THE TONGUE TIE

By Khoo Boo-Chai, M.B.,B.S.

Tongue gazing is an interesting and important clinical exercise. The clinician probes its shape, size, mobility and above all, the characteristics of its dorsum. There is no doubt that fond parents also gaze at tongues — but from an entirely different viewpoint. Hence, the medical practitioner is sometimes consulted by parents about the tongue tie. This is a condition in which the fraenum is thick and attached near the tip of the tongue. In severe cases, the tongue may be slightly forked. It is a common belief amongst parents that a baby with a tongue tie may find it difficult to talk clearly in later life. The authorities are still undecided on this point. (Sheldon, 1946; Hutchinson & Moncrieff, 1948; Watkins, 1949; Gaisford, 1953; Ellis, 1960). Although some concede that it might possibly be an impediment to sucking. However, almost all agree that blind snipping of the fraenum is a potentially dangerous operation.

When consulted by a worried parent, a good rule to go by is to see if the baby can protrude its tongue to the mucocutaneous junction of the lip. (Wallace, 1960). If so, then all that is needed is assurance which is given with firmness and tact. If on the contrary, then we advise that the fraenum be snipped with a pair of scissors. It is quite apparent that with the infant vigorously lashing away with its tongue, uncontrolled snips with scissors in a small oral cavity can be dangerous. The author would like to document a method which he has used with safety, success and satisfaction over the last 6 years.

OPERATIVE TECHNIQUE

It is advisable to ask the mother to refrain from feeding the baby before the operation. A hungry baby usually cries and thereby opens its mouth. The baby lies on the operating table securely wrapped up in a blanket and the assistant holds the baby's head firmly with his hands.

The depth of the cut is controlled by the first haemostat. Hence, this is the most important step. The writer uses a curved haemostat which is applied with its concavity lying under the baby's tongue (Fig. 1). If the first bite is found to be inadequate, the haemostat can be easily released and then reapplied taking with it a bigger bite. The second haemostat — a straight one — is applied a few millimeters below the

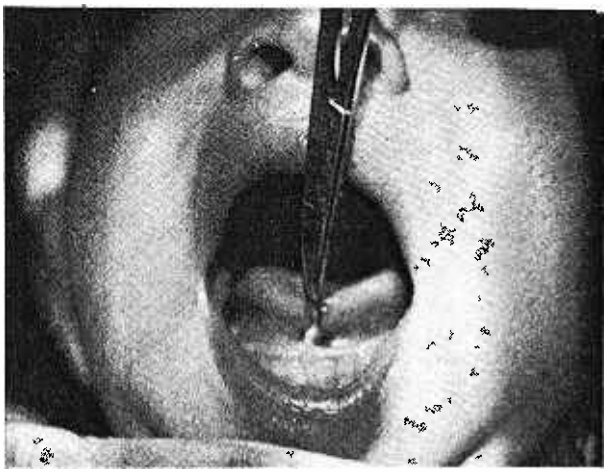

Fig. 1.

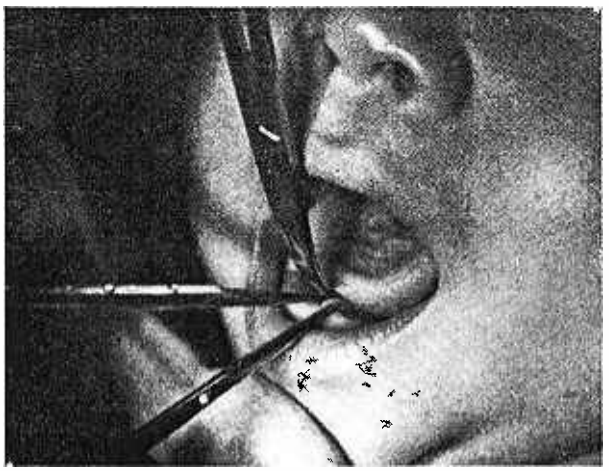

Fig. 2.

Fig. 3.

first (Fig. 2). In this way, that portion of the fraenum to be cut is steadied in spite of the vigorous movements of the tongue and the snip with a pair of iris scissors can be easily controlled. The cut is smooth and there is no tearing of the tissues of the fraenum (Fig. 3). The haemostats are left in for 3-5 minutes. The control of bleeding is an added advantage with this method. The baby is fed immediately after the operation. No post-operative medication is necessary. The wound heals rapidly and the post operative results are satisfactory.

SUMMARY

A technique for the surgical correction of the tongue tie is documented.

REFERENCES

Ellis, R. W. B. (1960): Diseases of infancy and Childhood. 3rd. Ed. p. 121. Edinburgh. E.S. Livingstone.

Gaisford, W. (1953): Disorders of the newborn. In Paediatrics for the Practitioner. Edited by Gaisford, W. & Lightwood, R. Vol. I. p. 99. London. Butterworth & Co.

Hutchison, R. & Moncrieff, A. (1948): Lectures on Diseases of Children. 9th Ed. p. 406. London. Edward Arnold & Co.

Sheldon, W. (1946): Diseases of Infancy and Childhood. 5th Ed. p. 181. London. J. A. Churchill.

Watkins, A. G. (1949): Anomalies of the Tongue and Floor of the Mouth. in Garrod, Batten & Thursfield's Diseases of Children. Edited by Paterson, D. & Moncrieff, A. 4th Ed. Vol. I. p. 433. London. Edward Arnold & Co.

Wallace, A. B. (1960): The Plastic Surgeon and the newly born child. In Modern Treatment Year Book. Edited by Cecil Wakeley. p. 159. London. Batlliere, Tindall & Cox.