Ankyloglossia and breastfeeding

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Abstract
Ankyloglossia (‘tongue-tie’) is a relatively common congenital anomaly characterized by an abnormally short lingual frenulum, which may restrict tongue tip mobility. There is considerable controversy regarding its diagnosis, clinical significance and management, and there is wide variation in practice in this regard. Most infants with ankyloglossia are asymptomatic and do not exhibit feeding problems. Based on available evidence, frenotomy cannot be recommended for all infants with ankyloglossia. There may be an association between ankyloglossia and significant breastfeeding difficulties in some infants. This subset of infants may benefit from frenotomy (the surgical division of the lingual frenulum). When an association between significant tongue-tie and major breastfeeding problems is clearly identified and surgical intervention is deemed to be necessary, frenotomy should be performed by a clinician experienced with the procedure and using appropriate analgesia. More definitive recommendations regarding the management of tongue-tie in infants await clear diagnostic criteria and appropriately designed trials.

Key Words: Ankyloglossia; Breastfeeding; Frenotomy; Infant; Tongue-tie

Background
Ankyloglossia (‘tongue-tie’) is a congenital anomaly observed in newborns and children, and is characterized by an abnormally short lingual frenulum. The tight frenulum can cause decreased tongue mobility to varying degrees.

Associations between tongue-tie, lactation problems, speech disorders and other oral motor disorders (eg, problems with swallowing or licking) have been inconsistent, and are an ongoing source of controversy within the medical community. One survey of otolaryngologists, paediatricians, speech pathologists and lactation consultants reported significant disparities within and among these groups with regard to their approaches to ankyloglossia and their beliefs regarding its association with feeding, speech and social problems. Dentists are similarly divided on the topic.

With a renewed emphasis on the benefits of breastfeeding (which the Canadian Paediatric Society fully supports), there is more pressure to diagnose ankyloglossia as a barrier to successful breastfeeding, thus increasing the demand for frenotomy.

The present statement specifically focuses on the evidence surrounding the association of ankyloglossia and breastfeeding difficulties in infants, and the efficacy of frenotomy in the context of ankyloglossia and breastfeeding difficulties. The present statement replaces the previous Canadian Paediatric Society document revised in 2011. Several studies have been published in the interim.

Definition
There is neither a universally accepted definition of ankyloglossia nor practical objective criteria for diagnosing this condition. Historically, definitions have been based on either anatomical characteristics of the lingual frenulum (ie, the degree of fusion between the child’s tongue and the floor of the mouth) or on functional impairment (ie, an inability to protrude the tongue past the incisal edge of the lower gingiva and other signs of decreased tongue mobility). In one classification system, ankyloglossia (Types I and II) is characterized by insertion at the tip of the tongue (Type I) or slightly behind the tip (Type II), while posterior ankyloglossia is characterized by a thickened frenulum (Type III) or a submucosal frenulum (a flat,
broad mound) that restricts movement at the base of the tongue (Type IV). These definitions are seldom used in the literature and rarely in the clinical domain. Hazelbaker[11] developed a descriptive assessment tool for lingual frenulum function; however, it is complex, lengthy and has not been validated in a controlled manner.[12] Criteria used to diagnose ankyloglossia show considerable variation, and there is no accepted standard. The lack of a consistent definition further fuels controversy regarding this condition and its clinical significance.

Etiology
The tongue is fused to the floor of the mouth in early development. Cell death and resorption free the tongue, with the frenulum left as the only remnant of initial attachment. The lingual frenulum typically becomes less prominent as a natural process of the child’s growth and development, when the alveolar ridge grows in height and the teeth begin to erupt.[2] This process occurs during the first six months to five years of life. Ankyloglossia can be classified based on the degree of fusion remaining between the tongue and the floor of the mouth.[2]

There may be a genetic predisposition to ankyloglossia.[13] This congenital anomaly typically occurs in isolation.

Prevalence
The reported prevalence of ankyloglossia in infants is variable in the literature, reflecting the lack of a consistent definition. Estimates range from 4.2% to 10.7% in newborns.[7][9]

Pathophysiology
The role of a short lingual frenulum as a cause of breastfeeding difficulties has been described in multiple anecdotal reports linking ankyloglossia to poor latch, maternal nipple pain and trauma, suboptimal infant weight gain, infant breast refusal and low maternal milk supply due to poor milk removal.[14][17] To nurse successfully, an infant must latch on to the areola using the upper gum ridge, buccal fatty pads and tongue. Suckling begins with forward movement of the jaw and tongue. The tongue helps to make a better seal, but with minimal action. The anterior edge of the tongue thins, cupping upward to begin a peristaltic ripple back toward the throat. At the same time, the lower jaw squeezes milk from the ductules.[18] It is clear that restriction of tongue movement must be extreme to interfere with sucking and swallowing.[2] It also appears that some mothers have particular breast, nipple or milk ejection characteristics that allow them to successfully breastfeed an infant with ankyloglossia.[16]

Ultrasound studies suggest that the mechanism of poor feeding in tongue-tied infants is due to restricted tongue movement, such that it may cause pain and/or trauma of the nipple, poor milk removal and unsustainable attachment to the breast. Frenotomy appears to restore sucking movements more analogous to breastfeeding infants without tongue-tie.[12]

Ankyloglossia and breastfeeding difficulties
Several studies have examined the association of ankyloglossia with breastfeeding difficulties. One study compared the rates of ankyloglossia in infants attending outpatient clinics for breastfeeding difficulties with the general population of normal term newborns, and reported a higher incidence of ankyloglossia in infants with breastfeeding difficulties (12.8% versus 3.2%).[8]

Another study recruited a cohort of 201 newborns with ankyloglossia and reported a high incidence of feeding difficulties (44%), but did not find a relationship between tongue-tie length and breastfeeding difficulties. This study also demonstrated that 56% of infants with tongue-tie can still feed adequately.[6]

One prospective trial showed a higher incidence of latching difficulties (19% versus 0%) and breastfeeding difficulties (25% versus 3%) in a group of 36 neonates with ankyloglossia compared with a control group of neonates with no ankyloglossia. Thirty (83%) of the 36 infants with ankyloglossia were successfully breastfed during the study period, compared with 33 (92%) of the 36 control infants (P=0.29). The duration of breastfeeding was similar in both groups.[9] This study also found no significant difference between ankyloglossia grades (moderate versus mild) or frenulum thickness in infants experiencing breastfeeding difficulties.[9]

Managing ankyloglossia
Management of tongue-tie is usually conservative, requiring no intervention beyond parental education, lactation support and reassurance. In cases of ankyloglossia and significant breastfeeding difficulties, there is some evidence that frenotomy can improve feeding. It remains controversial which tongue-ties
need to be surgically released and which can be left to observation.

Several studies, including recent randomized controlled studies, have been conducted to evaluate the effectiveness of frenotomy in the setting of ankyloglossia with breastfeeding difficulties (Table 1).\[6\][8][20][27]

The limitations of these randomized controlled trials and prospective trials are substantial, and include the following:

- Variability and poor definition for diagnosing ankyloglossia, leading to unclear inclusion criteria;
- Small trial size;
- Most studies involved near-total crossover of the control group to the frenotomy arm of the study, precluding a fair assessment of outcomes and making it difficult to interpret findings;
- The objective outcome measurements were often limited and based on the observation of one feed;
- No reports of demographic information were included (ie, first-time versus experienced mothers with later birth order infants);
- Poorly defined outcomes (eg, ‘feeding improvement’) in some cases.

Blinding of observers and mothers in such studies is very difficult to achieve. In one study, 100% of supposedly masked experienced mothers correctly identified division of tongue-tie in their infant.\[22\] Careful consideration must also be given to the ability of a new mother to respond objectively about improved breastfeeding when her infant has just undergone a procedure to which she consented.

Furthermore, there is a surprising paucity of literature describing the ‘normal’ breastfeeding learning curve for mother and infant. This lack, along with the fact that a control group was seldom preserved during trials, makes it difficult to determine whether breastfeeding difficulties would have improved with time and conservative management (ie, natural history).

In addition to the studies described, several other prospective cohort studies have shown an association of ankyloglossia with breastfeeding difficulties\[28\] as well as the benefit of frenotomy in infants with ankyloglossia who present with breastfeeding difficulties.\[10][29][32\] However, these studies also share some of the limitations cited above.

Therefore, while several randomized trials and some cohort and cross-sectional prospective studies have shown some effectiveness for frenotomy in newborns who are having difficulties with breastfeeding due to ankyloglossia, they all have significant limitations.

**Frenotomy procedure**

If a tongue-tie release is deemed necessary, a referral to an otolaryngologist or a physician with experience performing this procedure should be made. Appropriate analgesia should be provided for the procedure. Unfortunately, there is also a paucity of literature regarding effective analgesia for frenotomy. Case reports have cited the use of acetaminophen, lidocaine and sucrose for analgesia, but none of these have been studied. Benzocaine was studied in a randomized controlled trial and was shown to be ineffective compared with placebo.\[33\] Release of the tongue-tie appears to be a minor procedure, but may cause complications such as bleeding, infection or injury to Wharton’s duct. From the limited literature, the incidence of minor complications appears to be rare.\[22\]

A simple incision or ‘snipping’ of a tongue-tie (frenotomy) is the most common procedure performed for partial ankyloglossia. There is a risk that postoperative scarring may limit tongue movement even further, necessitating reoperation. Excision with lengthening of the ventral surface of the tongue, or a frenuloplasty release, are more complicated procedures. Both entail less postoperative scarring but carry the inherent risks associated with general anesthesia.\[33][34\]

Specialized private clinics are now performing frenotomy by laser ablation, but available data regarding the safety or efficacy of this procedure are limited.

**Conclusion**

Ankyloglossia is relatively common in the newborn population. Most of the time, ankyloglossia is an anatomical finding without significant consequences for infants affected by this condition. Current evidence appears to show that most newborns with this condition are still able to breastfeed successfully.

Based on available evidence, frenotomy cannot be recommended for all infants with ankyloglossia. There is no absolute relationship between ankyloglossia and...
breastfeeding difficulties. If an association between significant tongue-tie and major breastfeeding problems is identified and surgical intervention is deemed to be necessary, frenotomy should be performed by a clinician experienced with the procedure, using appropriate analgesia.

Consultation with a health care professional who has expertise in breastfeeding is recommended before referring a child for frenotomy.

**Recommendations**

Clear criteria are needed for the diagnosis of ankyloglossia, along with specific attention to characteristics of infants for whom a frenotomy would be of value to improve feeding. Identifying the specific characteristics of ankyloglossia that may guide the clinician in determining which infants are more likely to benefit from frenotomy is crucial for prognosis. Also, with respect to study design, future studies should include larger sample sizes and avoid crossover among study groups.

It is important to rule out other oral anomalies that may be causing breastfeeding difficulties. A thorough intraoral examination, including inspection of the tongue and its function, should be performed in newborns, particularly when there are feeding difficulties. The mother should then be interviewed regarding breastfeeding (latch, nipple pain, discomfort) and the feeding observed. If difficulties are identified, referral to a health care provider with experience in breastfeeding support should be considered.
<table>
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<th>Authors (reference), year</th>
<th>Study type Study population</th>
<th>Definition of ankyloglossia</th>
<th>Methods</th>
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<tr>
<td>Hogan et al [6], 2005</td>
<td>Randomized controlled trial 57 infants with ankyloglossia and feeding difficulties (breast or bottle) Mean age at randomization: 20 days</td>
<td>Percentage of tongue-tie gauged by eye, ranging from 100% (ie, to the tip) to 25%</td>
<td>Randomly assigned to frenotomy or control (advice) If no improvement noted in conservative group after 48 h, frenotomy offered</td>
<td>Telephone interview with mother at 24 h, weekly for four weeks and at four months</td>
<td>27/28 infants randomly assigned to the frenotomy group improved their symptoms after procedure compared with 1/29 in control group 28/29 infants in control group underwent frenotomy Mothers of 27/28 of these infants had improvement in symptoms</td>
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<td>Dollberg et al [20], 2006</td>
<td>Randomized, masked prospective study 25 infants (one to 21 days of age) with ankyloglossia and mothers with sore nipples</td>
<td>“The inability of the infant to protrude the tip of the tongue over the lower gum line while the tip was tied to the floor of the mouth by a tight cord of frenulum, and the tongue became heart-shaped when lifted up”</td>
<td>Randomized to one of two sequences: i) Frenotomy, BF, sham, BF (14 infants), or ii) Sham, BF, frenotomy, BF (11 infants) After the first procedure (frenotomy or sham), a standardized LATCH score [21] was assessed and a pain scale assessment (1 to 10) was obtained from the mother</td>
<td>Maternal pain score decreased from 7.1 to 5.3 (CI overlap) after frenotomy and insignificant increase in LATCH score</td>
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<td>Berry et al [22], 2012</td>
<td>Randomized, double-blinded controlled trial 60 breastfed infants (mean age 32 days) with BF problem (defined as difficulty with latch, nipple pain/trauma or inefficient feeding) and ankyloglossia</td>
<td>“Tongue-tie was present”</td>
<td>Randomized to immediate frenotomy (30 infants) or nonfrenotomy (30 infants) Preprocedure: LATCH scoring and Infant Breastfeeding Assessment Tool (IBFAT) [23] and maternal pain score (1 to 10) during the sample feed Postprocedure: (First feed reportedly blinded): Objective assessment as above Subjective maternal assessment and pain score (1 to 10)</td>
<td>21/27 (78%) of mothers in frenotomy group reported subjective improvement following procedure compared with 14/30 (47%) of infants in control group Objective observer reported no statistical significance in feeding (50% improved in frenotomy group versus 40% in control group) 30 infants in nonfrenotomy group later underwent procedure</td>
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<td><strong>Emond et al [24], 2014</strong></td>
<td>Randomized controlled trial</td>
<td>107 term infants (median age 11 days) with a mild or moderate degree of tongue-tie and difficulties with BF (defined by LATCH score ≤8)</td>
<td>Hazelbaker Assessment Tool for Lingual Frenulum Function Score (HATLFF) 6–12</td>
<td>Randomized to immediate frenotomy or standard care</td>
<td>Telephone call at one day and three months for subjective change in feeding, complications and BF rates</td>
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<td><strong>Ballard et al [8], 2002</strong></td>
<td>Cohort study</td>
<td>Recruited 127 (of 3036 examined term infants inpatient and outpatient) with ankyloglossia</td>
<td>HATLFF function score &gt;11/14 in the presence of an appearance score &lt;8/10</td>
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| **Buryk et al [26], 2011** | Randomized, single-blinded controlled trial | Infants with difficulty with BF and significant ankyloglossia (randomized at mean age of six days) | HATLFF function score >11/14 with failing lactation management or an appearance score <8/10 | Randomized to frenotomy (30 infants) or a sham procedure (26 infants) | BF assessed pre- and postintervention Short-Form McGill Pain Questionnaire (SF-MPQ) [27] nipple pain scale and IBFAT and at two weeks and regular follow-ups Secondary outcome of effect of frenotomy on length of BF | Both groups had statistically significant decreased nipple pain scores after the intervention IBFAT score not significantly different between frenotomy and control groups postintervention
References


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