CONDITION

Tongue tie

Tongue tie is a birth difference in which a tight tissue band under the tongue may limit its movement.

WHAT IT IS
Tight tissue band limiting tongue movement

BODY SYSTEM
Mouth and feeding

MAIN SYMPTOMS
Feeding difficulty, nipple pain, poor milk transfer, restricted tongue movement

WHAT CAUSES IT
Developmental difference present from birth

HOW IT IS DIAGNOSED
Feeding assessment and examination of tongue movement

MAIN TREATMENT
Feeding support, sometimes frenotomy

CAN IT BE CURED?
Sometimes - release can improve restricted movement

IS IT AN EMERGENCY?
No, except with signs of severe dehydration

LONG-TERM OUTLOOK
Many have few problems; some need support

Overview

Tongue tie, also called ankyloglossia, is a difference present from birth. The lingual frenulum-the band of tissue connecting the underside of the tongue to the floor of the mouth-is shorter, tighter, or less flexible than usual.

Everyone has a lingual frenulum. Tongue tie matters only when this tissue clearly limits tongue movement and causes a practical problem, such as difficulty transferring milk during feeding. The way the frenulum looks by itself does not show whether treatment is needed.

Some babies with tongue tie feed without difficulty. Others have trouble attaching to the breast, maintaining suction, or moving enough milk. The breastfeeding parent may experience persistent nipple pain or damage. Bottle-fed babies can also have feeding problems, although these symptoms may have other causes.

Later in life, restricted movement may affect certain speech sounds, eating, licking, or cleaning food from the teeth. However, many children and adults with a visible tongue tie have no meaningful problems.

Terms such as "anterior" and "posterior" tongue tie may be used to describe where restriction is thought to occur. There is no universally accepted definition of posterior tongue tie. Diagnosis should therefore focus on tongue function and symptoms, not a label or photograph alone.

Symptoms

In a baby, possible signs include:

A baby's tongue may not lift well toward the roof of the mouth or extend over the lower gum. The tip may look heart-shaped when the tongue is lifted or extended. These physical features do not prove that the frenulum is causing a feeding problem.

Feeding symptoms are not specific to tongue tie. Similar difficulties can result from positioning, milk supply, prematurity, illness, differences in the baby's palate or jaw, or problems coordinating sucking and swallowing.

In an older child or adult, restricted tongue movement may make it harder to:

Tongue tie does not usually prevent a child from learning to speak. When speech is affected, the concern is generally pronunciation of particular sounds rather than delayed language development.

- Difficulty attaching to the breast or staying attached
- Clicking sounds, leaking milk, or losing suction during feeds
- Very long, frequent, or tiring feeds
- Poor milk transfer or slower-than-expected weight gain
- Persistent nipple pain, cracking, or compression after feeds
- Produce certain speech sounds clearly
- Lick the lips or move food around the mouth
- Clear food from the teeth
- Perform movements that require lifting or extending the tongue

Causes and risk factors

Tongue tie develops before birth. The tissue under the tongue does not separate or become as flexible as usual during early development.

The reason this happens is often unknown. Tongue tie can occur in more than one family member, suggesting that inherited factors may sometimes contribute. It is not caused by anything a pregnant person did or did not do.

A visible frenulum is a normal part of the mouth. There is no single measurement or appearance that reliably separates a harmless frenulum from tongue tie. The key issue is whether it restricts movement enough to affect feeding or another function.

Tongue tie may be discussed alongside an "upper lip tie" or "cheek tie." These are separate tissue attachments. Evidence does not support routinely cutting them to improve infant feeding.

Diagnosis

Tongue tie is diagnosed through an examination and an assessment of function. No blood test or scan is needed.

For a baby with feeding difficulties, assessment should include watching a full feed where possible. A healthcare professional may examine how the baby attaches, sucks, swallows, breathes, and transfers milk. They may also review weight gain, feeding frequency, milk supply, and nipple pain or injury.

The mouth examination looks at how well the tongue lifts, extends, cups, and moves from side to side. Appearance alone is not enough. Several scoring tools exist, but no single tool should replace a complete feeding assessment.

A breastfeeding or lactation specialist can help identify positioning, attachment, or milk-transfer problems. A doctor, nurse practitioner, midwife, dentist, or ear, nose and throat specialist may assess whether restricted tongue movement is contributing.

For an older child with unclear speech, evaluation by a speech and language therapist can identify which sounds are affected and whether tongue restriction is likely to be important. Many speech differences have causes unrelated to tongue tie.

Treatment and management

Tongue tie does not need treatment when it is not causing a functional problem.

For infant feeding difficulties, the first step is usually skilled feeding support. This may include adjusting positioning and attachment, supporting milk supply, or adapting bottle-feeding technique. Other possible causes of poor feeding or nipple pain should also be considered.

If significant breastfeeding problems continue and restricted tongue movement is clearly contributing, a procedure called frenotomy may be considered. Frenotomy divides the restrictive frenulum to allow more movement. In young babies, it is usually a brief procedure. Feeding is often offered soon afterward.

Frenotomy can reduce nipple pain in some breastfeeding families. Improvement in milk transfer or feeding is less predictable. Some babies improve quickly, while others need continued feeding support or have little change.

A more extensive operation called frenuloplasty may be used for selected older children, adults, or more complex restrictions. It may involve stitches and an anaesthetic. The approach depends on age, anatomy, symptoms, and the clinician performing the procedure.

Frenotomy may be performed with sterile scissors or a laser. Current evidence has not shown that laser treatment gives better feeding outcomes than scissors. The clinician should explain the method, pain control, possible benefits, alternatives, and risks.

Routine repeated stretching that deliberately reopens the healing wound is not supported by good evidence and may cause pain. Aftercare instructions differ according to the procedure, so families should receive a clear plan from the service that performed it.

Speech therapy may help an older child whose pronunciation is affected. Surgery is not automatically required for every speech concern, and it does not replace speech therapy when therapy is needed.

Complications

When feeding is significantly affected, a baby may take in too little milk. This can contribute to poor weight gain or dehydration. Persistent feeding pain may also make breastfeeding difficult to continue, even when milk supply is adequate.

Possible complications of frenotomy include pain, bleeding, infection, scarring, and reattachment during healing. Injury to nearby salivary ducts is uncommon but possible. Some babies become temporarily unsettled or reluctant to feed after the procedure. Serious complications are unusual when the procedure is appropriately assessed and performed, but they can occur.

A procedure may not solve the original problem if tongue restriction was not the main cause. This is one reason a feeding assessment is important before treatment.

Claims that releasing a tongue tie will prevent future dental problems, sleep problems, or speech difficulties are not supported well enough to justify routine treatment in a baby who feeds normally.

Prevention

Tongue tie cannot be prevented because it develops before birth. It is not linked to a parent's diet, medicines, feeding choices, or actions during pregnancy.

Complications may sometimes be reduced through early feeding assessment. If feeding is painful, milk transfer seems poor, or a baby is not gaining weight as expected, timely support can help identify the cause. This does not mean a tongue tie will need to be divided.

Living with it and what to expect

Many babies with a visible tongue tie feed and grow normally without a procedure. As the mouth grows and feeding skills develop, some restrictions become less noticeable. The frenulum does not always disappear, but it may stop causing a practical problem.

When feeding is affected, progress may involve several steps rather than one immediate fix. Positioning support, time, management of milk supply, and treatment of nipple injury may still be needed after frenotomy. Follow-up is useful for checking feeding comfort, milk transfer, wound healing, and weight gain.

During childhood, most tongue ties do not cause major day-to-day limits. A child who eats, speaks, and cleans their mouth comfortably may need no treatment, even if the frenulum still looks tight.

New concerns can become clearer as speech develops or as a child tries movements that require greater tongue reach. These concerns can be assessed at that time. Preventive surgery solely because a future problem might occur is generally not supported by current evidence.

Adults may seek assessment because of speech, eating, oral hygiene, or discomfort with tongue movement. Treatment decisions should be based on the specific limitation and the likely benefit of a procedure. Improvement is possible, but surgery cannot guarantee a particular speech or feeding result.

When to get medical help

Arrange routine medical or feeding support if:

Seek urgent same-day care if a baby is taking much less milk than usual, has noticeably fewer wet nappies, has a very dry mouth, or is becoming unusually sleepy. These may be signs of dehydration or illness, whether or not tongue tie is present.

Get emergency help if a baby is difficult to wake, has trouble breathing, turns blue or grey, or has bleeding that does not stop after a procedure. Breathing problems are not a typical symptom of tongue tie and need immediate assessment.

- Breastfeeding remains painful despite help with positioning
- A baby repeatedly slips off, tires, or struggles during feeds
- Feeds are consistently very long or ineffective
- You are concerned about milk intake or weight gain
- An older child has speech or eating difficulties linked to tongue movement
- A frenotomy wound appears increasingly painful, swollen, or inflamed

Common questions

Does every baby with tongue tie need it cut?

No. Treatment is usually considered only when restricted tongue movement is causing an important problem, most often persistent feeding difficulty that has not improved with skilled support.

Will cutting a tongue tie fix breastfeeding?

It can reduce nipple pain and may improve feeding when the tongue restriction is a major cause. It does not help every baby. Attachment, milk supply, swallowing coordination, and other health or anatomical factors may also affect feeding.

Can tongue tie fix itself as a child grows?

The frenulum may stretch or become less restrictive as the mouth grows. A visible tie may remain but stop causing symptoms. It is not possible to predict this for every child.

Can tongue tie cause speech problems?

It may affect pronunciation of certain sounds in some children, but it does not usually cause delayed speech or language development. A speech and language assessment can show whether tongue movement is contributing to a specific difficulty.

Can a tongue tie grow back after frenotomy?

The divided area can heal with some reattachment or scarring, and symptoms can sometimes continue or return. This does not always mean another procedure is needed. Feeding and tongue function should be reassessed.

Is laser tongue-tie treatment better than scissors?

Evidence has not shown that laser produces better feeding results. Both methods can cause pain, bleeding, scarring, or reattachment. The experience of the clinician and whether the procedure is appropriate are more important than the instrument used.

Sources

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