Complementary Techniques to Address Tongue-Tie

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Do parents have any alternatives to surgery for addressing tongue-tie? Our panelists agree that latch issues should be assessed first. Other modalities include physical therapy, speech therapy, chiropractic, and craniosacral therapy. In addition, infants should be assessed for other issues, such as torticollis, that may co-occur with tongue-tie. For some parents, complementary techniques may be all that they need to address tongue-tie–related issues. For other parents, surgical release will still be necessary.

Keywords: tongue-tie; torticollis; complementary treatments; craniosacral therapy; physical therapy; chiropractic

Can Complementary Techniques Be Used to Treat Tongue-Tie? How Do You Decide?

Catherine Watson Genna

Basic lactation assistance (optimizing positioning and latch) should always be tried first. If the baby is unable to latch, or causes mother significant pain after a lactation consultation, and there is a clearly restrictive frenulum and no confounders, I refer. If there is torticollis, physical therapy can help, and speech therapy for weakness of tongue or oral muscles. I also refer to several occupational therapists and infant chiropractors who use craniosacral therapy as one of their modalities.

James Murphy

Although many body workers claim superior results from body work alone, in my experience, body work is an adjunct to surgical release, and may begin shortly before it, or begin at any time after surgical release. I do not advocate for body work alone when the mentioned criteria for diagnosis of a tongue-tie are met.

Martin Kaplan

Yes, if it is available. It should also be part of the routine comprehensive body evaluation. The concerns here, for me, are that there may be a physical restriction, whether musculoskeletal or fascia tension, that has not been identified for corrective treatment. Form and function are intimately related. If there is a body injury or restriction that the craniosacral therapist (CST) or infant chiropractor determines for treatment, then the physical correction performed body will assist in retaining a surgically necessary intervention.

Position of latch and ability to improve latch is huge. This is where an IBCLC, or other trained breast- or bottle-feeding specialist is hugely important. A factor that many surgical providers may not consider in the total care is maternal breast anatomy problems affecting latch, or there may have been previous breast surgery or chest traumas that affect the ability to produce milk. There may be a psychological component to breastfeeding. There may have been emotional abuse, rape or incest, and the ability of the mother to feel comfortable with this intimate contact cannot be sustained. A team of educated infant and mother dyad providers is necessary.

I decide by having the mother complete a comprehensive mother-and-baby symptom intake form. This includes the history of term (early/full or late), vaginal or cesarean section delivery, whether hospital or home birth, drug-induced delivery, breast milk letdown issues, who evaluated the baby, and mother nursing. We need to assure that there are no cases treated by visual assessment only. Not every presentation of frenum requires treatment. (See pp. 132–138 for intake protocols.)

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Alison K. Hazelbaker

Proper management always takes precedence over surgery and should be the first line of intervention. Proper management includes using evidence-based assessment to garner an accurate diagnosis alongside of typical lactation management strategies such as positioning and attachment technique. In my experience of using the Assessment Tool for Lingual Frenulum Function (ATLFF) over a 28-year period, scores do not significantly improve with nonsurgical lactation management when a baby is *truly* tongue-tied. The baby may become a better compensator, but actual tongue function does not normalize.

I decide what to do only after taking a thorough history, watching the baby feed, examining the baby, and by using a differential diagnosis process. If the baby has a borderline score on the ATLFF, and has other signs of a biomechanically based sucking issue, I use lactation management strategies in conjunction with craniosacral therapy. I sometimes refer to an occupational therapist (OT) and a chiropractor for optimal results.

Craniosacral therapy (the practice of which is the same as osteopathy as practiced in countries other than the United States) does not resolve a true-tie. But mounting evidence demonstrates its effectiveness in resolving or mitigating biomechanically based sucking issues (Frymann, 1966; Herzhaft-Le Roy, Xhignesse, & Gaboury, 2017; Lund et al., 2011; Maxwell, Fraval, & Osteo, 1998; Pizzolorusso et al., 2013). I am performing research with several colleagues in the United Kingdom, and planning research here in the United States, to further examine the role craniosacral therapy/osteopathy plays in resolving biomechanically based sucking issues.

Can craniosacral therapy/osteopathy be used successfully as an adjunct to surgery for tongue-tie? Anecdotally, we see good to excellent results. Formal research will provide more information on which to base our clinical decisions regarding this bodywork modality.

One may claim that a double standard exists. Why is it okay to use craniosacral therapy experimentally and not okay to experiment with surgical remedies? A simple risk assessment answers the question. In the case of torticollis or plagiocephaly-derived sucking issues, an OT and/or physical therapist *must* be a member of the team. These practitioners have the specialized knowledge and skills needed to quickly and effectively address these significant structural problems.

Carmela Baeza

The correct diagnosis and management of ankyloglossia in the breastfeeding dyad is mainly based, in my opinion, on clinical experience. There are certain types of tongue restriction on which the current assessment tools just don't shed enough light. At the end of the day, management is a judgment call based on the lactation consultant's experience.

This is the reasoning model that I (and the colleagues I work with) use, based on our knowledge and experience (and which will hopefully get more effective as we gain more knowledge and experience).

1. Anterior tongue-ties that do not limit function and do not impact on mother (no nipple discomfort or pain, obstructions, etc.), nor on infant (no weight gain issues). I do not intervene.

2. Anterior tongue-ties that impact on mother (nipple discomfort or pain, obstructions, etc.) and/or infant (weight gain issues), and that *do not* resolve with basic breastfeeding interventions (positioning, latch). Refer for revision. In a group of 68 dyads with these characteristic in the last year at my practice, 100% had great improvement after revision.

3. No visible anterior tongue-tie; when I explore baby tongue movement is limited (elevation and/or extension and/or lateralization), but there is no impact on mother (no nipple discomfort or pain, obstructions, etc.), nor on infant (no weight gain issues). I do not intervene.

4. No visible anterior tongue-tie; when I explore baby tongue movement is limited (elevation and/or extension and/or lateralization), and there is an impact on mother (nipple discomfort or pain, obstructions, etc.), and/or infant (weight-gain issues). We work with different positioning and latch techniques, and very frequently the problem is resolved.

5. No visible anterior tongue-tie; when I explore baby tongue movement is limited (elevation and/or extension and/or lateralization), and there is an impact on mother (nipple discomfort or pain, obstructions, etc.), and/or infant (weight-gain issues). Positioning and latch techniques do not work. I try nipple shields, if mother is willing. They work fairly often in these cases, although of course we have to make sure milk transfer is not diminished.

6. No visible anterior tongue-tie; when I explore baby tongue movement is limited (elevation and/

or extension and/or lateralization), and there is an impact on mother (nipple discomfort or pain, obstructions, etc.), and/or infant (weight-gain issues). Positioning and latch techniques do not work, nipple shields do not work, and this is where it gets murky. My next step is to refer for bodywork (craniosacral, osteopath, speech therapist; my referral is based on the provider's experience rather than the actual field of specialization). Some infants get better, some don't. Other infants I refer for posterior tongue-tie revision. This decision I make based almost solely on clinical experience: after revision, some improve, some don't (60% improve, according to data from our practice). And the few that don't improve after all these interventions are the dramatic cases where all our skills and all the referrals just are not enough. Sometimes, these dyads will get better as time goes by, and I am never quite sure which of the interventions did the job, or if it was the time and the support. Sadly, others will partially or totally wean despite our efforts.

Christina Smillie

Definitely. Except for really obvious anterior frenula, I am very reluctant to "diagnose" tongue-tie on the first visit. Anything that pulls on that hyoid bone has the potential to restrict tongue mobility. And restricted jaw mobility can also interfere with easy tongue mobility. Yes, a baby can have a very tight jaw as the result of restricted tongue mobility, but more often, it appears to me that a tight jaw is more likely the cause of what only appears to be restricted tongue mobility. So what looks like a posterior tongue-tie often disappears after a session, or three, with someone truly skilled in craniosacral therapy. Similarly, a baby with frank or subtle torticollis can have restricted tongue mobility, and the pseudo tongue-tie disappears when the torticollis is treated.

Plus, the word *tongue* is misleadingly simplistic: The tongue is a whole group of interconnected muscles, so the orolingual exam can change dramatically from moment to moment, depending on the baby's state, wakeful or sleepy, hunger or satiety, and so forth, as well as from day to day, depending on tone, on how well nourished or underweight, and so forth. Not that the tongue's anatomy actually changes, but the exam changes because the baby uses the tongue's muscles differently under different circumstances. I find my own very careful exam can look quite different, not just from visit to visit, but even from the beginning of a 2-hour appointment to the end of that same appointment.

Furthermore, a baby who is underweight may conserve energy, and limit his or her tongue use to "drinking at the water fountain" only moving slightly and only with high milk flow, making it look like he has restricted tongue mobility, whereas once his weight has caught up, he may use his tongue just fine, even on a soft breast and slow flow at the end of a feed. So whereas some professionals may see restricted tongue mobility as the cause of slow weight gain, I often view that apparently limited mobility to be the possible result of the underweight infant's low energy. When this is the case, the apparent posterior tongue-tie can magically disappear *after* we help the baby catch up on his weight and energy by offering him increased calories via a high-flow feeding method.

How do I decide? Primum non nocere. First do no harm. Simple anteriors involve snipping a thin little membrane, simple to diagnose and simple to treat, no negative outcomes to worry about. I'll do those the same day I see them, the sooner the better, if parents are prepared for and want it done. But with posteriors, we need to be careful, because history, exam, diagnosis, and management are *all* tricky. And for such intervention in a baby, we need to be sure the punishment fits the crime. The exam can change so much with the baby's level of activity, it needs to be repeated a couple times; the differential diagnosis is significant, including a lot of chicken-or-egg questions; and there are usually plenty of good rational management options that should be tried first.

Even when a first exam fairly strongly suggests restricted tongue mobility, which might be caused by a submucosal or posterior restriction of the tongue, I will first do whatever else the history and physical suggests might be primary, and give it typically at least a week with other obvious and more benign interventions before jumping to any conclusions. Particularly because this whole diagnosis of posterior tongue-tie is only a dozen years old, and we have yet to see good studies that help guide us as to what signs or symptoms can best predict who will do well by intervention and who won't.

Roberta Martinelli and Irene Marchesan

These techniques are not usual in Brazil. Some health professionals indicate several breastfeeding maneuvers to avoid early weaning and the revision.

Pamela Douglas

This is, in my view, *the* most important question!

The promotion of surgical release of posterior tongue-tie (PTT) and upper lip-tie (ULT) is the latest in a

series of inappropriately medicalized interventions for breastfeeding problems (Douglas, 2012, 2013). We inhabit complex biophysical and sociocultural contexts, where "trusting instinct" is definitely not enough for many. The painstaking art and science of supporting a woman and her baby's competence is easily sacrificed to the seduction of the medicalized silver bullet.

Fussing at the breast, difficulty latching, pulling or slipping off, back-arching (signs of positional instability and poor fit and hold), and/or excessive flatus, explosive frothy stools (signs of functional lactose overload) have been mistakenly diagnosed as signs of gastroesophageal reflux disease (GERD), allergy, or lactose intolerance since the early 1990s and are now often attributed to oral ties. Similarly, excessively frequent feeding, excessively broken sleep, and marathon feeding are signs of poor milk transfer, often associated with crying because of poor satiety, but are also still commonly misdiagnosed as signs of GERD, allergy, lactose intolerance, and, most recently, oral ties (Douglas, 2005, 2012, 2013; Douglas & Hill, 2011). These three very common breastfeeding problems are often inappropriately medicalized, still: suboptimal fit and hold, functional lactose overload, and conditioned hyperarousal of the sympathetic nervous system (Douglas & Hill, 2013).

Suboptimal fit and hold leads to suboptimal positional stability, which may result in nipple pain and damage, poor milk transfer, and fussing at the breast. The neurobiological model of infant crying describes the conditioned sympathetic nervous system hyperarousal that occurs if an infant is repeatedly frustrated during breastfeeds by positional instability and poor fit and hold (Douglas & Hill, 2013). Nipple pain is also commonly inappropriately medicalized because of thrush, or even attributed to functional lactose overload, but (as long as we have excluded unusual medical conditions) is a result of poor fit and hold (Berens, Eglash, Malloy, & Steube, 2016). An overly abundant supply may result in both the baby pulling off during the let-down and a functional lactose overload but won't result in nipple damage if the baby is positionally stable because of optimal fit and hold (Douglas, 2012, 2013).

To further illustrate the scale of the blind spot that we have in our health system concerning clinical breastfeeding support right now, mothers are still widely taught the strategy of shaping the breast with the ipsilateral hand, supporting the infant on the back of the neck, and stimulating a gape before bringing the baby on. Yet, this approach has been demonstrated, in Thompson and colleagues' (2016) recent large and well-conducted Australian study to increase the risk of nipple pain fourfold.

The physiological approach to breastfeeding has been a major advance by our clinical breastfeeding-support pioneers over the past decade, and is foundational (Schafer & Watson Genna, 2015). However, baby-led breastfeeding is simply not enough for many of our women, who still develop nipple pain and other problems. Multiple well-conducted studies show that currently popular fit and hold strategies, including mammalian methods, do not improve breastfeeding outcomes (de Oliveira et al., 2006; Forster et al., 2004; Henderson, Stamp, & Pincombe, 2001; Kronborg, Maimburg, & Væth, 2012; Kronberg & Væth, 2009; Labarere et al., 2003; Schafer & Watson Genna, 2015; Wallace et al., 2006).

We have not yet paid enough attention to the complexities of empowering women to fit together with their baby across our gloriously diverse anatomies for pain-free efficient milk transfer. This needs to occur across great diversities of breast shape; breast tissue elasticity; nipple shape, and length, and elasticity; breast–abdominal interface; and infant chin, palate, tongue, lips, and oral connective tissue.

It is not surprising that when clinical approaches are failing, breastfeeding-support professionals look at variations of oral connective tissue, and refer for surgical intervention. Yet, the breastfeeding problems don't result from tight oral connective tissues but from inadequate health system investment at the frontier of clinical breastfeeding-support skills. The controversy about oral ties in which we find ourselves mired is historically constructed, and no individual's fault; breastfeeding-support professionals are simply doing their absolute best every working day to help mothers, in the context of inadequate health system investment in clinical breastfeeding-support research and training.

To further research in this field, women need a teachable, reproducible, and profoundly empowering approach to fit and hold in breastfeeding. In the hope that it might be helpful for others, we have taken steps to make the Gestalt breastfeeding approach, which we have found so effective in our clinic, widely available (Douglas & Keogh, 2017). Gestalt breastfeeding builds on the work of our clinical pioneers, to integrate our own clinical experience and new understandings from ultrasound imaging, to empower women as they activate their baby's breastfeeding reflexes and experiment with

positional stability and intra-oral breast tissue volume across diverse anatomies. Gestalt breastfeeding also integrates psychological strategies for managing difficult thoughts and feelings.

The digital intra-oral maneuvers and massage interventions of craniosacral therapy, designed to stretch or relax muscles and connective tissue, and teach the tongue new movements, are also based on the same outdated understanding of the biomechanics of infant suck. Unfortunately, a course of craniosacral therapy is an expensive intervention for parents, lacks an evidence-base, and is orally intrusive despite best intentions. Craniosacral therapy, and related techniques, simply cannot compare with healthy effects on postural alignment and functional musculoskeletal health achieved by optimal positional stability and fit and hold, repeated over and over for many hours each day.

Anything that directs parental financial resources and time investment away from the practice of optimal fit and hold delays the critical repair of the disrupted breastfeeding relationship and is disempowering for women.

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