Association of Tongue-tie Practitioners

Guideline for the management of bleeding post frenulotomy

A small amount of bleeding post division is common and to be expected. Allowing the baby to feed treats this best, as feeding will compress the floor of the mouth.

If there is an unusual amount of bleeding after division, it is likely to be dark venous bleeding. Bright red arterial bleeding is very rare.

1. Put some gauze on the raw diamond under the tongue and hold in place firmly with one finger. Sit down with the baby sitting up on your knee and continue to press for at least 5 timed minutes. When applying pressure ensure that the airway is maintained. Keep baby warm and calm.
2. If the gauze becomes soaked while you are pressing, you are not pressing in the right place. Replace the gauze and check you are pressing under the tongue on the raw diamond, but now press with two fingers, side by side, to ensure you are pressing on the outer edges as well as the centre. Sit down again and wait for at least 5 timed minutes.
3. **Do not** continually remove the gauze to see if the bleeding has stopped – wait for **at least 5 minutes** and then look.
   This should control 99.7% of bleeding. (1:300 chance of continued bleeding)
4. If there is still an ooze, using a tea bag soaked in cold water, press with one or two fingers for a further timed 5 minutes. Remove the teabag when the bleeding has stopped. Kaltostat may be used as an alternative to a tea bag.* This should control 99.99% (1:10,000 risk of continued bleeding). (In paediatric dentistry, teabags are recommended by many people to stop bleeding from the gums).

   If you are not in a hospital, consider calling an ambulance if initial control of the bleeding is impossible or if the bleeding recurs despite successful pressure control. This decision should be based on professional judgement and experience taking into account the level of blood loss, the age, size and condition of the baby and distance to the nearest Accident and Emergency Department. (The location of the nearest ambulance station also needs to be considered as a lot of ambulances are not dispatched from hospitals.) It is never going to be easy, but everyone will err on the side of safety.

5. In a controlled, hospital environment, with suitable monitoring, put a few drops of 1:100,000 adrenaline on a gauze swab and press for 5 minutes, as before. (or lignocaine 1% with 1:100,000 adrenaline). There is no correct dose, but this seems to be a safe compromise between a stronger concentration of adrenaline and the theoretical side-effects of systemic absorption.

6. If all this fails, you will have to invoke surgical help… (estimated risk 1: 100,000) Silver Nitrate, electrocautery and suturing are options at this point.
   This group of babies have had a long period of sublingual pressure followed by some form of surgery. This causes considerable oedema and some oral aversion, so they need to be kept under very close supervision, potentially as an inpatient for several days, until they are feeding normally. A prompt naso-gastric tube for initial stress-free feeds is very useful and avoids an unnecessary IV line.

*Kaltostat 10cm x 10cm may be easier to use than 5cm x 5cm and can be cut to make it smaller if needed. It can be obtained through the usual NHS supply chains for dressings or for private practice purchased from Amazon or online medical suppliers.

Guidance on bleeding for parents

There have been a few reported cases of prolonged and/or heavy bleeding which has occurred sometime after the procedure when the babies have returned home. So, it would seem prudent to provide parents with advice on how to manage this in the very unlikely event it should occur. Below is an example of the kind of guidance you may choose to give to your clients:

There have been reported cases of bleeding which has occurred sometime after tongue-tie division, usually on the same day, when the babies have returned home. If this occurs the bleeding is usually very light and is triggered by strenuous crying (resulting in the tongue lifting and disturbing the wound) or when the wound is disturbed during feeding, particularly if the wound is caught by a bottle teat or tip of a nipple shield.

1. *If you notice any blood in your baby's mouth then offer the baby the breast or bottle and feed them. This will usually stop the bleeding within a few minutes just as it did immediately after the procedure. If the baby refuses to feed then sucking on a dummy/pacifier or your clean finger will have a similar effect.*
2. *If the bleeding is very heavy or does not reduce with feeding and stop within 15 minutes then apply pressure to the wound under the tongue with one finger using a clean piece of gauze or muslin for 5 minutes. Do not apply pressure under the baby's chin as this can affect breathing.*
3. *If bleeding continues after this time continue to apply pressure to the wound and take your baby to hospital (call an ambulance if you live more than a very short distance from the Accident and Emergency Department).*
4.

If a baby needs to go to hospital, give a copy of this document to either the parents or directly to the paramedics/A&E staff. As significant bleeding after tongue-tie division is a rare event they are unlikely to be familiar with this type of bleeding or the potential subsequent feeding problems.

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All of these articles are available in full pdf format on the ATP website www.tongue-tie.org.uk.

Notes about this guideline

This guideline was originally written by Mr Mervyn Griffiths, Consultant Paediatric Surgeon, Southampton and Sarah Oakley, Independent Nurse, Health Visitor and Lactation Consultant in 2014. It was revised in 2015 by Mervyn and in March 2017 was reviewed by Nigel Hall, Consultant Paediatric Surgeon, Head of Wessex Tongue-tie Service, Southampton. There are no published papers specifically on the management of bleeding in infants post frenulotomy. Heavy and prolonged bleeds are rare so the guidance here is based on strategies used by members of ATP that have been found to be effective. It is up to individual NHS Trusts to develop their own policies on this. Issues have been raised about the use to tea bags, which may disintegrate if too wet, but they are used in dentistry and there is evidence in the literature of their efficacy in controlling bleeding (see papers on the ATP website that accompany this guidance). Some NHS Trusts are concerned about using Kaltostat as there is potential for fibres to be left in the wound once the dressing is removed and it is not licensed for use in babies under one year. Other Trusts have taken the view that if it effectively stops bleeding and an escalation to more invasive treatment such as suturing, which can then prevent a baby feeding orally for several days and potentially damage the breastfeeding relationship, then it's use is justified. Alternatives to Kaltostat have been suggested. **Surgicel** is an option but is very expensive. There are cheaper cellulose based haemostats available including Gelita Cel. ATP have sought advice from the manufacturer of Gelita Cel and they have confirmed that the **Gelita Cel Sponges** are suitable for use in the mouths of babies under age one. Their other products are not suitable. We are not aware of any cases where Surgical or Gelita Cel Sponges have been used but **if members of ATP could share their experiences with managing bleeding it will help the development of this guideline further.** Rebound bleeding after the use of Adrenaline has been raised as a potential problem but has not been reported in the cases where is has been used in babies post frenulotomy. Silver nitrate is commonly used in the USA but does not seem to be used much in the UK.