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INSTRUCTIONS FOR PARENTS

ANKYLGLOSSIA ("TONGUE TIE")

1. What is Ankylglossia ("Tongue Tie")?

Ordinarily, the tongue is freely mobile from the structures of the "floor of the mouth" so that the tongue is able to be fully thrusted beyond the lower gum or teeth line and can easily be elevated to touch the roof of the palate. However, in some children, the under surface of the tongue is stuck down to the floor of the mouth structures because of a band of tissue that isn't fully stretched out or is so thick that normal tongue motion is significantly restricted. This is called Ankylglossia.

2. How does Ankylglossia affect my child?

Ankylglossia can affect your child in one of two ways.

1. In the newborn, significant tongue restriction can, on occasion, result in poor "latching on" to the breast or for bottle-feeding. This inability to make an adequate seal around the nipple prevents the baby from taking in an appropriate amount of nutrition.

2. As your child grows, a significant degree of ankyloglossia can also affect speech acquisition and language development because *articulation problems* can arise if the child's tongue is not able to be appropriately placed. This may result in a functional lisp. Examples include "TH" sounds that sound more like "S" sounds and "L" sounds that may be muffled or sound "garbled" within the mouth.

3. How does one treat a child with significant tongue-tie?

In the newborn period, if significant "latching on" or feeding problems are recognized, a simple "tongue clipping" in our office is often all that is necessary to free the tongue and allow it to function more normally. This relatively painless procedure (for the child) is performed under topical anesthesia and with minimal blood loss, if any. With a dose or two of an over-the-counter medication such as acetaminophen or ibuprofen *(ibuprofen cannot be given under 6 months of age)*, there are almost no post-procedural difficulties. The clipping of the restrictive tissue in the office is called a **frenotomy** and can usually be safely performed up to several months of age.

In older children, however, because the tissue has matured and is usually thicker, an office procedure is generally not recommended. In some cases, tongue exercises, such as which normally occur with eating and learning how to speak, result in greater stretching out of the band of tissue underneath the tongue and functional deficits become less noticeable. In these children, surgery to release the band of tissue is not necessary. Because true speech articulation issues are not noticed until the child is generally over 12 months of age, there is time to see if these conservative measures will be effective for your child.

If your child does have the development of articulation issues, then a brief surgical procedure under anesthesia is often recommended. This relatively painless procedure involves the release of the restrictive tissue band and, sometimes, with the need to create small "flaps" of tissue and a few closing sutures designed to promote additional length and mobility as well as to reduce the potential for scar formation. (For example, in some cases of office "clipping" in older children, secondary scarring under the tongue occurs such that functional restriction of tongue movement remains.) The surgical procedure performed under anesthesia in the operating room is called either a **frenectomy** or a **frenoplasty** depending on what was done.

3. What can I expect after my child has a frenotomy, frenectomy or frenoplasty?

Since office frenotomy is performed on infants, in whom speech issues are not relevant, you should simply expect to see improvement in the ability to latch on to the breast, or bottle nipple, and for feeding to improve. If desired, you may feed your newborn/infant in the office shortly after the procedure has been completed.

In older children who have had a frenectomy or frenoplasty and without a great deal of preoperative speech acquisition, significant improvement is often noted within the first several weeks to several months. In older children, however, in whom speech articulation errors have already developed, it may take longer for the "bad habits" to be unlearned and, therefore, speech therapy intervention, either at home or in combination with therapy provided through the school system, or through private speech pathology services, is generally recommended.

4. Are there any long-term problems from frenotomy, frenectomy or frenoplasty?

1. Bleeding is rarely, if ever, a problem.
2. Pain is rarely a problem outside the first 24-48 hours, and is usually well controlled with non-narcotic over the counter pain medications if needed.
3. Taste sensation is not affected as the taste buds are on the top surface of the tongue.
4. Saliva production is generally not affected but it should be noted that the restrictive band of tissue usually goes right between the opening of two major salivary glands ducts, which you can see in your child's floor-of-mouth. This is one reason why a few stitches ("sutures") are sometimes placed in order to minimize the potential injury to those structures.