

Ankyloglossie: quand traiter?

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Déontologie médicale

Homo homini lupus
Sacerdos sacerdoti lupior
Medicus medico lupissimus

Godwin



Mike Godwin

- ▶ Utilisé d'abord sur Usenet puis Internet
- ▶ Loi de Godwin: Plus une discussion en ligne dure, plus la probabilité d'y trouver une comparaison impliquant les nazis ou Adolf Hitler s'approche de un.
- ▶ Point de Godwin: un des interlocuteurs atteint le point Godwin lorsqu'il en réfère au nazisme, à Hitler ou à la Shoah, pour disqualifier l'argumentation de son adversaire
- ▶ ≠ Reductio ad Hitlerum (végétarianisme à rejeter car Hitler était végétarien)

Sujets dangereux en pédiatrie

- ▶ Bubble CPAP
- ▶ Dépistage de la dysplasie de hanche
- ▶ Circoncision
- ▶ Frein de langue

Questionnement: S1 E1

Hello !

J'ai été interpellé par une nurse avec une question étrange : « On ne coupe plus les freins de langue ? ». La question concernait un enfant (date de naissance indéterminée pour le moment) qui avait un frein de langue et qui avait été envoyé à l'ORL pour une frénulotomie.

Je me pose quelques question :

- Si la frénulotomie est indiquée, pourquoi ne pas la faire nous-même ? Je ne crois pas le geste si délicat, non ?
- Si l'indication néonatale n'est pas claire, pensons-nous que l'ORL sache mieux que le pédiatre décider de l'indication ? Il est vrai que l'attitude définitive quant aux indications est aussi difficile à repérer qu'un caméléon,... Mais je crains que l'on entre dans la systématique « Problème donc spécialiste »

Qu'en dites-vous ?

Cordialement

De nos jours, je pense que nous devrions quand même le faire faire sous AL, avoir accès à une hémostase, au cas où, et tenir l'indication stricte aux cas qui sont gênés pour téter (ou parler plus tard).
En tout cas, moi j ne désire plus le faire, et j'envoie aux chir.ped. Pascal s'en charge volontiers.

Hello everybody

Not doing / requesting frenulotomy too much those days. Have not done any for 20 years actually...but guidelines are there for reflexion, not for following them blindly, as I say. So it might be that there is someone somewhere who will benefit from it. And apparently lactating women benefit more than infants...

in the rare case when there is some indication, I would ask now the surgeon / ENT to perform it, as it seems to be the rule, and in case of accident we might be more liable....????

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Questionnement: S1 E2

Les assistants hier soir m'ont fait part de leur inconfort face à des demandes croissantes et parfois pressantes des sages-femmes pour réaliser avant la sortie des sections de frein de langue chez des nouveaux nés.

Au vu de l'évidence dans la littérature (merc [redacted]), il semble peu adéquat que cette pratique devienne une norme ou une mode.

Peut-être faudrait-il prévoir, plutôt que de céder à des demandes subjectives en urgence et afin d'éviter des problèmes juridiques, de réaliser un protocole/procédure qui documenterait des indications objectives comme l'échelle de HAZELBAKER, la perte de poids de l'enfant à 14 jours, des lésions/douleurs sur les mamelons maternels et qui définirait également quelle personne selon la situation est la plus à même de réaliser le geste (pédiatre, ORL, chir), la liste du matériel nécessaire dans le service (élévateur, ciseaux, compresses, ...), l'antalgie adéquate (sucrose, pâte de benzocaïne, emallotage), la gestion des saignements (compresses, gelatine hémostatiques, ...), l'anticipation des complications et un formulaire de consentement éclairé signé par parents, une liste de spécialistes d'accords pour être référents pour faire le geste dans les situations à risque (frein de langue vascularisé), etc...

A discuter à un prochain colloque médico-infirmier ?

Merci pour ces informations, j'ai moi-même été surprise de cette pratique qui semble être banalisée sans réelle préparation et sous une influence très insistante des sages-femmes. J'ai été particulièrement surprise de la phrase d'une d'entre elle qui dit, je cite : « la mère n'était pas pour mais j'ai tellement insisté qu'elle est d'accord maintenant alors il faudrait le faire au plus vite ».

Je pense en effet qu'établir un protocole bien règlementé et clair serait très bien !

Belle journée à tous,

Je pense effectivement qu'un colloque médico-soignant avec les sages-femmes est sans doute utile pour avoir « une » bonne pratique
Un frein de langue court empêche uniquement de sucer une glace correctement.....ou de tirer la langue à ses parents
J'avoue que je n'ai pas refait de littérature récente sur l'évidence based.....
Et même les indications logopédiques sont rares
Donc à dispo s'il faut en discuter

Bonjour Pascal,

Vu que ceci te concerne aussi, voici ci-dessous l'échange concernant les frénulotomies abusives.

Comme [redacted] je pense aussi, qu'il soit important d'avoir un protocole très clair qui règlemente l'indication à une frénulotomie.

C'est inacceptable de nos jours, qu'une sage-femme met la pression pour effectuer ce geste. Et c'est désécurisant pour les parents si ensuite le pédiatre dit le contraire.

Pourrais-tu t'en charger peut-être?

Merci d'avance.

Bonjour à tous,

Le fait qu'une sage-femme ose faire la pression sur la mère intrigue, puisque l'indication à faire un gest devrait être la responsabilité des médecins.

Il me semble que les sages-femmes n'aiment pas les petites peaux « qui servent à rien ».

Avant c'étaient les prépuces collés et maintenant c'est les frénulums de la langue.

Un protocole qui met les choses au claire et empêche ces demandes non fondées, protégerait les bébés des douleurs inutiles et des procédures potentiellement risquantes.

Un protocole de plus, mais voilà, c'est ce qu'il se passe quand il n'y a plus de bon sens.....

Amicalement

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Questionnement: S1 E2

Bonjour à tous!

C'est malheureusement un peu plus compliqué que cela.

Les néonatalogues s'intéressent à ce frein de langue, et les avis sont malheureusement assez différents... mais aussi malheureusement divers. Les pratiques ont changé avec les années, mais avec parfois des mouvements de balanciers, ce qui fait que les attitudes extrêmes (TOUJOURS intervenir ou JAMAIS intervenir) sont les deux fausses. De magnifiques vidéos d'ultrasons montrent combien les mouvements de la langue lors de la tétée peuvent être limités par un frein de langue.

Des indications claires (mais pas si fréquentes) demeurent, comme celles que mentionne [redacted]. S'il est des frénulotomies abusives je peine à en croire qu'il y en ait eu dans notre service (j'ose espérer qu'aucun assistant ne s'est amusé à en faire dans son coin sans en parler à son cadre de référence).

Une attitude qui me plaît beaucoup est celle qui se base aussi sur la démonstration que des douleurs ressenties par la mère lors de l'allaitement (et qui sont parfois dues à un frein de langue court) sont un handicap à l'allaitement et diminue son succès... ce que les pédiatres ne peuvent que vouloir empêcher. Comme d'ailleurs les pressions mises sur les mamans par les nurses / sages-femmes (volontiers [redacted] si tu peux me dire en privé le nom de la sage-femme qui agit de façon si peu professionnelle... une telle attitude doit impérativement être recadrée)

On ne parle ici que des indications néonatales bien sûr, et pas des indications logopédiques ou pratiques, esthétiques ou amoureuses. Elles méritent cependant d'être discutées par intérêt.

Le but de la question initiale d'il y a quelques temps (merci à [redacted] et [redacted] d'avoir monté leur intérêt pour cette question et répondu à mon mail du 5.9) était de savoir ce qu'en pensaient divers collègues, car j'ai comme les assistants (mais probablement avec moins d'agressivité) été interpellé par les ages-femmes / nurses, est qu'il me semblait important de recadrer la question.

Merci donc de votre intérêt.

Je partage aussi les réticences de [redacted] au sujet des protocoles, mal nécessaire... mais nécessaires du moment que le bon sens est dépassé et que les polémiques enflent à loisir...

A bientôt donc pour un colloque sur ce sujet... et un protocole de plus.

Bonne journée

Cela rappelle quelque chose,...

the most problematic attitude I ever encountered was resistance to the idea that tongue-tie could create a breastfeeding problem. (1). This resistance was purely due to lack of knowledge about the physiology of infant suck. Occasionally back then, I might have met someone whose resistance was ego-driven: the "Not Invented Here" line of thinking but that was the exception rather than the rule.

Today, the controversy over various aspects of the tongue-tie phenomenon are liberally laced with ego-driven resistance. It seems as if the entire world of practitioners has something to say about tongue-tie, regardless of level of expertise on the subject.

A dialectic between smart people who have no vested interest other than to help others remains ever useful. An out and out brawl between various factions of people spouting dogma that is liberally littered with poorly informed opinion does not. I am all for helping moms and babies, but I am definitely for helping them using solid evidence so that they get the right kind of help, at the right time, from the right practitioner.



Questions

- ▶ Quelle(s) évidences?
- ▶ Quelles indications?
- ▶ Quelles modalités?
- ▶ Quels timings?

Quelles évidences?



Authors' conclusions

Frenotomy reduced breastfeeding mothers' nipple pain in the short term. Investigators did not find a consistent positive effect on infant breastfeeding. Researchers reported no serious complications, but the total number of infants studied was small. The small number of trials along with methodological shortcomings limits the certainty of these findings. Further randomised controlled trials of high methodological quality are necessary to determine the effects of frenotomy.

PLAIN LANGUAGE SUMMARY

Surgical release of tongue-tie for the treatment of tongue-tie in young babies

Review question: Tongue-tie is a potentially treatable cause of breastfeeding problems - if a baby is tongue-tied and is having feeding difficulties, does releasing the tongue-tie help?

Background: Tongue-tie is a condition whereby the membrane between the tongue and the floor of the mouth is too tight or too short. This may cause feeding problems for the baby and/or nipple pain for a breastfeeding mother.

Study characteristics: Five randomised controlled trials enrolling 302 infants met the inclusion criteria.

Key results: In an infant with tongue-tie and feeding difficulties, surgical release of the tongue-tie does not consistently improve infant feeding but is likely to improve maternal nipple pain. Further research is needed to clarify and confirm this effect.

Quality of evidence: The quality of the evidence is very low to moderate because overall only a small number of studies have looked at this condition, the total number of babies included in these studies was low and some studies could have been better designed.

Figure 4. Forest plot of comparison: I Frenotomy versus no frenotomy or sham procedure, outcome: I.1 Infant breastfeeding assessed by a validated scale.

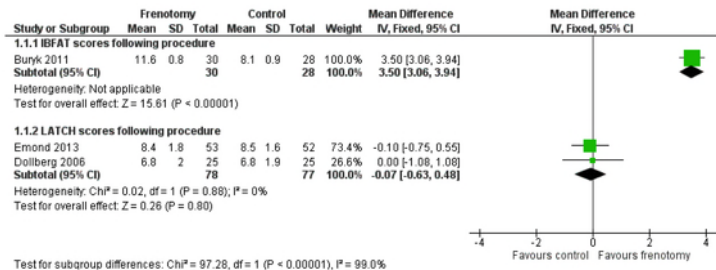
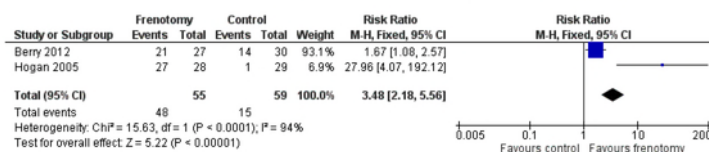
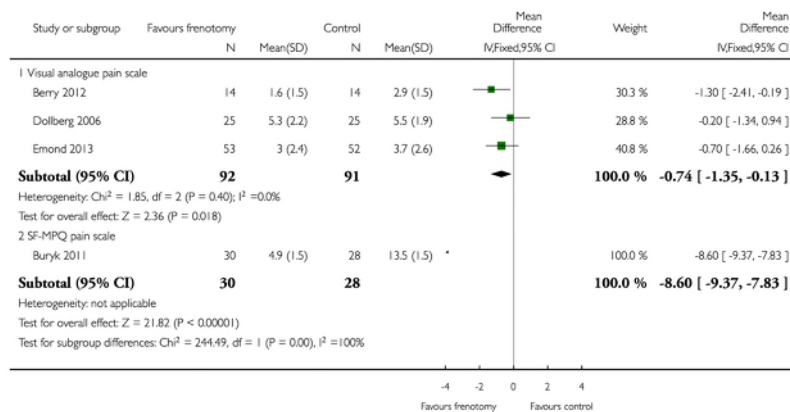


Figure 5. Forest plot of comparison: I Frenotomy versus no frenotomy or sham procedure, outcome: I.6 Qualitative assessment of infant feeding by parental survey performed within 48 hours of the procedure.



Analysis I.3. Comparison I Frenotomy versus no frenotomy or sham procedure, Outcome 3 Maternal nipple pain assessed by a validated pain scale.

Review: Frenotomy for tongue-tie in newborn infants
Comparison: I Frenotomy versus no frenotomy or sham procedure
Outcome: 3 Maternal nipple pain assessed by a validated pain scale



La seule douleur vraiment supportable c'est celle des autres

Autre problème: hétérogénéité importante

- ▶ Sham / pas sham
- ▶ Echelles d'évaluation
- ▶ Âge à la procédure (< 4 mois, < 1 mois, < 3 sem, ???, < 4 sem)

- ▶ Etude FROSTTIE (Frenotomy and breastfeeding support Or breastfeeding Support without frenotomy to investigate continuation of breastfeeding for babies with Tongue-TIE)

FROSTTIE

FROSTTIE is a multi-centred randomised trial for babies with breastfeeding difficulties who are thought to have tongue-tie and who are receiving breastfeeding support and there is uncertainty about whether frenotomy would help continuation of breastfeeding.

The aim of the trial is to find out if skilled support for breastfeeding on its own, or together with a frenotomy helps mothers and their babies to breastfeed.

Plan

- ▶ Histoire
- ▶ Embryologie
- ▶ Anatomie
- ▶ Incidence et Génétique
- ▶ Frein de langue et allaitement
- ▶ Frein de langue et autres indications
- ▶ Conclusion

Définition: ankyloglossie

- ▶ Pas de définition standard
- ▶ Ankyloglossie antérieure (ou anomalie du frein de langue antérieur):
attachement du frein à la pointe de la langue ou près de la pointe, limitant
les mouvements et la protrusion

Histoire

- ▶ Ankyloglossie mentionnée par Aristote (III^{ème} siècle av JC)
- ▶ Bible: « ... le lien de sa langue se délia, et il parla aisément. » (Marc 7:35)
- ▶ Technique de frénotomie mentionnée au VII^{ème} siècle
- ▶ Couramment pratiquée au moyen âge
 - ▶ Sages femmes avec l'ongle, chirurgiens avec des instruments
- ▶ Frénotomie recommandé pour faciliter l'allaitement au XVIII^{ème} siècle

Histoire

- ▶ Couramment pratiquée jusque vers 1950
- ▶ Abandonnée vers 1950 - 1960 (allaitement artificiel?)
- ▶ Regain d'intérêt dès milieu des années 1970 (LM?)
- ▶ Intérêt +++ ces dernières années
- ▶ Prises de positions fortes,... et opposées

Histoire

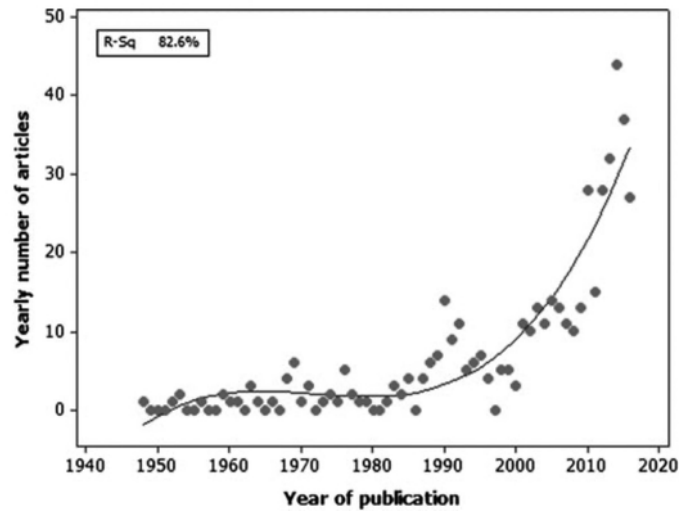
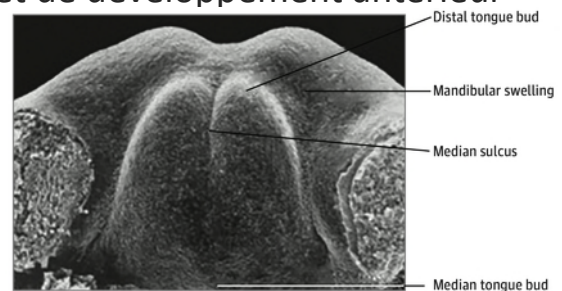


FIG. 1. Yearly number of tongue tie-related articles (Y-axis) versus year of publication (X-axis).

Bin-Nun A et al. A dramatic increase in tongue tie- related articles: a 67 years systematic review

Embryologie

- ▶ Langue formée à partir des 4 premiers arcs branchiaux
- ▶ Masse qui s'individualise
- ▶ Sillons linguogingivaux se forment et vont définir la mobilité de la langue
- ▶ Frein formé à 4^{ème} semaine
- ▶ Ankyloglossie: combinaison de apoptose incomplète, de fusion trop importante des proéminences latérales et de développement antérieur insuffisant?



Plusieurs systèmes

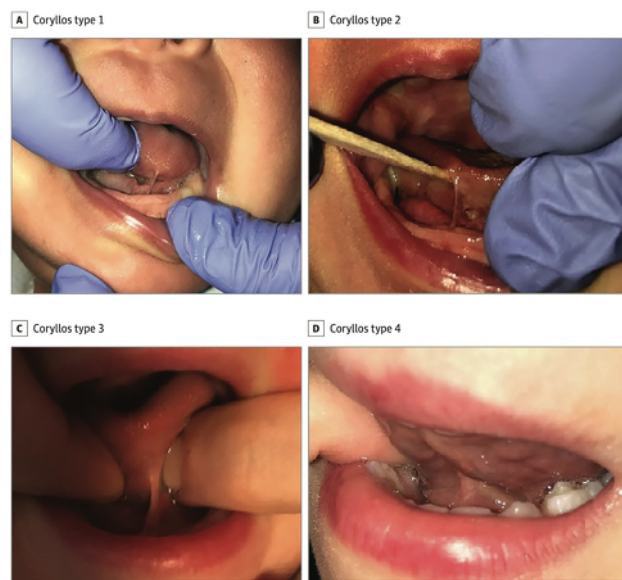
Table 1. Common Grading Systems for Ankyloglossia

Grading System (Source)	Anatomical Classification Criteria	Posterior Ankyloglossia Classification
Coryllos system (American Academy of Pediatrics Section on Breastfeeding, ²⁶ 2004)	Type 1: Attachment of frenulum to the tongue tip, usually in front of the alveolar ridge Type 2: 2-4 mm behind the tongue tip and on or just behind the alveolar ridge Type 3: Attachment to the midtongue and middle of the floor of mouth Type 4: Against the base of the tongue	Consists of types 3 and 4 with functional impairment
Kotlow system (Kotlow, ²⁷ 1999)	Normal: >16-mm free tongue length Class I (mild): 12 to 16-mm free tongue length Class II (moderate): 8 to 11-mm free tongue length Class III (severe): 3 to 7-mm free tongue length Class IV (complete): <3-mm free tongue length	Consists of normal and class I with functional impairment
Kotlow system revised (Kotlow, ²⁸ 2011)	Class I: 0 to 3-mm attachment from the tongue tip Class II: 4 to 6-mm attachment from the tongue tip Class III: 7 to 9-mm attachment from the tongue tip Class IV: 10 to 12-mm or submucosal attachment from the tongue tip	Consists of classes III and IV with functional impairment
Tongue elevation (Lalakea and Messner, ²⁴ 2003; Williams and Waldron, ²⁹ 1985; Notestine, ³⁰ 1990; and Ruffoli et al., ³¹ 2005)	Normal: >23 mm Mild: 17-22 mm Moderate: 4-16 mm Severe: ≤3 mm	NA
Tongue protrusion (Lalakea and Messner, ²⁴ 2003; Messner and Lalakea, ²⁵ 2002)	Normal: 20-25 mm Ankyloglossia: <15 mm	NA

Abbreviation: NA, not applicable.

Coryllos

Figure 2. Coryllos Frenulum Classification



Type 1 indicates attachment of the frenulum to the tongue tip; type 2, attachment 2 to 4 mm behind the tongue tip and on or just behind the alveolar ridge; type 3, attachment to the midtongue and middle of the floor of mouth; and type 4, attachment against the base of the tongue.



Grading ↗ ⇔ Sévérité ↘

Frein postérieur

- ▶ Controversé
- ▶ Frein sous-muqueux derrière base du frein « visible »
- ▶ Caractérisation difficile
- ▶ Palpation nécessaire
- ▶ Incidence difficile à définir: 59%????

Incidence

- ▶ Très variable: 0.02 % à 12 %!!!
- ▶ Lié à absence de consensus sur définition
- ▶ Selon classification de Coryllos, frein 1 à 4 présent chez 199 / 200 NNés
 - ▶ Pas de corrélation entre grade et difficultés d'allaitement
 - ▶ > 50% (voire 75%!!!) ont ZERO symptôme
- ▶ Selon HATLFF: 4.2 % à 12.8%
- ▶ Facteurs extrinsèques? Cocaine chez la mère

Traiter ou ne pas traiter?

Augmentation? Plutôt changements culturels et cliniques

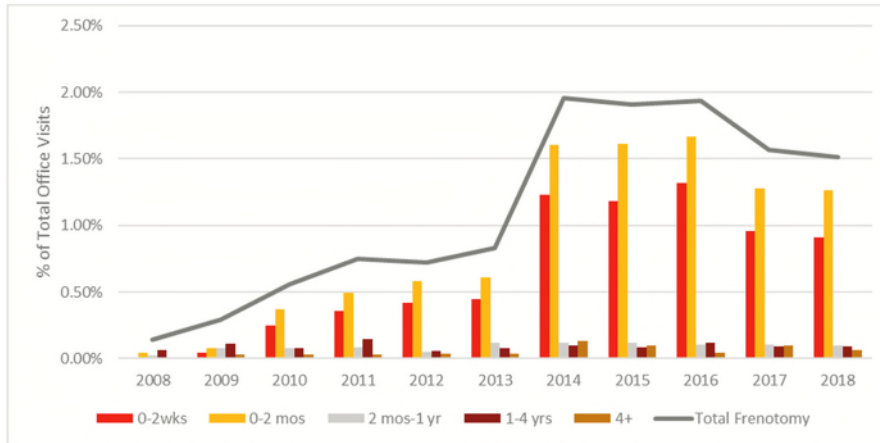


Fig. 1. Frenotomy visits as a percentage of total office visits separated by age group. Significant increases were seen in the 0-2 weeks ($P < 0.0001$) and 0-2 months ($P < 0.0001$) age groups. Frenotomy across all age groups also increased significantly over the study period ($P < 0.0001$).

Traiter ou ne pas traiter?

Augmentation? Plutôt changements culturels et cliniques

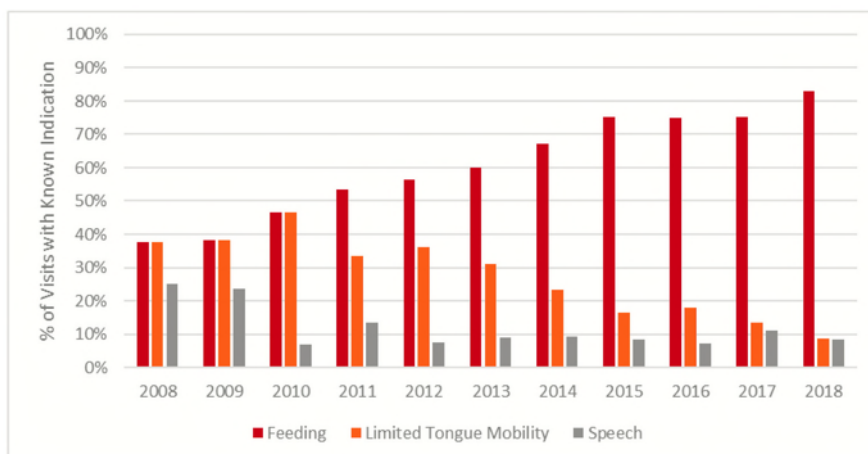


Fig. 2. Trends in indications for frenotomy procedures. Of frenotomy visits with documented indications, procedures for feeding increased over the study period ($P < 0.0001$).

Génétique

- ▶ Prédominance masculine (1.1: à 3:1)
- ▶ Cas sporadiques ont prédominance masculine > cas familiaux
- ▶ Cas familiaux x-linked ou autosomal dominant avec pénétrante incomplète
- ▶ Prédominance masculine diminue avec augmentation de la sévérité
- ▶ Syndromes:
 - ▶ X-linked cleft palate syndrome
 - ▶ Opitz
 - ▶ van der Woude
 - ▶ Beckwith-Widemann
 - ▶ Simosa
 - ▶ ...

Clinique

- ▶ Asymptomatique
- ▶ Découverte lors d'investigations de difficultés alimentaires. Causalité?
- ▶ Découverte lors d'investigations pour problèmes de langage. Causalité?
- ▶ Allaitement difficile (douleurs)
- ▶ Hygiène orale problématique
- ▶ Problèmes sociaux (sucrer la glace, tirer la langue, baiser)
- ▶ Difficultés à jouer de certains instruments à vent

Impact sur l'allaitement

Impact sur l'allaitement

- ▶ Le plus étudié
- ▶ Allaitement nécessite sceau étanche entre bouche du bébé et sein de la mère
- ▶ Frein important ⇨ étanchéité insuffisante
- ▶ Frein important ⇨ sceau superficiel
- ▶ Position de la langue est différente selon que frein de langue ou non (vu aux US)

Impact sur l'allaitement

Si frein trop important

- ▶ Douleur
- ▶ Rhagades
- ▶ Saignements
- ▶ Ulcération
- ▶ Mastite
- ▶ Arrêt de l'allaitement
- ▶ Absorption de lait moins efficace
- ▶ Aérophagie

Présentes seulement dans 25% des « tongue-tied »

Walsh J et McKenna Benoit M. Ankyloglossia and other oral ties. *Otolaryngol clin N Am* 2019;52:795-811
 Bowley DM et Arul GS. Fifteen minutes consultation: The infant with a tongue tie. *Arch Dis Child Educ Pract Ed* 2014;99:127-129
 Ghaheri BA et al. Breastfeeding improvement following tongue-tie and lip-tie release: a prospective cohort study. *Laryngoscope* 2017;127:1217-1223

Complaint	Prevalence
Poor latching	81%
Falls asleep while attempting to nurse	73%
Creased, flattened, or blanched nipples after nursing	68%
Gumming or chewing of nipple when nursing	67%
Poor or incomplete breast drainage	60%
Slides off nipple when attempting to latch	60%
Severe pain when infant attempts to latch	59%
Cracked, bruised, or blistered nipples	49%
Reflux symptoms	45%
Unable to hold a pacifier in mouth	40%
Poor weight gain	32%
Colic symptoms	24%
Bleeding nipples	24%
Plugged ducts	21%
Mastitis or nipple thrush	14%
Infected nipples or breasts	6%

Comment quantifier?

- ▶ Système de Coryllos
- ▶ Système de Kotlow
- ▶ Mesure de la distance pointe-frein
- ▶ Cordon palpable

FIG. 1. Tip-frenulum measurement. With the infant's tongue retracted superiorly, the distance from the junction of the dorsal papillated and ventral mucosal tongue (A) to the attachment of the lingual frenulum (B) is measured. Color images available online at www.liebertpub.com/bfm

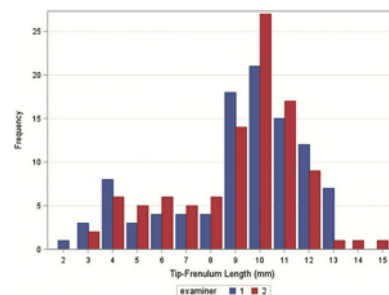


FIG. 2. Distribution of newborn tip-frenulum distances. Color images available online at www.liebertpub.com/bfm

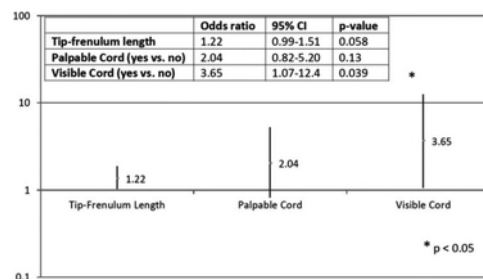


FIG. 4. Odds ratios for higher maternal nipple pain. Values may not be directly comparable due to differences in continuous (length) versus categorical predictors. CI, confidence interval.

Walker RD et al. Defining tip-frenulum length for ankyloglossia and its impact on breastfeeding: a prospective cohort study. *Breastfeeding Med* 2018;13(3):

Au delà de l'apparence, la fonction.

Examen nécessaire

- ▶ Enfant couché, tête vers l'examineur
- ▶ Observation bouche et lèvres, ainsi que de l'apparence cranio-faciale
- ▶ Examen de position de repos de la langue
- ▶ Elévation de la langue (doigt, élévateur fendu) et caractérisation du frein
- ▶ Evaluation de la qualité de la succion
 - ▶ Verrouillage
 - ▶ Etanchéité
 - ▶ Péristaltisme
- ▶ Repas d'épreuve

Au delà de l'apparence, la fonction.

Une qualification de la fonction est indispensable

- ▶ HATLFF (Hazelbaker Assessment Tool for Lingual Frenulum Fonction)
- ▶ BTAT (Bristol Tongue Assessment Tool)
- ▶ BBAT (Bristol Breastfeeding Assessment Tool)
- ▶ TABBY (Tongue-tie And Breastfed Baby)
- ▶ BSES (Breastfeeding Self-Efficacy Scale)
- ▶ BSES-SF (Breastfeeding Self-Efficacy Scale Short Form)
- ▶ IBFAT (Infant Breastfeeding Assessment Tool)
- ▶ LATCH (Latch, Audible swallowing, Type of nipple, Comfort, Hold)

HATLFF (Hazelbaker Assessment Tool for Lingual Frenulum Fonction)

Table 2. The Hazelbaker Assessment Tool for Lingual Frenulum Function*

Item Description	Score
Appearance	
Appearance of tongue when lifted	
Round or square	2
Slight cleft in tip apparent	1
Heart shaped	0
Elasticity of frenulum	
Very elastic (excellent)	2
Moderately elastic	1
Little or no elasticity	0
Length of lingual frenulum when tongue lifted	
More than 1 cm or absent frenulum	2
1 cm	1
<1 cm	0
Attachment of lingual frenulum to tongue	
Posterior to the juncture between the body and blade of the tongue	2
In front of the juncture between the body and the blade of the tongue	1
At the tip with or without notching	0
Attachment of lingual frenulum to inferior alveolar ridge	
Attached to floor of mouth	2
Attached to the backside of the inferior alveolus	1
Attached to ridge of inferior alveolus	0

Function	
Lateralization	
Complete	2
Body of tongue but not tongue tip	1
None	0
Lift of tongue	
Tip to middle mouth	2
Only edges to middle mouth	1
Extension of tongue	
Tip over lower lip	2
Tip over lower gum only	1
Neither of the above or anterior or middle tongue humps and/or dimples	0
Spread of anterior tongue	
Complete	2
Moderate or partial	1
Little or none	0
Cupping	
Entire edge, firm cup	2
Side edges only or moderate cup	1
Poor or no cup	0
Peristalsis	
Complete anterior to posterior	2
Partial or originating posterior to tongue tip	1
None or reverse motion (tongue-thrust)	0
Snapback	
None	2
Periodic	1
Frequent or with each suck	0

* Assessment includes 10 points for frenulum appearance and 14 points for tongue function. For a function score of 14, regardless of appearance item score, surgical treatment not recommended. A functional score of 11 is acceptable only if the appearance item score is 10. A functional score of less than 11 indicates impaired function. Frenotomy should be considered if management fails. Frenotomy is necessary if the appearance item score is less than 8. Adapted with permission from Alison Hazelbaker, PhD.⁵⁴

Complexe
Long
Nécessite formation

Walsh J et Tunnel D. Diagnosis and treatment of ankyloglossia in newborn and infants. JAMA Otolaryngol Head Neck Surg 2017;143(10):1032-1039
Walsh J et McKenna Benoit M. Ankyloglossia and other oral ties. Otolaryngol clin N Am 2019;52:795-811

LATCH (Latch, Audible swallowing, Type of nipple, Comfort, Hold)

Table 1 LATCH score

Parameter	Score	Details
Latch	2	Grasps breast, tongue down, lips flanged, rhythmical sucking
	1	Repeated attempts for sustained latch or suck, hold nipple in mouth, stimulate to suck
	0	Too sleepy or reluctant, no sustained latch or suck achieved
Audible	2	Spontaneous and intermittent (<24 h old) or spontaneous and frequent (>24 h old)
	1	A few with stimulation
	0	None
Type of nipple	2	Everted (after stimulation)
	1	Flat
	0	Inverted
Comfort	2	Soft, non-tender
	1	Filling reddened/small blister or bruises/mild-moderate discomfort
	0	Engorged/Cracked, bleeding, large blisters or bruises/Severe discomfort
Hold	2	No assist from staff, mother able to position and hold infant
	1	Minimal assist (i.e., elevate head of head, place pillows for support)/Teach one side, mother does other/Staff holds and then mother takes over
	0	Full assist (staff holds infant at breast)

A 48 h:
LATCH-score $\geq 7.5 \Leftrightarrow$
allaitement exclusif à
6 sem
- sens 93.5%
- FP 7.9%

Wakhanrittee J et al. The outcome of a frenulotomy on breastfeeding infants followed up for 3 months at Thammasat University Hospital. Pediatr Sur Int 2016;32:945-952
Sowjanya SVNS et Venugopalan L. LATCH score as a predictor of exclusive breastfeeding at 6 weeks postpartum: a prospective cohort study. Breastfeeding med 2018;13(6):444-449

Au delà de l'apparence, la fonction.

BSES-SF (Breastfeeding Self-Efficacy Scale Short Form)

Here are statements that describe the activities of breastfeeding. Please circle the number that best describes the feeling of confidence you have for each statement. There are no right or wrong answer for each statement.

1 2 3 4 5
Not at all confident Not really confident Sometimes confident Confident Very confident

No	STATEMENT	Not at all confident → Very Confident				
		1	2	3	4	5
C1	I believe I can always make sure that my baby is getting enough milk.	1	2	3	4	5
C2	I believe I can always breastfeed my baby, the same as I do other challenging tasks.	1	2	3	4	5
C3	I believe I can always breastfeed my baby without the need to add formulated milk.	1	2	3	4	5
C4	I believe and am always sure that my baby is suckling in the right method, over the period of breastfeeding.	1	2	3	4	5
C5	I believe I can always manage breastfeeding up to my satisfaction.	1	2	3	4	5
C6	I believe I can always breastfeed, even when my baby was crying.	1	2	3	4	5
C7	I always want to breastfeed my baby.	1	2	3	4	5
C8	I am always comfortable breastfeeding my baby, even in the presence or in front of other family members.	1	2	3	4	5
C9	I am always satisfied with my breastfeeding experience.	1	2	3	4	5
C10	I can always accept the fact that breastfeeding process will take a long time.	1	2	3	4	5
C11	I can always fully breastfeed on the same breast, before switching to the second breast.	1	2	3	4	5
C12	I can always continue to breastfeed my baby without problems, at each feeding session.	1	2	3	4	5
C13	I can always manage to breastfeed every time my baby asks for milk.	1	2	3	4	5
C14	I am always able to recognize the time my baby is finished and satisfied with the breastfeeding session.	1	2	3	4	5

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Au delà de l'apparence, la fonction.

IBFAT (Infant Breastfeeding Assessment Tool)

Infant Breastfeeding Assessment Tool (IBFAT)

Check the score which best describes the baby's feeding behaviours at this feed.

	3	2	1	0
In order to get baby to feed:	Placed the baby on the breast as no effort was needed.	Used mild stimulation such as unbundling, patting or burping.	Unbundled baby, sat baby back and forward, rubbed baby's body or limbs vigorously at beginning and during feeding.	Could not be aroused.
Rooting	Rooted effectively at once.	Needed coaxing, prompting or encouragement.	Rooted poorly even with coaxing.	Did not root.
How long from placing baby on breast to latch & suck?	0 - 3 minutes.	3 - 10 minutes.	Over 10 minutes.	Did not feed.
Sucking pattern	Sucked well throughout on one or both breasts.	Sucked on & off but needed encouragement.	Sucked poorly, weak sucking; sucking efforts for short periods.	Did not suck.

MOTHER'S EVALUATION

How do you feel about the way the baby fed at this feeding?
3 - Very pleased 2 - Pleased 1 - Fairly pleased 0 - Not pleased

IBFAT assigns a score, 0,1,2, or 3 to five factors. Scores range from 0 to 12.
The mother's evaluation score is not calculated in the IBFAT score.

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Au delà de l'apparence, la fonction.

BBAT (Bristol Breastfeeding Assessment Tool)

	0 Poor	1 Moderate	2 Good	Score
POSITIONING Baby well supported; Tucked against mother's body; Lying on side /neck not twisted; Nose to nipple; Mother confident handling baby	No or few elements achieved Needs to be talked through positioning	Achieving some elements Some positioning advice still needed	Achieving all elements No positioning advice needed	
ATTACHMENT Positive rooting; Wide open mouth; Baby achieving quick latch with a good amount of breast tissue in mouth; Baby stays attached with a good latch throughout feed	Baby unable to latch onto breast or achieves poor latch. No/few elements achieved Needs to be talked through attachment	Achieving some elements Some advice on attachment needed	Achieving all elements No advice on attachment needed	
SUCKING Able to establish effective sucking pattern on both breasts (initial rapid sucks then slower sucks with pauses). Baby ends feed.	No effective sucking; no sucking pattern	Some effective sucking; no satisfactory sucking pattern; on and off the breast	Effective sucking pattern achieved	
SWALLOWING Audible, regular soft swallowing- no clicking	No swallowing heard; clicking noises	Occasional swallowing heard; some swallows noisy or clicking	Regular, audible, quiet swallowing	













Fig. 1. Bristol Breastfeeding Assessment Tool.

Ingram J et al. The development of a new breast feeding assessment tool and the relationship with breast feeding self efficacy. Midwifery 2015;31:132-137

Au delà de l'apparence, la fonction.

TABBY (Tongue-tie And Breastfed Baby)

TABBY Tongue Assessment Tool

	0	1	2	SCORE
What does the tongue-tip look like?				
Where it is fixed to the gum?				
How high can it lift (wide open mouth)?				
How far can it stick out?				

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Fig. 1 TABBY assessment tool

8: normal
6 - 7: borderline
≤ 5: malfunction possible

Ingram J et al. The development and evaluation of a picture tongue assessment tool for tongue-tie in breastfed babies (TABBY). Int Breastfeeding J 2019;14:31

BTAT (Bristol Tongue Assessment Tool)

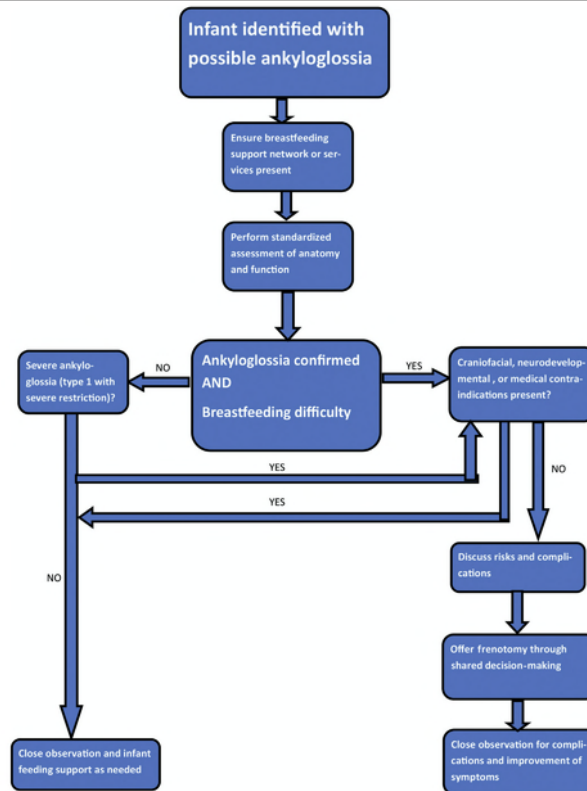
Table 1 Bristol Tongue Assessment Tool (BTAT)

	0	1	2	Score
Tongue tip appearance	Heart shaped	Slight cleft/notched	Rounded	
Attachment of frenulum to lower gum ridge	Attached at top of gum ridge	Attached to inner aspect of gum	Attached to floor of mouth	
Lift of tongue with mouth wide (crying)	Minimal tongue lift	Edges only to mid-mouth	Full tongue lift to mid-mouth	
Protrusion of tongue	Tip stays behind gum	Tip over gum	Tip can extend over lower lip	

Traitements

- ▶ Dépend de l'indication , de la sévérité et de l'âge
- ▶ Non chirurgicaux
 - ▶ Consultation de lactation
 - ▶ Téterelle
 - ▶ Positionnement
 - ▶ Stretching de la langue
 - ▶ Autres (physiothérapie, logopédie, ostéopathie, naturopathie,...?)
- ▶ Chirurgicaux
 - ▶ Frénotomie / Frénulotomie
 - ▶ Frénulectomie ± myotomie ± plastie en Z
 - ▶ Ciseaux, scalpel, laser

Traitements



Walsh J et McKenna Benoit M. Ankyloglossia and other oral ties. Otolaryngol clin N Am 2019;52:795-811

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Traiter ou ne pas traiter?

Comment décider???

- ▶ Parfois les règles les plus simples sont les meilleures?

Mère avec douleur ou traumatisme du mamelon lors de l'allaitement
ET/OU impossibilité de maintenir l'étanchéité ET/OU mauvaise prise de poids de l'enfant (<15g/j) ET/OU membrane visible antérieurement à la base de la langue, qui restreint les mouvements de la langue, conduisant à

- ▶ une impossibilité de toucher le palais OU
- ▶ une impossibilité à englober le doigt de l'examineur OU
- ▶ une impossibilité de la langue à dépasser la gencive à la protrusion

Frénotomie

- ▶ Analgésie au sucrose (anesthésie locale inutile et dangereuse)
- ▶ élévation de la langue
- ▶ Section du frein (avec ciseaux à bout mousse)
- ▶ Hémostase par compression si nécessaire (très rarement)
- ▶ Allaitement

Technique simple. Geste infirmier?

Walsh J et Tunnel D. Diagnosis and treatment of ankyloglossia in newborn and infants. JAMA Otolaryngol Head Neck Surg 2017;143(10):1032-1039

Walsh J et McKenna Benoit M. Ankyloglossia and other oral ties. Otolaryngol clin N Am 2019;52:795-811

Brooks A et Bowley DM. Tongue tie: the evidence for frenotomy. Early Hum Dev 2014;90:765-768

Rose K et al. Developing a nurse-delivered frenulotomy service. Otolaryngol Head Neck Surg 2015;151(1):149-152

Complications de la frénotomie

- ▶ Beaucoup plus rares que pour la frénulectomie ou plastie
- ▶ Saignement (3 - 5 % par pédiatres, 8% par ORL (frénulectomie?))
- ▶ Cicatrice et récurrence (2% par pédiatres, 14% par ORL (frénulectomie))
 - ▶ Nécessité de révision 2.6 - 6.5%
- ▶ Complications graves rarissimes, encore plus pour simple frénotomie
 - ▶ Angine de Ludwig (1 case report), saignements graves (2 case reports), obstruction des VAS chez patient avec Pierre-Robin /2 case reports)
- ▶ Pas de report de lésion des canaux salivaires (selon âge)
- ▶ Troubles de la sensibilité

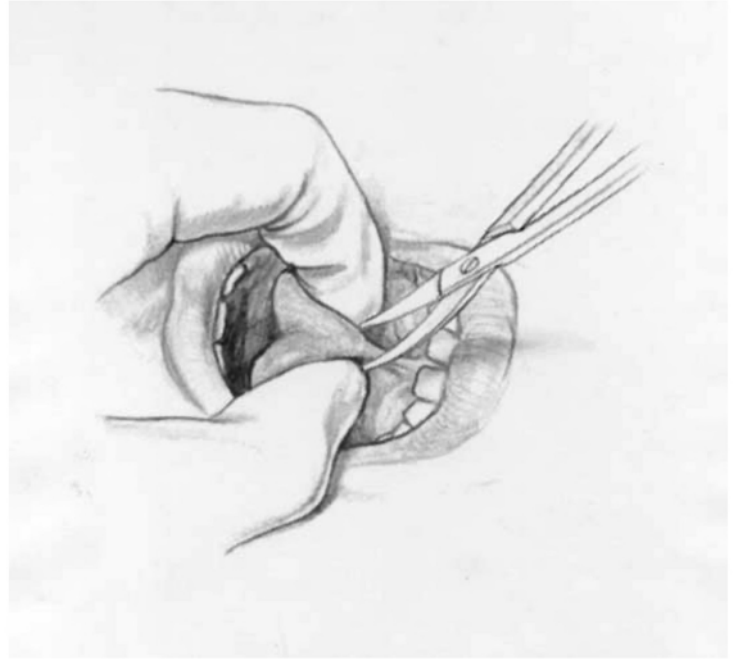
Complications augmentent avec âge et complexité technique

Walsh J et Tunnel D. Diagnosis and treatment of ankyloglossia in newborn and infants. JAMA Otolaryngol Head Neck Surg 2017;143(10):1032-1039

Brooks A et Bowley DM. Tongue tie: the evidence for frenotomy. Early Hum Dev 2014;90:765-768

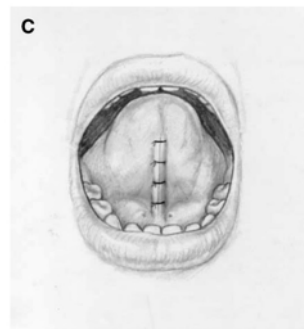
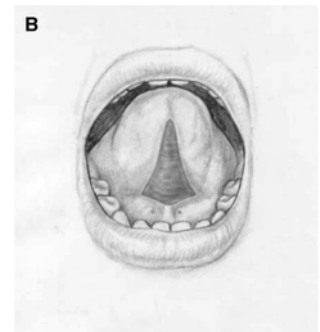
Varadan M et al. Etiology and clinical recommendations to manage the complications following lingual frenectomy: a critical review. J Stomatol Oral Max Surg 2019;120:549-553

Frénotomie ou frénulotomie



Lalakea ML et Messner AH. Ankyloglossia: does it matter? *Pediatr Clin N Am* 2003;50:381-397

Frénuloplastie



Lalakea ML et Messner AH. Ankyloglossia: does it matter? *Pediatr Clin N Am* 2003;50:381-397

Contre-indications à la frénotomie néonatale

- ▶ Pierre-Robin
- ▶ Possibilité de troubles de la crase
- ▶ Suspicion d'infection néonatale
- ▶ Evaluation insuffisante
- ▶ Vitamine K pas donnée

Walsh J et Tunnel D. Diagnosis and treatment of ankyloglossia in newborn and infants. JAMA Otolaryngol Head Neck Surg 2017;143(10):1032-1039
Power RF et Murphy JF. Tongue-tie and frenotomy in infants with breastfeeding difficulties: achieving a balance. Arch Dis Child 2015;100:489-494

Qui dit quoi?

AAP
UNICEF Baby
Friendly Initiative



Soc ped Canada
Soc ped Japon
Soc ped Hollande

Traiter ou ne pas traiter?

Efficacité de la frénotomie

- ▶ Difficile à établir de façon « blinded »
 - ▶ Sham procedure
 - ▶ Cross-overs nombreux
 - ▶ Hétérogénéité des études
- ▶ Difficultés d'allaitement sont d'origine multifactorielles (ankyloglossie plus diagnostiquée chez enfants de mères qui allaitent pour la première fois,...)

Traiter ou ne pas traiter?

- ▶ Hogan (randomised, non-blinded): 96% amel subjective, contre 3%
- ▶ Dollberg (randomise, blinded): amel non signif LATCH-score, amel significative de la douleur
- ▶ Buryk (randomised, blinded): amel significative IBFAT-score et douleur
- ▶ Berry (randomised, double-blinded): amel significative scores et douleurs
- ▶ Emond (randomised, non-blinded): amel HATLFF et BSES, pas d'amel LATCH et IBFAT
- ▶ Geddes: amel dynamique aux US et quantité de lait prise
- ▶ Amélioration de la douleur constante (Srinivasan et al, Ballard et al, Geddes et al, Argiris et al,...)
- ▶ Amélioration du succès de l'allaitement à 6 sem, 3 mois, 4,5 mois et 6 mois (biais, car basée sur registres et peut avoir sélectionné mères motivées)

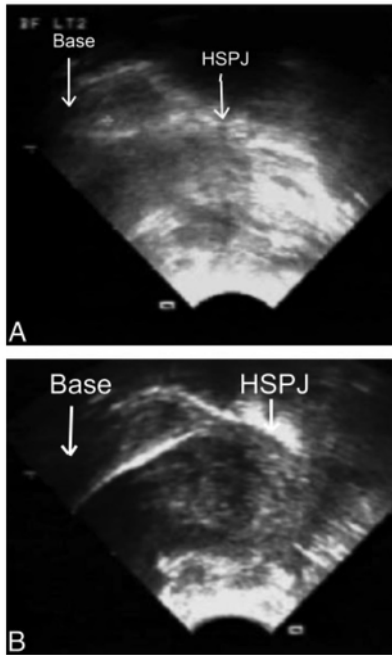


FIGURE 3
A, Ultrasound image of an infant with ankyloglossia pre-frenulotomy. The base of the nipple is compressed. B, Post-frenulotomy, the base of the nipple is compressed to a lesser degree compared with pre-frenulotomy.

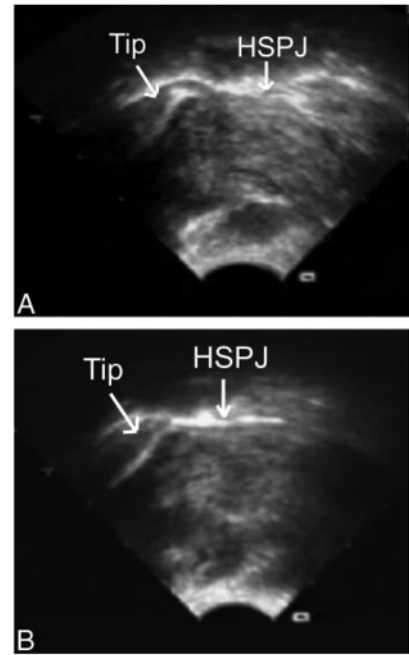


FIGURE 5
A, Ultrasound image of an infant with ankyloglossia pre-frenulotomy. The tip of the nipple is compressed. B, Post-frenulotomy the tip of the nipple is compressed to a lesser degree compared with pre-frenulotomy.

Geddes DT et al. Frenulotomy for breastfeeding infants with ankyloglossia: effect on milk removal and sucking mechanism as imaged by ultrasound. *Pediatrics* 2008;122(1): e188-e194 53



Traiter ou ne pas traiter?

Amélioration du LATCH score et de la douleur (328 pat)

Table 4 The comparison of LATCH score and nipple pain score during infant's suckling between pre-frenulotomy and post-frenulotomy period (at 24 h and 1 week)

Outcome	Pre-frenulotomy	Post-frenulotomy at 24 h	<i>P</i> value	Post-frenulotomy at 1 week	<i>P</i> value
Nipple pain score*	5 (3–7)	2 (0–4)	<0.001	1 (0–1)	<0.001
LATCH score**	6.67 ± 1.34	8.59 ± 1.19	<0.001	8.80 ± 1.13	<0.001

* Median (interquartile range), *P* value from Wilcoxon sign-rank test

** Mean ± standard deviation

Traiter ou ne pas traiter?

Amélioration de l'allaitement, des symptômes chez l'enfant et de la douleur (237 pat)

TABLE III.
Overall Preoperative and All Postoperative Average Outcome Measure Scores (n = 237).

Breastfeeding Outcome Measures	Preoperative Mean (SD)	1 Week Postoperative, Mean (SD)	1 Month Postoperative, Mean (SD)	F Test Statistic, df = 2	P Value*
BSES-SF total score	43.9 (12.6)	52.3 (11.4)	56.5 (10.8)	212.3	<.001
I-GERQ-R total score	16.5 (6.1)	13.2 (5.0)	11.6 (4.9)	85.3	<.001
VAS pain score	4.6 (2.7)	2.2 (1.8)	1.5 (1.7)	259.8	<.001

*P values reflect overall significance between all within-subjects time points using repeated measures analysis of variance F test results.

BSES-SF = Breastfeeding Self-Efficacy Scale-Short Form; df = degrees of freedom; I-GERQ-R = revised Infant Gastroesophageal Reflux Questionnaire; SD = standard deviation; VAS = visual analog scale;

Traiter ou ne pas traiter?

Timing est important: > 4 semaines ⇨ ↗ risque abandon allaitement

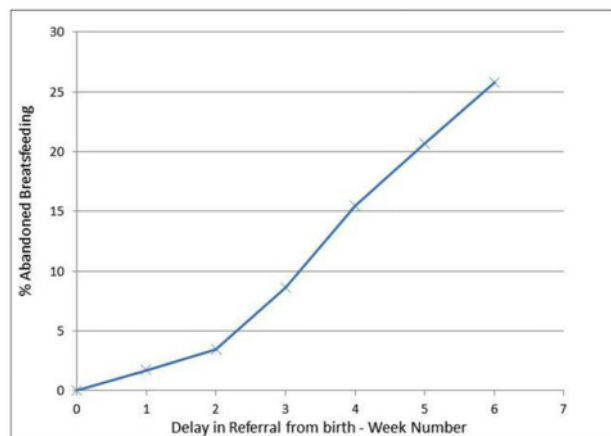


Figure 1: Proportion of babies abandoning breastfeeding by time of delay to clinic appointment

Traiter ou ne pas traiter?

Difficultés d'allaitement sont multifactorielles,... et ankyloglossie en fait partie

	Odds ratio (CI)	P
No breastfeeding experience	4.4 (2.6-7.2)	0.001
Preterm infant (35th +0/7 - 37th +0/7 week of pregnancy)	3.6 (1.9-6.7)	0.000
Low birth weight (<2500 g)	2.9 (1.6-5.4)	0.001
Tongue-tie	2.6 (1.6-4.3)	0.014
Caesarean section	1.6 (1.1-2.4)	0.023

Note: Multivariate analysis.

Abbreviation: CI, confidence interval.

Conclusion: Tongue-tie had a significant impact on breastfeeding and so did low birth weights and prematurity. Frenulotomy proved helpful when breastfeeding problems were reported.

Schlatter SM et al. The role of tongue-tie in breastfeeding problems - A prospective observational study. Acta Paediatrica 2019;108:2214-2221

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Traiter ou ne pas traiter?



TITLE: Frenectomy for the Correction of Ankyloglossia: A Review of Clinical Effectiveness and Guidelines

- ▶ No evidence-based guidelines
- ▶ Evidence that
 - ▶ Frenectomy is safe
 - ▶ Benefit for short-term breastfeeding effectiveness as perceived by the mother
- ▶ Less robust evidence
 - ▶ Long term breastfeeding
 - ▶ Objective reduction in breast and nipple pain
 - ▶ Increased breastfeeding duration
 - ▶ Increased growth
- ▶ When appropriate and conducted by a qualified practitioner, frenectomy is safe and likely beneficial to the patient

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Traiter ou ne pas traiter?

Etude post-interventionnelle « Web-based »

- ▶ Etanchéité améliorée de 100% pour grades 1 et 2, et de 49% pour grade 4 (le plus léger)
- ▶ Douleur améliorée de 79% pour grade 1 et 2, et de 63% pour grade 4

Traiter ou ne pas traiter?

Ne concerne que l'allaitement maternel?

4.1 | Recommendations for practice

Despite the limitations of the studies reviewed, breastfeeding assessments and nipple pain improved post-frenotomy. The possibility of tongue tie causing nipple pain and the evidence that frenotomy improves nipple pain should be considered by healthcare providers during feeding assessments and when mothers report prolonged pain with breastfeeding. It is reasonable for healthcare providers to add tongue tie as a differential diagnosis when nipple pain is present and persists despite position changes, latch adjustment and/or lactation support. Providers should be trained in the appropriate method for screening and diagnosing tongue tie, with the understanding that an improved screening measure is necessary. Issues with bottle feeding, such as difficulty latching, clicking, dribbling, excessive gas or prolonged feedings also warrant oral assessment. Tongue tie should be considered as a potential factor in the development of infant GERD. With the known adverse effects of acid-reducing medications,⁶⁸ an oral assessment to rule out tongue tie as a potential cause of GERD is reasonable prior to initiation of these medications.

5 | CONCLUSION

It is reasonable to add tongue tie as a differential diagnosis when an infant presents with symptoms of GERD, excess gas, substantial dribbling from a bottle or when a breastfeeding mother reports persistent nipple pain or difficulties with infant latch. The growing interest in this topic and anecdotal reports of improvements following frenotomy warrant research to examine the effectiveness of frenotomy for varied degrees of tongue tie severity. Referral and treatment guidelines cannot be established without use of a valid and reliable diagnostic method and evaluation of infant feeding improvements post-frenotomy using a comprehensive feeding measure. The research on frenotomy demonstrates short-term improvements in maternal symptoms but does not provide strong evidence to support frenotomy as treatment for infant feeding difficulties.

Traiter ou ne pas traiter?

FDTBD (Frenotomy Decision Tool for Breastfeeding Dyads)

Date:					
Baby:		Mum:			
PART 1 (Yes = 1 No = 0 Not applicable = N/A)					
1. Mother with nipple pain/trauma while breastfeeding					
2. AND/OR infant with inability to latch or maintain latch					
3. AND/OR endless feeds described by mother					
4. AND/OR poor milk transfer observed					
5. AND/OR infant (>5 days) with weight gain < 20g/d without supplementation					
Total =		/5			
PART 2 (Yes = 1 / No = 0)					
An infant with a visible or palpable membrane anterior to or at the base of tongue restricting tongue movement and leading to any of the following:					
1. An inability to elevate tongue at least mid-way with wide open mouth					
2. An inability for the tongue to cup/maintain suction on an examining finger or on the breast					
3. An inability to protrude the tongue past the gum line or a central dimpling (bowl shape) of the tongue on extension					
4. Diminished lateral movement of tongue					
5. White tongue with absence of white patches elsewhere (pseudoleukoplakia)					
Total =		/5			
PART 3 (Yes = 1 / No = 0)					
An infant with a visible or palpable labial membrane at the center of the upper lip between the lips and the gums leading to any of the following:					
1. Upper lip folds in, puckering or pursed lips					
2. Perioral blanching and/or naso-labial folds					
3. Two tone lips (lighter interior of inner aspect of lips)					
4. Persistent lip blisters					
Total =		/4			
SCORING: There needs to be positive scores in two parts (1 & 2 or 1 & 3)					
Part 1	/5 + Part 2	/5 =	/10	≥ 2 lingual frenotomy recommended	<input type="checkbox"/> Yes <input type="checkbox"/> No
Part 1	/5 + Part 3	/4 =	/9	≥ 2 labial frenotomy recommended	<input type="checkbox"/> Yes <input type="checkbox"/> No

Traiter ou ne pas traiter?

L'intervention stresse-t-elle les parents?

► Moins que le Guthrie!!!

Autres impacts

Impact sur l'hygiène dentaire

- ▶ Langue mobile nécessaire à bon nettoyage de la bouche
- ▶ Augmentation des caries

Impact sur le langage

Pas d'évident substantielle mais indices

- ▶ Messner: amel chez 9/11 patients post frénotomie
- ▶ Dollberg: troubles de l'articulation 2 X plus fréquents chez enfants sans frénotomie postnatale que avec
- ▶ Walls: meilleur développement du langage (identique que si pas de rien de langue anormal) si frénotomie post natale

Demeure controversé

Systematic review: « no significant data to suggest causative association »

Brooks A et Bowley DM. Tongue tie: the evidence for frenotomy. *Early Hum Dev* 2014;90:765-768

Chinnadurai S et al. Treatment of ankyloglossia for reasons other than breastfeeding: a systematic review. *Pediatrics* 2015;135(6):e1467-e1474

Webb A et al. The effect of tongue-tie on breastfeeding and speech articulation: a systematic review. *Int J Pediatr Otorhinolaryngol* 2013;77:635-646

Salt H et al. Speech production in young children with tongue-tie. *Int J Pediatr Otorhinolaryngol* 2020;134:1-6

Dollberg S et al. Evaluation of speech intelligibility in children with tongue-tie. *Acta Paediatr* 2011;100:e125-e127

Impact sur la dentition

Probable

- ▶ Elongation du palais
- ▶ Etroitesse du maxillaire
- ▶ Etroitesse de la mandibule
- ▶ Association entre grade ankyloglossie et type malocclusion

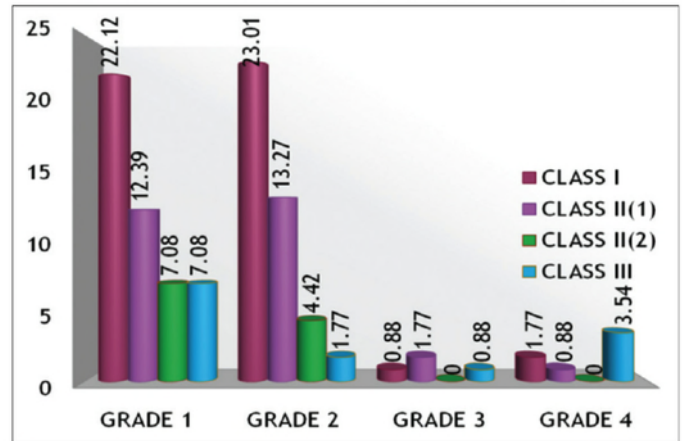
Yoon AJ et al. Ankyloglossia as a risk factor for maxillary hypoplasia and soft palate elongation: a functional - morphological study. *Orthod Craniofacial Res* 2017;20:237-244

Srinivasan B et Chitharanjan AB. Skeletal and dental characteristics in subjects with ankyloglossia. *Progress in Orthodontics* 2013;14:44-50

Probable

- ▶ Elongation du palais
- ▶ Étroitesse du maxillaire
- ▶ Étroitesse de la mandibule
- ▶ Association entre grade ankyloglossie et type malocclusion

Figure 1: Grades of tongue-tie and its association with malocclusion seen in the total population

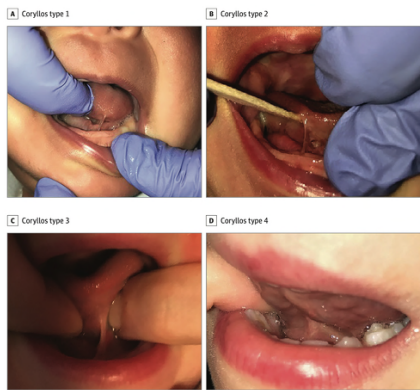


Yoon AJ et al. Ankyloglossia as a risk factor for maxillary hypoplasie and soft palate elongation: a functional - morphological study. Orthod Craniofac Res 2017;20:237-244
 Srinivasan B et Chitharanjan AB. Skeletal and dental characteristics in subjects with ankyloglossia. Progress in Orthodontics 2013;14:44-50
 Vaz AC et Bai PM. Lingual frenulum and malocclusion: an overlooked tissue or a minor issue. Indian J of Dental Research 2015;26:488-492

Impact sur la dentition

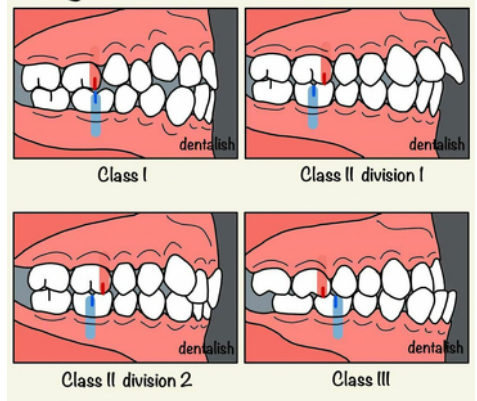
Type of malocclusion	Grade I	Grade II	Grade III	Grade IV
Class I malocclusion	22.12	12.39	7.08	7.08
Class II (1) malocclusion	23.01	13.27	4.42	1.77
Class II (2) malocclusion	0.88	1.77	0.00	0.00
Class III malocclusion	1.77	0.88	3.54	0.00
Total	47.79	28.32	15.04	8.85

Figure 2. Corylios Frenulum Classification



Type 1 indicates attachment of the frenulum to the tongue tip; type 2, attachment 2 to 4 mm behind the tongue tip and on or just behind the alveolar ridge; type 3, attachment to the midline and middle of the floor of mouth; and type 4, attachment against the base of the tongue.

Angle's classification 1899



Conclusions: As the grade of tongue-tie increased, its association with Classes I and II malocclusion decreased. The lower grades of tongue-tie are associated with increased lower incisor crowding. Shorter, tight frenulums are more associated with maxillary constriction, anterior open bite, and spacing of the lower anteriors.

Vaz AC et Bai PM. Lingual frenulum and malocclusion: an overlooked tissue or a minor issue. Indian J of Dental Research 2015;26:488-492

Divers effets évoqués

- ▶ Embrasser
- ▶ Manger glace
- ▶ Jouer instrument à vent
- ▶ Moqueries



How To Take Your Kissing To The Next Level



Shutterstock

Posted by u/ThunderLump 5 years ago

↑ 6 ↓ Difficulties with kissing due to Tongue-Tie?

Hello there.

Although I haven't been professionally diagnosed, I am fairly certain I have Ankyloglossia or tongue-tie. Basically a congenital condition that makes the strip of flesh connecting the tongue to the floor of the mouth unusually thick and short, which in turn causes the tongue to devlop to be rather thick and without any defined point, and rather immobile.

I'd never really thought about it until recently but I exhibit all the symptoms, and I can barely extend my tongue beyond my lips downwards, and virtually not at all straight out.

This had never really been particularly relevant to my life until I started kissing with other live human beings. I started relatively late for my age, but have now had my first kiss and attend student parties and so forth where it happens rather a lot.

It is all very pleasant, but I fear more for me than my ill fated partner. I've never been told outright but I get the impression that I'm rather awful at it.

This could be chalked down to alcohol and inexperience of course but I imagine that having a Tongue quite so lacking in dexterity would make it enormously difficult for me to ever kiss properly.

Is having an abnormally short tongue something that can be worked past in terms of passionate kissing, or am I just a bit fucked?

I believe it should be a relatively simple procedure to sever the frenulum, which should certainly help, but I'm not quite sure whether or not my tongue has already developed abnormally, and if it's too late to return entirely normal structure and function to it.

Either way, it may be some time before I could get such a procedure so I'll have to live with it for a while longer.

Innit?

Et le « french kiss »?

Aug 6, 2003

speg
Diamond Member

Apr 30, 2000
3,681
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Hey guys, just wanted to get a quick question in. I'd answer this myself but alas I haven't been able to have the opportunity yet. Anyway what I wanted to inquire about is this. Has anyone, or does anyone have any experience with french kissing if you are "tongue tied".

That is there is a small piece of flesh from the bottom of your tongue attached to the bottom of your mouth, thus not allowing you too much tongue action, if you know what I mean. Is this a problem? As you can probably tell I'm quite the newbie when it comes to these types of things 😊

And has anyone who was "tongue tied" gotten it cut, I was at the doctors once when I was a kid and he said he could snip it but that didn't (and still doesn't) sound to appealing...

Claire Elizabeth Fulmer LaBerge, Has done her fair share of kissing
Answered January 21, 2017

In my experience, no. I am tongue tied, so my tongue can only extend about an inch out of my mouth. If my boyfriend really wanted me to stick my tongue down his throat, I suppose that could be a drawback, but as it is, even though it's short, I can fully interact with his mouth and tongue. When I asked him, he said this saying applies well:

"It's not the size [or length] that matters, it's how you use it."

17.2K views · View 8 Upvoters

Richard Rayner, Various Electrical and Electronics Engineering & Mathematics, Lord Mayor Treloar College/University (1973)
Answered June 30 · Author has 299 answers and 61.3K answer views

Why? Are you trying to choke your partner? You don't shove it in to reach there tonsils, or to nick their chewing gum. Your tongue need only reach just far enough to carress the inside of the lips, palate & just inside your partners cheeks any further will cause jaw ache after a few minutes and wont increase sensitivity anyway.

The most sensitive places are just inside the lips. just behind the top front teeth and the front of the inside of the cheeks. The touching of the tongues is also very sensual.

1.3K views

Traiter ou ne pas traiter?

Delphi: consensus

Table 13. Ankyloglossia and Oral Tie Action Statements for Clinicians.^a

No.	Statement	Mean	Outliers
10	Breastfeeding difficulties are common in the newborn period and evidence shows that anterior ankyloglossia is a potential contributor to infant feeding problems	7.82	1
12	Maternal pain and poor infant latch can be caused by ankyloglossia but these symptoms can also be present with other etiologies of breastfeeding difficulties	8.73	0
8	Ankyloglossia in an infant should be evaluated by a careful history (including lactation history) and physical examination, including inspection and palpation	8.85	0
22	Before performing a frenotomy on an infant with breastfeeding difficulty, it is appropriate to evaluate the child for other potential head and neck sources of breastfeeding problems such as nasal obstruction, airway obstruction, laryngopharyngeal reflux, and craniofacial anomalies (e.g. cleft palate).	8.00	1
23b	Relative contraindications to infant frenotomy include, but are not limited to, retrognathia, micrognathia, neuromuscular disorder, hypotonia, and coagulopathy.	8.18	0
27	Informed consent for lingual frenotomy should include mention of the possibility of failure to experience improvement in breastfeeding.	8.82	0
30b	Topical anesthetic agents are not recommended prior to infant frenotomy.	7.82	1
30c	Injected anesthetic agents are not recommended prior to infant frenotomy.	7.82	1
30d	Oral sucrose has been shown to decrease pain response in infants undergoing procedures and can be given to an infant prior to undergoing frenotomy.	7.73	1
13b	Ankyloglossia does not typically affect speech.	7.82	1
48b	Ankyloglossia may cause social/mechanical issues in older children (difficulty licking, difficulty keeping teeth clean, lower central incisor diastema, sense of social embarrassment).	7.55	1
15	Presence of an upper lip frenulum is normal in an infant.	8.45	0
17c	Upper lip tie has an unclear relationship to breastfeeding difficulties.	7.27	1
56c	Upper lip frenotomy in infants or children with primary dentition will not prevent the occurrence of an upper interincisor diastema.	7.82	0
36	Surgery to release a "buccal tie" should not be performed.	8.64	1
54	Ankyloglossia does not cause sleep apnea.	8.36	0

Messner AH et al. Clinical consensus statement: ankyloglossia in children. Otolaryngol Head Neck Surg 2020;162(5):597-611

^aThis table is a composition of important action items regarding ankyloglossia for clinicians to consider.

Attention

Table 1. One Week and 1 Month Overall Improvements.

One week			
Answer	Speech, N = 30, % (n)	Feeding, N = 33, % (n)	Sleep, N = 35, % (n)
Significantly worse	0 (0)	0 (0)	0 (0)
Somewhat worse	0 (0)	3.0 (1)	2.9 (1)
No change	23.3 (7)	27.3 (9)	11.4 (4)
Somewhat better	43.3 (13)	45.5 (15)	48.6 (17)
Significantly better	33.3 (10)	24.2 (8)	37.1 (13)
One month			
Answer	Speech, N = 28, % (n)	Feeding, N = 30, % (n)	Sleep, N = 30, % (n)
Significantly worse	3.6 (1)	0	3.3 (1)
Somewhat worse	0	3.3 (1)	6.7 (2)
No change	7.1 (2)	13.3 (4)	6.7 (2)
Somewhat better	39.3 (11)	46.7 (14)	26.7 (8)
Significantly better	50.0 (14)	36.7 (11)	56.7 (17)

Attention

Table 3. Feeding Improvements Reported at 1 Week or 1 Month.

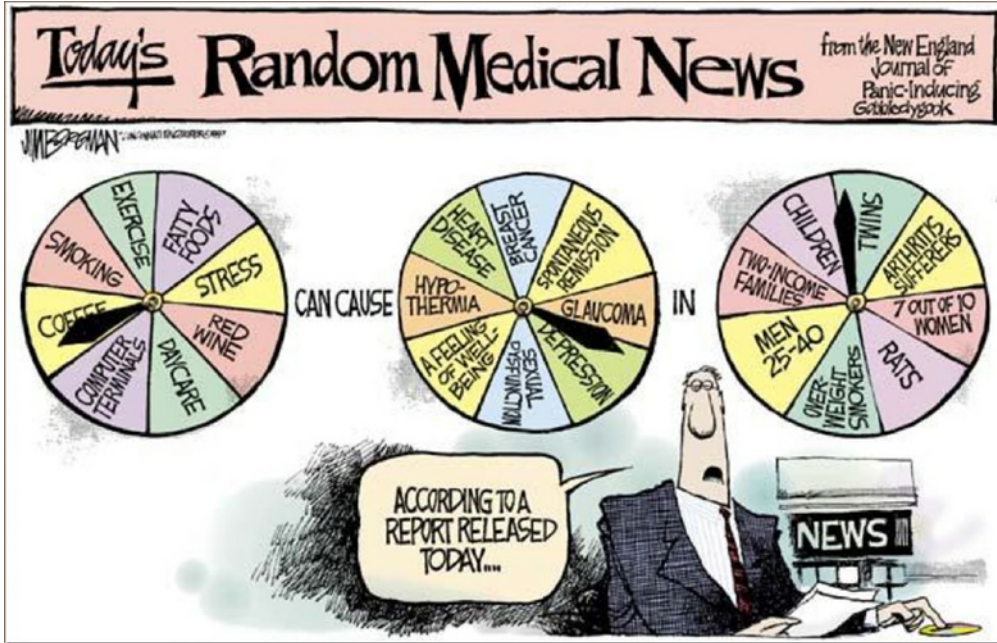
Item	N	Problem indicated	Improvement indicated ^a	Total improvements ^b	P
Frustration when eating	37	4	3	18	.250
Difficulty transitioning to solid foods	37	6	3	18	.250
Slow eating/does not finish meals	37	21	16	18	<.001**
Grazing throughout the day	37	21	16	22	<.001**
Packing food in cheeks	37	10	5	13	.063
Picky eater	37	28	10	11	.002**
Choking or gagging on food	37	17	10	16	.002**
Spits out food	37	17	11	17	.001**
Will not try new foods	37	15	4	15	.125

^aRelates to individuals who had previously reported an issue.

^bRelates to individuals who reported an improvement without reporting the problem initially.

**Significant at 1%.

Traiter ou ne pas traiter?



Conclusion

Un protocole va sortir,...



Stay tuned

Merci pour votre attention