POSITION STATEMENT

Routine aftercare and wound management following infant frenulotomy

This statement outlines the current position of the Association of Tongue-Tie Practitioners (ATP) on the *routine* management of post frenulotomy[1] wound site and aftercare in infants. It refers to a first frenulotomy undertaken on an infant and the *routine*[2] advice given to parents in the days following frenulotomy.

POSITION STATEMENT'S WIDER BACKGROUND and CONTEXT

It is important to take into account aspects of the current clinical practice, published evidence and educational context in which this statement is written.

The ATP committee agree the following:

1. Education and training for frenulotomy surgical procedure is very varied in the UK as is the approach to aftercare. Therefore, there is no overall consistency in procedure or aftercare recommendations. **This position statement does not seek to prescribe practice to individual practitioners, merely to state a current majority position.**

2. All ATP members are registered healthcare practitioners, who must base their practice on their own professional code of practice and on what they believe is the optimal interpretation of the current evidence base. Interpretations may vary.

3. The ATP seek to encourage and support further research and evidence gaining in all aspects of tongue-tie practice.

4. The ATP will seek to revise all position statements according to further future evidence being available.

Footnotes:

[1]Frenulotomy (or division) is the surgical cutting (or dividing) of the frenulum which is attached to the floor of the mouth and the underside of the tongue. It can be done using scissors or laser.

[2]This position statement is NOT intended to cover situations whereby there are subsequent individual 'follow-up' appointments with women and babies post first or second frenulotomy (re-division) during which a practitioner (rather than the parent) performs interventions on a bespoke basis.

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Frenulotomy on an infant is undertaken to improve either breast or bottle feeding. It aims at freeing the tongue that is restricted in its function and movement due to a short frenulum. The desired result (although not always achieved) is that the freed tongue achieves optimal sucking, which results in more effective feeding.

Frenulotomy has several recognised complications. Two of which throw the spotlight on wound healing and *routine* aftercare practices. Firstly, wound infection (although theoretical or very low risk due to the properties of saliva and breast milk) and secondly the apparent re-formation, reappearance or 're-growth' of the frenulum after healing which can cause the tongue to become restricted again and the return of feeding difficulties. In some cases, this could then necessitate a second frenulotomy (re-division) needing to be undertaken which is undesirable.

The incidence of 're-growth' and restriction forming as the first frenulotomy heals is difficult to determine but is thought to be in the region of 2-4% (ATP, 2021). With a view to minimise this occurring, there are several post frenulotomy aftercare instructions which are *routinely* given by practitioners to parents. These are classified below starting with the least intervening and progressing to the most, with many different timings and regimes being suggested to parents:

LEVEL 1
No intervention, feeding the baby as usual
(Other than observing for any bleeding or signs of infection no other action is taken)

LEVEL 2
Feeding the baby as usual and also encouraging parents to do 'tongue exercises' with the baby
(These exercises might include: Encouraging baby to suck a clean finger and withdraw the finger slowly in a 'tug of war' game; running a clean finger along baby's lower gums to encourage sideways tongue movement; parent(s)sticking their tongue out at the baby to encourage the baby to mimic the action). These are detailed on the current ATP '**Care After Tongue-Tie Division (Frenulotomy)**' leaflet.

LEVEL 3
Encouraging 'tongue lifting'
(The parent is encouraged to insert either one or two of their fore fingers under the baby's tongue, with the finger tips at each side of the wound and lifts the tongue upwards enough to stretch the wound site. Touching the wound site itself is not encouraged. The second way of achieving the tongue lift is on a sleeping baby, pressing down on the baby's chin, thereby moving the lower jaw open and down lowering the floor of the mouth and causing the wound to stretch).

LEVEL 4
Active wound management (AWM) or disruptive wound massage/management (DWM)
(This involves using a clean finger(s) in a 'sweeping', rubbing or circular motion (massaging) across the opened wound site. Sometimes including stretching or opening the wound in addition)

There is currently no published evidence as to which of these LEVELS achieve optimal healing thereby avoiding the need for second frenulotomy (re-division). There is also professional discussion about the acceptability of the different LEVELS, particularly LEVELS 3 and 4 to parents as well as to babies.

The key concerns of LEVEL 3 & 4 for parents are:

- Causing their baby discomfort or pain by undertaking the exercises
- Being able to accurately perform the exercises as well as understanding the timings and/or regimes the exercises should be undertaken.

The key concerns of LEVEL 3 & 4 for babies are:

- Being caused pain and discomfort
- Increased likelihood of oral aversion and/or 'feeding strike'
- Increasing the likelihood of causing infection due to placing (albeit clean) fingers close to the wound site
- Disturbing the wound healing inadvertently causing reformation, reappearance or 're-growth' of the frenulum instead of preventing it.

Mindful of the above, the ATP supports up to classification LEVEL 2 for *routine* aftercare and wound management following frenulotomy. This care is outlined in the current ATP 'Care After Tongue-Tie Division (Frenulotomy)' leaflet.

The ATP bases its position on the following two principles:

-In practice, the onus is on an intervention to demonstrate (with published evidence) its safety and effectiveness before being adopted into mainstream practice.

-That practitioner's must firstly 'do no harm'.