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Dear Editor

We are writing on behalf of the Association of Tongue-tie Practitioners (www.tongue-tie.org.uk) and Tongue-tie UK, a grass roots organisation which aims to raise awareness of tongue-tie issues (www.tonguetieuk.org) in response to the article by J. Cawse-Lucas et al (2015) *Does frenotomy help infants with tongue-tie overcome breastfeeding difficulties?* Journal of Family Practice 2015 February;64 (2):126-127.

The article begins by answering the question with 'probably not' and says that 'evidence concerning improvements in maternal comfort is conflicting. At best, frenotomy improves maternal nipple pain by 10% and maternal subjective sense of improvement over the short term (0 to 2weeks)'.

Research on the efficacy of tongue-tie division is limited. But the article seems to focus only on the RCTs, ignoring other research, and we have some concerns in the way the evidence from these has been interpreted in this article.

The first study cited by Cawse-Lucas J et al (2015) was conducted by Buryk M, Bloom D, Shope T (2011). This was a single blinded RCT involving 58 infants with a mean age of 6 days. The Short-Form McGill Pain Questionnaire (SFMPQ) was used to assess maternal nipple pain before and after frenotomy. Mean scores were 16.8 in the intervention group and 19.2 in the control (sham) group prior to frenotomy. Immediately after frenotomy mean pain scores fell to around 4.5 in the intervention group. There was also some improvement in the control group with scores of 14.5. So some improvement resulting in a mean 4.7 point drop in pain scores was seen without frenotomy. However, with frenotomy mean pain scores dropped considerably more by 12.3 points. In the intervention group pain scores then fell to about 2.5 at two weeks, one at 4 weeks and to around zero at 2, 6 and 12 months. All except one participant in the control (sham) group went on to have frenotomy by 2 weeks and their pain scores post intervention then showed a similar pattern. So, we are not sure how the conclusion that improvement in pain in this study persisted at two weeks, but not at 4 weeks and beyond has been drawn. The graph in figure one of the Buryk, et al (2011) paper suggests that the nipple pain resolved by around 2 months and remained resolved as pain scores did not then increase.

Cawse-Lucas J et al (2015) then go on to discuss the unblinded RCT by Hogan M, Griffiths M, Westcott C (2005). This involved 40 infants, mean age 14 days. Maternal subjective ratings of

improvement were gathered by phone interview at 24 hours. Obviously this study does not provide any evidence of long term improvement in feeding. But this is because long term outcomes were not evaluated as part of this study.

Two newer RCTs by Emond A et al (2014) and Berry J, Griffiths D, Westcott C (2012) are then reviewed. J Cawse-Lucas et al (2015) conclude that the former study 'found no breastfeeding improvements'. Yet the discussion section of the Emond et al (2014) paper states 'while the simple VAS used in the Bristol Trial (this study) was not sensitive enough to show differences between the groups, the relief of painful sucking provided by frenotomy was a clear theme emerging from the qualitative interviews'. The study concluded that early frenotomy does improve maternal self efficacy which has been shown to impact positively on breastfeeding duration. It also found that at 5 days a 15.5% increase in bottle feeding in the control group and a 7.5% in the intervention group. So there was some evidence of improvement in pain, albeit subjective and fewer of the intervention group were bottle feeding at 5 days.

The Berry J, et al study, although published in 2012, was in fact conducted in 2003/4. Cawse- Lucas J, et al (2015) state that it found no improvement in breastfeeding. Yet the breastfeeding rate amongst the babies who have received frenotomy at the 3 month follow up (mean age 4.5 months) was 50%, almost twice the national average of 29%. It is not unreasonable to assume that frenotomy played a part in this impressive figure. Surely the continuation of breastfeeding is the most important measure of success in any breastfeeding intervention.

It is interesting that Cawse-Lucas J et al (2015) refer to the position statement from the Community Paediatrics Committee of the Canadian Paediatric Society (Rowan-Legg A, 2011). However, the authors make no reference to the NICE Guidance (2005) from the UK which concluded that:

Current evidence suggests that there are no major safety concerns about division of ankyloglossia (tongue-tie) and limited evidence suggests that this procedure can improve breastfeeding. This evidence is adequate to support the use of the procedure provided that normal arrangements are in place for consent, audit and clinical governance.

<http://www.nice.org.uk/guidance/ipg149/chapter/1-guidance>

Furthermore the Canadian position statement (Rowan-Legg A, 2011) is itself contradictory:

Based on current available evidence, frenotomy cannot be recommended. If, however, the association between significant tongue-tie and major breastfeeding problems is clearly identified and surgical intervention is deemed necessary, frenotomy should be performed by a clinician experienced with the procedure and with appropriate analgesia.

The authors make no reference to the systematic reviews that have found an association between frenotomy and improved breastfeeding including Finnigan V & Long T (2013) which looked at 5 RCTs and 9 case studies and concluded that frenotomy offers long term improvements in over 50% of cases, Edmunds J, et al (2011) which looked at 25 papers and concluded that 'frenotomy offered the best chance of improved and continued breastfeeding' and Ito Y (2014) which concluded that there is an 'overall moderate quality of evidence for the effectiveness of frenotomy for the treatment of breastfeeding difficulties'.

But setting aside the RCTs and systematic reviews, what about the views of mothers. These are some of the comments sent in to Tongue-tie UK by mothers after they read the Cawse-Lucas J et al (2015) article:

'Made a big difference to us in breastfeeding and our baby was older than the ones studied here. Frankly if it helps with nipple pain then that's a win as most quit due to pain...Our baby went from the 10th percentile to the 60th 3 months after procedure.'

'The improvement in every area was unbelievable. My son put on weight and started to thrive and his colic stopped. I'm still feeding him myself now - he turned 15 months today.'

'We noticed a mild posterior tongue tie in my son at birth but decided not to snip initially as it was so minor. 9 weeks of poor weight gain later and it was really the only thing left to rule out, so we snipped it and he began gaining a pound a week from then on.'

'My 11 week old son had a severe tongue tie, I was advised to use nipple shields until his tongue tie could be snipped which despite an urgent referral being sent could take a few weeks, despite using shields feeding was excruciating, my nipples were bleeding and I was using tonnes of lanolin... He had his tongue tie snipped at our local hospital when he was 5 days old, I fed him straight after and I noticed an improvement in latch immediately and within days I was able to feed him without the use of nipple shields. Now he feeds beautifully and is gaining weight brilliantly (not that weight was an issue) and I barely even notice he is feeding. I don't think I would have been able to carry on breastfeeding if he hadn't had his tongue tie snipped as I was starting to dread feeds and was in seriously excruciating toe curling pain each feed and was so close to giving up.'

'Straight away feeding was easier, her latch was deeper but I did have to re teach her to feed. It took a good few weeks for the pain to go but neatly 12 months in and we are still feeding.'

There is no doubt that more research is needed in the area of frenotomy. But randomised controlled trials are not the only form of evidence we should be considering when looking at outcomes. The very nature of the procedure and breastfeeding difficulties means that RCTs are always going to be fraught with difficulty as it is virtually impossible to blind mothers to the intervention (especially now there is so much information about the procedure, bleeding afterwards and wound healing in the public domain) and there are ethical issues in withholding treatment from the control group which may increase the duration of breastfeeding. Measurement of outcomes is always going to be at least partially subjective as mothers will vary in their expectations and perceptions of breastfeeding.

Qualitative data from mothers needs to be used to inform quantitative research and we need to be cautious about the interpretation of any results. No one is claiming that frenotomy is effective at sustaining breastfeeding in all cases. The breastfeeding relationship between a mother and baby is a complex one and for all mothers and babies there will be other factors, other than tongue-tie and frenotomy, that influence outcomes. But given the numbers of mothers who give up breastfeeding in the first two weeks and the very low breastfeeding rates we have in most of the Western world we need to explore and offer any interventions, that are deemed safe, which have the potential to help improve breastfeeding duration.

Whilst we are sure the authors of this article did not intend for their medical colleagues to read it and dismiss frenotomy as ineffective at improving breastfeeding outcomes, there is a risk that this is how it will be interpreted by many of those who are not working with mothers of tongue-tied babies and are not hearing their stories.

Yours faithfully

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References in addition to those cited in the original article:

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