Frenotomy Decision Tool for Breastfeeding Dyads

© 2020CaroleDobrich[1]

Please read and follow the *Guide for Using the Frenotomy Decision Tool for Breastfeeding Dyads (FDTBD)*

Date:	**Evaluator:**
Baby: **Age:**	**Parent:**

PART 1 (Yes = 1 No = 0) choose all that apply	**1**	**0**
1. Mother/lactating parent with nipple pain/trauma while breastfeeding		
2. Infant with inability to latch or maintain latch (possible clicking sounds or milk leakage)		
3. Endless feeds described by mother/lactating parent (their description)		
4. Poor milk transfer observed (high suck to low swallow ratio – few audible swallows)		
5. Infant (>5 days) with weight gain < 20g/d without supplementation		
Total =		**/5**
PART 2 (Yes = 1 / No = 0) choose all that apply	**1**	**0**
An infant with a visible or palpable membrane anterior to or at the base of tongue restricting tongue movement and leading to any of the following:		
1. Inability to elevate tongue at least mid-way with wide open mouth		
2. Inability for tongue to cup/maintain suction on breast or examining finger		
3. Inability to protrude tongue past gum line and/or central dimpling of tongue on extension (bowl or heart shape)		
4. Diminished lateral movement of tongue		
5. White tongue with absence of white patches elsewhere (pseudoleukoplakia)		
Total =		**/5**
PART 3 (Yes = 1 / No = 0) choose all that apply	**1**	**0**
An infant with a visible or palpable labial membrane at the center of the upper lip between the lips and the gums leading to any of the following: (There is limited research in this area)		
1. Upper lip folds in, puckering or pursed lips		
2. Perioral blanching and/or naso-labial folds		
3. Two tone lips (lighter interior of inner aspect of lips)		
4. Persistent lip blisters		
5. Tension/blanching of gum/gingiva while flanging upper lip towards nose tip		
Total =		**/5**

SCORING: ***There needs to be positive scores in two parts (1 & 2 or 1 & 3)***

Part 1	/5 + Part 2	/5 =	/10	≥ 2 further assessment required, possible treatment	☐ Yes ☐ No
Part 1	/5 + Part 3	/5 =	/10	≥ 2 further assessment required, possible treatment	☐ Yes ☐ No

Lingual frenotomy performed	☐ Yes ☐ No
Labial frenotomy performed	☐ Yes ☐ No

Evaluator's name

Signature

For more information, please contact Carole Dobrich at carole@health-e-learning.com
June 2020

Frenotomy Decision Tool for Breastfeeding Dyads

Please read and follow the *Guide for Using the Frenotomy Decision Tool for Breastfeeding Dyads (FDTBD)*

Guide for using the Frenotomy Decision Tool for Breastfeeding Dyads (FDTBD)

***** Print this guide and keep it for future use*****

As breastfeeding is the normal feeding behaviour it is important to observe the mother/lactating parent-baby dyad breastfeeding. Infants may have visible or palpable frenulum's that are not interfering with breastfeeding. Just because you see or feel one does not mean it needs to be treated. Basic breastfeeding techniques such as skin to skin, laid back breastfeeding and latch adjustment need to be addressed as well as ensuring maintenance of milk production should the tight frenulum be causing problems. *Families working with knowledgeable, trained and skilled doctors, dentists, IBCLCs, and body workers, as well as other experts in the field, will provide the best outcome for the dyad.*

The FDTBD is a tool to help health care professionals in their evaluation of breastfeeding infants with tongue and or lip tie. The FDTBD is only **one** part of the tongue or lip tie evaluation. The tool is a guide in the decision making related to lingual frenotomy or release of the labial tie. As breastfeeding is a dyad behaviour both mother/lactating parent and infant need to be evaluated. The tool is divided into 3 parts. Part 1 & 2 relate to lingual-tie and Part 1 & 3 relate to labial (lip) tie.

Part 1 is an evaluation/description of breastfeeding looking at both mother/lactating parent and infant

1. **Mother/lactating parent with nipple pain/trauma while breastfeeding.** The mother/lactating parent will describe their pain level. The pain will remain present throughout the feeding, it may vary in intensity. Latch adjustment doesn't eliminate the pain completely. The mother/lactating parent may have cracks or wounds on their nipples from continuous irritation by the tight frenulum.
2. **Infant with inability to latch or maintain latch, clicking sounds, milk leakage.** Some infants simply can't latch or open wide, others latch but slide back onto the nipple, and can't maintain a deep latch. There may be clacking sounds with feeding as the tongue can't maintain the seal. If milk supply is not compromised milk leakage while feeding may be noticed. If a lactation device is used the infant may have limited transfer of milk because latch can't be maintained.
3. **Endless feeds DESCRIBED by mother/lactating parent.** How does the mother/ lactating parent describe their breastfeeding "*the feeding go from one to the other*," "*I can't count them because I don't know when they start or finish*," "*feedings last for hours*," "*baby never seems satisfied*"
4. **Poor milk transfer observed (high suck/low swallow ratio – few audible swallows).** You **need to observe** a feeding to evaluate this. You may notice the baby does lots of sucking but not a lot of audible swallowing. There is a chewing like motion while breastfeeding. Baby often fatigues as the feeding continues, at breast yet NOT transferring much milk. Need to evaluate urine and stool output. If a lactation device is tried the baby often can't transfer the milk easily as maintaining a strong vacuum to draw and maintain the milk flow is difficult.
5. **Infant (> 5 days) with weight gain < 20g/d without supplementation.** Most infants will stabilize their weight and start gaining by day 5. You may indicate N/A if < 5 days. Weight gain varies with age and the grams/day will also vary. The infant may be just maintaining or a little under the expected average weight gain. Some infants are failure to thrive, many are unable to maintain the average weight gain and supplementation has been recommended. Some infants do well initially while milk supply is under hormonal influence and then weight becomes an issue when infant is ineffective with milk transfer and doesn't stimulate the breasts effectively to maintain milk production.

For more information, please contact Carole Dobrich at carole@health-e-learning.com June 2020

Frenotomy Decision Tool for Breastfeeding Dyads

Please read and follow the *Guide for Using the Frenotomy Decision Tool for Breastfeeding Dyads (FDTBD)*

Part 2 is an evaluation and description of the infant oral anatomy related to tongue visuals, movements, and restrictions.

Infant with a visible or palpable membrane anterior to or at the base of tongue restricting tongue movement and leading to any of the following.

1. **Inability to elevate tongue at lease mid-way with wide open mouth.** When the baby opens its mouth does the tongue elevate without restriction. Does the mother/lactating parent notice the infant's tongue at rest on the roof of the mouth? Does the tongue stay flat on the floor of the mouth when infant cries?
2. **Inability for the tongue to cup/maintain suction on an examining finger or on the breast.** Some infants are able to latch yet don't stay well latched, sliding back to the nipple or the seal breaks during feeding. There might be a humping rather than cupping of the tongue on suction.
3. **Inability to protrude tongue past gum line and/or central dimpling of tongue on extension (bowl or heart shape).** Mother/lactating parent will often state they noticed the infant doesn't stick its tongue out or when infant cries the tongue edges elevate and the center stays low forming a dimple or a bowl or a heart shape.
4. **Diminished lateral movement of tongue.** Infant's tongue will bunch or look thick as infant tries to move tongue from side to side. The tip of the tongue does not lateralise widely.
5. **White tongue with absence of white patches elsewhere (pseudoleukoplakia).** This is an observation by many practitioners that the tongue midway back has a white coating that is often confused with candida. Often the dyad has been treated for candida without improvement.

There needs to be a positive score in both parts 1 & 2. If the total score is ≥ 2 referral to a skilled knowledgeable trained infant feeding specialist is essential. Frenotomy may be required following a full feeding evaluation and assessment. Higher the score, higher the likelihood a frenotomy maybe needed.

Part 3 is an evaluation and description of the infant oral anatomy related to upper lip, labial membrane, and gums by visuals and restrictions. (Limited research in this area)

An infant with a visible or palpable labial membrane at the center of the upper lip between the lips and the gums leading to any of the following:

1. **Upper lip folds in, puckering or pursed lips.** Infant doesn't form a complete seal. Lips are not even with the seal**.** It is often stating that they have to "flip out the upper lip".
2. **Perioral blanching and/or naso-labial folds.** Post feeding infant has notable blanching above and below the lips and or red lines/prominent folds at the upper lip or between lips and cheeks.
3. **Two tone lips (lighter interior of inner aspect of lips).** After feeding there will be a lighter and darker colour of the lips which was not evident before the feeding.
4. **Persistent lip blisters.** These may be just central upper lip or over both lips.
5. **Tension/blanching of gum/gingiva while flanging upper lip towards nose tip.** You may notice a colour change of the gums/gingiva and/or around the restriction on lip elevation.

There needs to be a positive score in both parts 1 & 3. If the total score is ≥ 2 referral to a skilled knowledgeable trained infant feeding specialist is essential. Labial frenotomy may be required following a full feeding evaluation and assessment. Higher the score, higher the likelihood a frenotomy maybe needed.

For more information, please contact Carole Dobrich at carole@health-e-learning.com June 2020