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Exposing the top 10 Myths (takes) in Diagnosing and Treating Tethered Oral Tissues (Tongue-Ties and Lip-Ties) in Breastfeeding Infants

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Introduction

Every day I can treat anywhere from 4-10 infants in need of surgical revisions of the lip and tongue (TOTS) or tethered oral tissues for difficulties latching on to their mother's breast? The symptoms they mother and infant present with can include for the mother; nipple damage, thrush, spasm, severe pain, engorgement and in some instances the emotional impact can lead to postpartum depression when the mother-infant bond fails to properly develop [1-6]. Among the infant's symptoms; reflux, sleep apnea, pain from gas, sleepless nights, falling to sleep when latching and non-nutritional feeds. When these parents seek care, the stories they hear from their healthcare providers, which have no credible scientific or medical basis are many. From the many comments that have been repeated to me by mothers and fathers, I have chosen the top ten what I call MYTHS (takes) to write about in this article.

Myths and facts

Myth: Tongue-ties (ankyloglossia) do not have anything to do with problems related to breastfeeding.

Fact: Breastfeeding depends on the ability of an infant to create a vacuum to express milk from the breast. The upward and downward motion of the posterior portion of the tongue creates this vacuum. If the tongue is prevented from making this motion, the infant may not be able to express milk painlessly and efficiently leading to many breastfeeding problems such as; failure to thrive, reflux, colic, non-nutritional breastfeeding, short episodes of breastfeeding crying, gagging, obstructive sleep apnea, plugged ducts and mastitis (Figure 1).

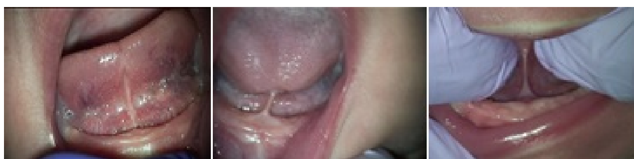

Figure 1: Tongue-ties.

Myth: Upper lip-ties do not have anything to do with breastfeeding.

Fact: Breastfeeding depends on the ability of an infant to form a good seal on the mother's breast. When the upper lip is prevented from flanging upward this seal may be shallow or incomplete. This often leads to clicking and swallowing excessive amounts of air in the infant's belly. This creates the appearance of colic and reflux. It is not a true acid reflux but aerophagia or the swallowing of air. This also leads to similar problems such as failure to thrive, reflux, colic, non-nutritional breastfeeding, and short episodes of breastfeeding, crying, gagging, obstructive sleep apnea, plugged ducts and mastitis. Infants may display lip blisters. Lip-ties may also hold mother's milk on the facial surfaces of the upper front teeth during nighttime at-will feeding and contribute to dental decay (Figure 2) [7-12].

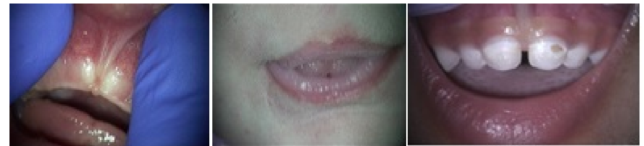

Figure 2: Upper lip-ties.

Myth: Placing an infant on acid reflux drugs will aid in the resolution of air-induced reflux.

Fact: In reality these drugs do little to relieve the pain and discomfort. In addition, when air-induced reflux continues during the nighttime hours, an infant may display morning sinus congestion, which is sometimes diagnosed as allergies or other medical conditions [13-19]. Reflux and vomiting are usually due to swallowing air when a poor latch results in clicking on the breast or bottle (Aerophobia).

Myth: A healthcare provider can adequately rule out the presence of a tongue-tie and lip-tie by examining an infant in a parent's lap?

Fact: When examining an infant for tethered oral tissues (TOTS). The examiner should to be able to examine the entire oral area including the outer lip condition, cheeks, the upper and lower lip attachments, tongue attachment, hard and soft palates. In order to accomplish this examiner needs excellent visualization and infant control. Optimal visualization and patient control is achieved when the infant is placed in the examiner's lap with the infant's head facing the same direction as the examiner and the mother controlling infant movements for tethered oral tissues (Figure 3).

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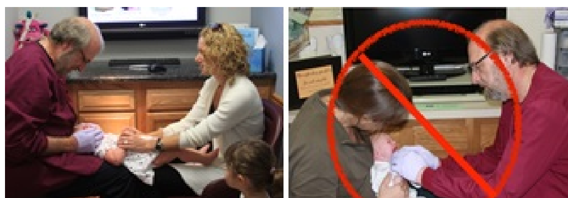

Figure 3: Tethered oral tissues.

Myth: Infant suffering from reflux should see a pediatric GI doctor and undergo extensive tests.

Fact: The prudent treatment should include ruling out the presence of a tongue and lip tie and when diagnosed, revise the attachments.

Myth: Revising the upper lip-tie will create floppy lips, require sutures, will cause the upper primary teeth's roots to rot out, should wait until the infant is a 12 or 13 years of age and after orthodontics closes any gaps, (diastema), surgery will cause scarring, surgery will require general anesthetics, the operating room, or that the parent should wait until the infant falls and rips the lip-tie.

Fact: Not one of these so-called facts is based upon any evidence-based studies. They are all based on hearsay and have no scientific facts to support such statements.

Myth: Lasers are not safe for use in infants and children.

Fact: The FDA approved the manufacture of both soft and hard tissue lasers in the late 1990s. Lasers are in safer than scissors, scalpels, and electrosurgical instruments. Lasers are fast, efficient, and bactericidal. They pose no risks to patients. They do require the operator to have taken courses in laser safety, laser physics and instruction on the particular laser they are using. Laser glasses are required for everyone in the area of the laser being used.

Myth: Once the lip and tongue have been revised, no additional care is required.

Fact: After the lip and tongue attachments are diagnosed as a problem, just surgically revising these areas does not complete treatment. Active wound management is required to prevent the surgical sites from healing back to their original position. This requires keeping the surgical areas apart for least two weeks by actively separating the tissue three times a day. In addition to this active wound management, infants and mothers should be followed by their lactation consultant (IBCLC) and when recommended have additional body work by the appropriate Chiropractor or cranial sacral therapist (Figure 4).

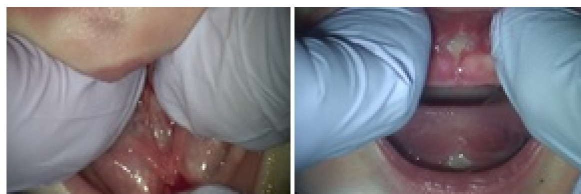

Figure 4: Chiropractor or cranial sacral therapist.

Myth: Mother's need to understand breastfeeding may be painful. They need to wait until their nipples get tough and not be so wimpy. If they cannot breastfeed, just pump or switch to formula and give the baby a bottle.

Fact: Breastfeeding should be a time where a mother and her infant can bond together. This bond created lasts a lifetime. Mothers who cannot breastfeed often become depressed and are told it is their fault. Breastfeeding should not be an all-day effort and painful. Mothers know best. When a mother thinks there is something wrong, there usually is.

Myth: My infant was examined in the hospital and I WAS TOLD EVERYTHING WAS JUST FINE.

Fact: Many hospitals, all over the world, have what is quietly called the "GAG 'rule. Nurses and Lactation consultants based in hospitals are told they cannot discuss tongue and lip ties with patients [20-25].

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