complications with laser use than scissor use. In fact, I have seen almost no post-release complications when scissors are used. I think in this case, you need to weigh risk of re-attachment, which in my area has been extremely rare to the risk of significant wound, feeding strike, pain, and cost associated with laser.