



Tongue-Tie and the Breastfed Baby

Diana West, BA, IBCLC

Many new mothers hear horror stories about how painful breastfeeding can be. Of course, it isn't *supposed* to hurt. Nipples don't need to "toughen up" and any pain beyond initial tenderness means something isn't right. But when those nipples start to really hurt, most mothers think that they are doing something wrong. They ask lactation experts to "check their latch." They study information about latching and positioning techniques in books and on websites. And it often works: positioning baby better and latching him more deeply fixes the problem and they are able to go on to nurse painlessly.

Tongue-tied



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But sometimes it's not enough. No matter what these mothers try, latching is still painful. And when latching hurts, the amount of milk the baby is able to get is usually also reduced because he isn't attached deeply enough. Sometimes, mothers don't have any pain at all because their nipples fit well in the baby's mouth, but the baby still can't remove the milk well.

So what's going on in these situations? One strong possibility is that the baby's tongue movement is restricted by a tether of tissue called a *frenum* (FREE-num) or *frenulum* (FREN-yew-lum) which

binds it too tightly to the base of his mouth. When a baby has this tight band of tissue under the tongue, it is called "tongue-tie" or *ankyloglossia*. Tongue-tie has been documented to affect 3–10% of all babies.^{1, 2} As we learn more about how to accurately identify it, some lactation consultants are beginning to think even more babies are affected.

Having a tongue that is tied to the base of the mouth can make it hard for a baby to breastfeed because there are several motions his tongue needs to make to remove milk effectively. It must

extend *comfortably* past the lower lip so that it can grasp an adequate amount of breast for latching deeply. The sides of the tongue need to be able to cup the breast to stabilize it in his mouth. The tip of the tongue needs to be able to lift higher than halfway when the mouth is open, and the back of the tongue needs to lift and then drop to create the vacuum that pulls out milk.³

There are several "red flags" that a baby might be tongue-tied. One of the most obvious is difficulty achieving or maintaining a deep latch. There may also be sucking

blisters on the lips (caused by friction using the lips to hold onto the breast when the tongue can't), pain during latching, clicking or popping sounds during breastfeeding from breaks in suction, a persistently wounded or blistered nipple, or a flattened nipple when baby unlatches. There may be a high and narrow palate (because the tongue can't lift to spread it), a tongue that rolls under or has a flat front edge when extended, a tongue that doesn't lift when the baby cries, or one with a crease down the middle. There may be a dip in the center of the tongue when lifted or when the baby cries



... there are potential problems beyond feeding: untreated tongue-tie can cause later difficulty with crowded teeth requiring orthodontia, speaking clearly, cleaning the teeth with the tongue, swallowing pills, licking ice cream cones, and kissing

because the frenulum is pulling the center of the tongue down. The baby may have difficulty opening his mouth widely enough to latch deeply because the tight frenulum is pulling on the hyoid bone in the neck that supports the root of the tongue, which in turn pulls the jaw muscles. His tongue may shake from the overexertion of working against the pull of the frenulum. He might end the feeding too early because he runs out of energy before his tummy is full and may wake up hungry about 20 minutes later wanting to nurse again, or he might nurse for really long periods of time to get enough milk.^{4, 5, 6}

A frenulum can be attached on the bottom side of the tongue anywhere from the base to the tip and is connected to the floor of the mouth anywhere from the base of the tongue to the top of baby's gum ridge. It may look like a thin, stretchy web that is almost transparent, or it may be more like a thick rope or knot. A *submucosal frenulum* runs under the floor of the mouth, often pulling the floor up when baby tries to lift his tongue, like a rope pulling up the center of a carpet. Any type of tight frenulum can lead to feeding fatigue, poor milk transfer, slow weight gain and, ultimately, low milk production if the baby cannot remove milk effectively from the breast.⁷

Because tongue-ties occur in all these variations, the effect on baby's suck depends on where the frenulum connects. With an attachment close to or at the front of the tongue, only the sides of the tongue can rise when baby tries to lift it, sometimes forming a characteristic heart shape. A notch may be visible at the tip when he attempts to extend his tongue, or the tongue tip may even roll downward. When the frenulum is attached tightly at the base of the tongue, the tip is able to lift more but still not as much as it should, while the back cannot rise and drop enough to create a good vacuum. As a result, a frenulum attached too tightly to the base of the tongue can be even more problematic.⁸

Many doctors and nurses recognize tongue-ties with the frenulum attached to the tip of the tongue, especially if it pulls the center of the tongue into a notch or heart shape. But not all understand that a frenulum can also attach just behind the tip of the tongue, or in the middle, or at the base. And, unfortunately, frenula that are attached to the base of the tongue are the hardest to see and sometimes cause the worst problems.

Some less experienced providers will acknowledge the impact of tongue-tie on breastfeeding but suggest waiting to see if the frenulum will stretch or break on its own. This may not happen enough or at all, which is why there are older people who still have a tight frenulum. It's true that the mouth will enlarge as baby grows so that he may be able to take in more breast tissue and increase the amount of milk removal, but while a mother waits for the growth to happen her milk supply is in jeopardy as is the likelihood of successful breastfeeding. Even bottle-feeding may not solve the problem because babies with tongue-tie often have difficulty using bottles, too. And there are potential problems beyond feeding: untreated tongue-tie can cause later difficulty with teeth, speech, cleaning the teeth with the tongue, swallowing pills, licking ice cream cones, and kissing.⁹

The most common treatment for tongue-tie is a procedure called *frenotomy* or *frenulectomy* that uses surgical scissors or a laser to divide the membrane and release the tongue. In most cases, a frenulum connected to the front part of the tongue is very thin with few blood vessels or nerves in it, so there is very little bleeding or pain when it's cut. A tight frenulum at the base of the tongue is thicker and may bleed slightly more. The procedure itself takes only seconds; your baby may feel some stinging, but generally a frenotomy is no more traumatic than an immunization, and baby can usually be put to the breast within a minute or so for soothing.

Frenotomy is safe, rarely has complications, and is highly effective when performed correctly. After the procedure, the surgeon or lactation consultant may suggest stretching exercises to help baby relearn effective tongue movements.^{10, 11, 12, 13, 14, 15}

In discussing the possibility of tongue-tie with your baby's doctor, it may be helpful to refer him or her to *Supporting Sucking Skills in Breastfeeding Infants*, by Catherine Watson Genna, and *Tongue-tie: Morphogenesis, Impact, Assessment and*



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Treatment, by Alison Hazelbaker (tongue-tie.aidanandevapress.com), for detailed tongue-tie diagnostic criteria and treatment information. If your baby's doctor is reluctant to treat the frenulum but you believe that treatment would benefit you and baby, don't hesitate to consult another practitioner who is familiar with the diagnosis and treatment of tongue-tie. Leaders and lactation consultants usually know which local health care providers, often ear, nose and throat (ENT) specialists, are willing and able to assess and treat a tight frenulum. There is also a list of surgeons who specialize in assessing and treating posterior tongue-ties at lowmilksupply.org/frenotomy.shtml.

Your baby may experience a little discomfort when latching on for a week to ten days after the procedure. Babies are careful moving their tongues while the underside heals and it takes a while to learn how to move the tongue more effectively and strengthen the muscles that were not used before the procedure. Nursing will probably improve after the tongue has fully healed and your baby has figured out how to use it. If it's not better by two weeks after the procedure, let the surgeon know. Sometimes the frenulum isn't snipped deeply enough and a second procedure is needed.

Until the frenotomy can be done, or especially if isn't done for some reason, it may be necessary to pump after feedings to ensure thorough milk removal and provide any necessary supplement.

Although tongue-tie is a common cause of breastfeeding problems, it is also one of the easiest breastfeeding problems to fix. Countless babies have had their tongue-ties released and gone on to breastfeed very happily. There are mothers in almost every area whose babies have been treated for tongue-tie and who are pleased to talk about their experiences. If not, there are many online. Connecting with these mothers can be very reassuring and a great resource for further information.

Tongue-Tie Resources Online

- l11i.org/nb/nbsuckproblems.html
- cwgenna.com/quickhelp.html
- lowmilksupply.org/tonguetie.shtml
- tonguetie.net
- kellymom.com/babyconcerns/bfhelp-tonguetie.html
- <http://tinyurl.com/LingualFrenum2010-pdf>

The Murphy Maneuver

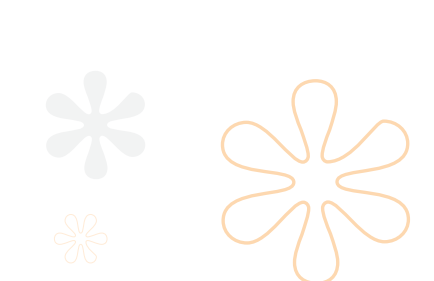
If baby is having trouble breastfeeding and you aren't sure if he is tongue-tied, San Diego, USA, pediatrician Dr. James Murphy suggests pushing your little finger to the base of the tongue on one side and sweeping it across to the other side to see what you can feel.

If you feel little or no resistance more than a small "speed bump," then most likely there is no problem. Should you feel a large speed bump that you can get past with a little more effort, it is most likely a "tree trunk" frenulum, a short, wide band of tissue buried in the floor of the mouth and attached to the base of the tongue. It usually, though not always, restricts tongue movements and causes latch problems even though it looks like there isn't enough there to be a problem.

When you can't sweep your finger across without pulling it back to "jump over a fence," the frenulum is a fibrous band attached closer to the front of the tongue. It may be buried underneath the floor of the mouth or visible as an external web.

If you see a narrow white streak running down the middle of the floor of the mouth that feels like a wire, it usually extends to the front of the tongue like a string. Pushing your finger into this "piano wire" frenulum will often cause the tip of the tongue to tilt downward and the center of the tongue to pull down and crease along the middle.

Tree trunk, fence, and piano wire type frenulums are red flags for significant tongue function impairment.



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- Tongue Tie and Breastfeeding Information Sheet LLLGB 2011 <http://www.lllgbbooks.co.uk/product/476/Tongue-Tie-and-Breastfeeding/default.aspx>

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