Tongue Tied Babies - Ref 274

with Dee Bell

5th December 2022

TRANSCRIPT

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Steven Bruce
Dee is a midwife and a lactation consultant, as well as being a specialist in tongue ties. So welcome to you Dee.

Dee Bell
Hi, there. Thank you for having me.

Steven Bruce
No, no, I'm delighted you can spare the time to be with us. You've got quite a connection with osteopaths, haven't you?

Dee Bell
I have, that's right. Yeah. So I sort of work in collaboration with a lady called Gilly Woodhouse. And she has been kind enough to advertise some of my courses. So my tongue tie awareness kind of training was initially, I kind of wrote it with midwives and birth workers in mind. But it has particularly appealed to paediatric osteopaths as a kind of ideal sort of partnership with what they do, and also to support infant feeding.

Steven Bruce
Audio drops out Woodhouse she's been on the show a number of times before, she runs a business called osteobiz because she set this up because her own son benefited hugely from cranial osteopathy when he was very small. But she is open to chiropractors and Dee is very open to work with chiropractors as well. It just happens that the connection so far has been with osteopaths but it's manual therapists isn't it?

Dee Bell
Absolutely, right. I told Gilly Woodhouse what I do that I support new parents with breastfeeding and she was sort of totally warmed to the subject and then I said to her, well, actually, I'd really like to be able to reach, you know, sort of manual workers. And she said, well, that's what I do so let's collaborate and then she advertised to them. And it's been a real kind of dream collaboration between the two disciplines.

Steven Bruce
That's interesing, because when I qualified as an osteopath, if someone had mentioned tongue ties to me in babies, i'd had just assumed I've got no role to play here. This is something I'm going to farm this out to a paediatric specialist in the NHS, and they'll have a snip, and that'll be it. But we've had loads of people in the studio, it seems like loads, over the last six months or so who have mentioned that tongue ties are often snipped unnecessarily, and it just seems to be the first port of call. It's an assumption made by many midwives, many mothers and many others in the medical professions. Is that the case?

Dee Bell
Well, it's very hot topic at the moment and I believe it's being overdiagnosed, so whilst there is something that's a true tongue tie, and can I go into the definition of a tongue tie, because that would help? Yeah, so a tongue tie means that the frenulum, which is the fold of skin underneath the tongue, is abnormally short or restrictive, and is impeding tongue function. And it's estimated that around 10% of babies that

are born, are born with a sort of, obviously short or tight, restrictive frenulum. However, there's also a title or a sort of theory about something called posterior tongue tie. And that means that the frenulum is further towards the back of the underside of the tongue. And I think the problem is, we all have a frenulum, or 99.5% of people, babies are born with frenulums. And these frenulums are being called a tongue tie. And because more and more parents are sort of trying to breastfeed and then maybe struggling to achieve the feeding that they want to, due to the lack of the support, everyone's kind of pointing the finger towards tongue tie. And parents sort of want an intervention that's going to help. And within the NHS, there's a really long waiting list. And then some parents are going private to have this done. And I think, you know, it's sort of fair to say that, potentially in some cases, there may be kind of financial aspects that kind of drives this overdiagnosis.

Steven Bruce
My experience of tongue ties myself is very limited, my grandson had a tongue tie that was snipped. And I'm assured that it resolved the feeding difficulties that were going on at the time. So, does that mean that it was definitely a tongue tie that needed to be snipped?

Dee Bell
Yeah, I would say so. So if the only thing that changed was the intervention of having the frenulum released, then obviously what they achieved was better tongue function. So when a frenulotomy is going to be performed, what we want is the normal tongue function, the ideal tongue function to be achieved. If the tongue is restricted or tethered in some way, then the tongue can't work in the way it needs to work to milk the breast, or even in some cases to bottle feed. So it can affect both bottle and breastfeeding. But you may hear about quite a few babies that have tongue ties released, and then the parents say it didn't work. And that's usually because the problems are coming much more from positioning and attachment. And that's the thing that we should be starting with, looking at what interventions should there be done before we're looking at surgery?

Steven Bruce
Right. And how would we recognise this as osteopaths? I'm not a paediatric osteopath, if patients come to me and they're talking about, as they do, about their children, you know, what might give me the clue that this is where they should be going?

Dee Bell
Well, the parent's likely to be consulting the osteopath with symptoms of difficulty latching the baby, possibly reflux. This is, you know, colic, obviously, these are the reasons that people are looking for support. And what we really need to do is find out first how the baby's being fed and have they sought the right support first. So rather than a midwife or a health visitor, the person to be able to do a proper assessment of breastfeeding would be a lactation consultant, or an infant feeding coach. And I think you'll find that the baby, when someone brings a baby to see the osteopath, they often haven't looked at the basics of feeding for first, so I would be wanting to make sure that they'd had those positioning and attachment looked at. And then looking at tongue function, and there are various tools that an osteopath can use depending on the training, one of the sort of simpler ones that's a very visual tool, is called the tabby tool. And this is basically a pictorial view of how the tongue should look. And that you're able to just visually see whether or not the tongue's lifting or creating a heart shape, I can show you something on

one of the slides, which shows you the difference between anterior and posterior tongue tie. And that might sort of explain it a little bit more. So within anterior tongue tie, this is the one on the far left, you have that membrane of skin, it's a fold, and it can be going all the way to the tip. Halfway, it just shows you in the middle there, and then anything further back than halfway is called posterior. But arguably, if you haven't looked at, you know, in the mirror at your own tongue, this picture of the posterior tongue tie there, will be what most people's frenulum actually looks like. But when you have the fold of skin coming right to the tip of the tongue, it's obviously going to prevent the tongue lifting as it needs to do in the mouth. And we will need it to create a nice sort of peristaltic motion like that. When you have a tight membrane at the front of the tongue, you get kind of an up and down motion, which sort of impedes the baby feeding well, they may also be taking in air, they may be coming on and off the breast, or delatching from the bottle. So if an osteopath were to do a physical assessment of the baby, they might want to be also looking at, can the tongue extend? Can it lateralise side to side, if you do sort of oral examinations, then we get the baby to suckle on the finger and see whether the baby's able to wrap the babies' tongue around, so if they can cut, and if they can use that peristaltic motion. But one of the main things with this posterior tongue tie argument is also something called the faux tie. And that's where it appears that the baby's tongue isn't functioning as well as perhaps it could, but doing a frenulotomy or doing a surgery procedure is not going to do anything to help loosen up the muscles. And it could be something to do with, you know, the neck joint, it can be to do with the root of the tongue, you know, sort of sub occipital. So we really want some manual work to be done to see what they can do to get the baby sort of functioning correctly, particularly if there's been assisted birth, so babies being born with one, two, so forceps, those babies have got quite a lot of sort of, you know, stresses on the body and need to recover. We don't want to be going in, you know, sort of releasing the frenulum, when actually it may not be necessary at all.

Steven Bruce
But in that faux tongue tie, you say that there certainly wouldn't be an anterior frenulum.

Dee Bell
No.

Steven Bruce
So there's not really any obvious need to snip other than the fact that the feeding is not going well.

Dee Bell
Yeah, exactly. Yeah. So if the frenulum appears to be towards the back, feeding isn't going well. It could just be muscular tensions. And I would want that baby to be treated first. And also have a full breastfeeding or feeding assessment from someone that knows what they're doing before we're talking about doing a surgical intervention. I think the main problem is parents want a quick fix. So if you're told that actually the baby just needs a frenulotomy, they're keen to have as you say, a snip done, thinking that that's going to solve all their problems. And then obviously, they're usually quite disappointed to find that, you know, it hasn't, maybe weight gain's still a problem, reflux may still be a problem. And those problems aren't sorted out. So the gold standard really is to look at the interventions that can be done without it being invasive.

Steven Bruce
Okay, and you mentioned earlier on, obviously, I mentioned, and you mentioned you're a lactation specialist. Are all lactation specialists midwives?

Dee Bell
No, no. So you can be a lactation consultant, which is an international board certified lactation consultant, and that might be the only thing that they do. Midwives may be only trained in midwifery but may also be a lactation consultant. And then there are the various levels of breastfeeding supporters as well.

Steven Bruce
So for example, could osteopaths and chiropractors become lactation consultants?

Dee Bell
Yes. Yeah. So you would have to study to do that. Sorry, just a second. A bit of noise outside, sorry. Yeah, you'd have to study to do that. But to become a lactation consultant, you do 1000 hours of supervised practice, and you take a five-yearly exam to remain registered.

Steven Bruce
That won't be undertaken likely, 1000 hours of supervised practice.

Dee Bell
Exactly. But an osteopath that was a lactation consultant would be amazing, would be a great thing. We do have a group of osteopaths that have trained with me, who have trained to come in from feeding coaches. So now what they're offering is sort of mother and baby checks. And they're also able to provide support with feeding as well.

Steven Bruce
Okay, thank you. I've got some questions coming in for you. I got quite a few questions coming in for you here. But I'm gonna ask one of my own first of all, we've talked a lot about frenulotomies, which I now know when I'm using the correct term, I think at last, is there any downside to this? So given that it's a quick fix, in some cases, is it worth trying anyway, because there's no harm done?

Dee Bell
The babies do feel it for a start. So I'm often told by parents, oh, the baby won't feel it, will they? And I know that the baby does feel it. It's quite minor. And it's a very quick procedure. But I can definitely tell you that, you know, when the baby does feel it, and when they don't feel it, but they cry for maybe 10 seconds. So it is minimal, but it's like having a you know, a vaccination or something like that. If you were to release the mucosa, and the fascia underneath the tongue, potentially, there's always a minimal risk for bleeding, which we quote at about one in 7000, there's about a one in 10,000 risk of infection. But they are still a small risk, you know, that can happen. Usually, with one frenulotomy, we don't see any downside, but potentially, you could be causing scar tissue. And some parents, I've known parents have two or three procedures done on their baby. After a second procedure, the majority of us from the Association of Tongue Tie Practitioners, we wouldn't do more than two. But I have heard of babies having

as many as four or even five procedures, while the parents are still trying to sort of solve a problem. And obviously, in that case, you could be causing more and more scar tissue underneath the tongue.

Steven Bruce
So I guess my question there, and I'm delaying these questions, again, is if you're going to have more than one procedure, is that because that some part of the frenulum has healed and grown back, sealed back up, if you like, or are they just cutting further and further towards the back of the tongue to try and get the problem solved?

Dee Bell
Yeah, so it can be a couple of things. So sometimes, there are some surgeons that might do what we call a cosmetic release. And that would be just cutting just a very, very small amount of the anterior part of the frenulum. And it may not be enough to allow true tongue function. So that might mean that they need a second procedure to fully complete the release. Usually, when we do a tongue tie release, a trained practitioner will do what we call a full release, and that opens up the mucosa and the fascia. And I've got a picture here actually, that I can show you of before and after a tongue tie release that will depict this for you. Just one second, there we go. So this is a really anterior frenulum and a really thick one that's coming from the underside of the tongue right down to the back of the gum. And then on the right-hand side there, you can see what happens when that's released, it opens up into a diamond. Now that diamond shape has to repair, and you get sort of like a wet scab over it so it looks like a ulcer. And what potentially happens is as that heals, it can contract down and thicken, and those sometimes need to be rereleased. What we want is for the floor of the mouth to repair with that kind of new sort of height and release to the tongue function. And that's what we're trying to achieve. So you've seen there where the tongue was only able to lift you know about a centimetre from the gum, suddenly, it's free to lift all the way up. And that's what we're trying to keep to allow the tongue to keep its function.

Steven Bruce
How do you encourage that to remain the case after that drastic, frenulotomy there, presumably feeding is going to help. But what can you do to prevent it from shortening, thickening and becoming less effective, less functional?

Dee Bell
So, within the NHS, they don't recommend anything other than regular feedings. So with a young baby, they'll just recommend that the baby's fed every two to three hours. Within the Association of Tongue Tie Practitioners, we recommend non-invasive oral exercises. So that would be doing things like sucking onto the parents' finger and gently tugging the finger away as the baby suckles, so the tongue is hanging on to the finger and moving it, encouraging extension by tapping on the baby's lips to get the baby to bring their tongue forward. And also, the parent being able to hold and look at the baby's sort of about 30 centimetres away where they can focus and stick their tongue out at the baby because they will mirror it. And you can also do lateral exercises where you're just rubbing either side of the gums to get the baby's tongue to go side to side. So really, what we're doing is what we call physio, or oral play. In my opinion, it should always be something that's fun for the parents, pleasurable for the baby, they enjoy doing this. And it should never be anything that's stressful or painful. There are some advocates for what we call disruptive wound management. And this is what's recommended in America. And that actually involves

breaking the wound open, any of the healing fibres, actually rubbing off the slough, breaking the fibres open and doing what we call stretches. But that's not advocated usually in the UK and not by the Tongue Tie Practitioners, the Association of Tongue Tie Practitioners.

Steven Bruce
Well, all those things you've just said, presumably, they're good after any frenulotomy, not just a fairly drastic one, like that last one. And all of those things are things we could mention to our breastfeeding parents parents in passing as part of their own treatment, couldn't we? Your child had a frenulotomy, have you made sure you're doing these things just to make sure the tongue stays mobile? Would that be worth us mentioning?

Dee Bell
Absolutely, yeah. Because what we want is also the brain to realise that the tongue has now got a different range of motion. So it's about that kind of connection of the brain and the tongue kind of connecting together and realising, getting the baby's tongue, particularly like extending because it needs to come out and scoop the breast. And also for preparation for speech in later life, you want that full range of motion, the frenulum will have been tethered from the embryo all the way through the pregnancy, and right up until the point that it's released, so that baby's tongue has never had that full range of motion.

Steven Bruce
Okay, well, for years, when I've been out in the high streets or in cafes, and I'd see small children, I stick my tongue out of them because they seem to find it amusing. I shall now extend that policy to babies when I see them as well, just in case. Questions from the audience. Pip says, how frequently do you think babies with tongue ties should be treated especially post frenulotomy?

Dee Bell
So how frequently should they be...

Steven Bruce
Treated.

Dee Bell
By the osteopaths, do you mean?

Steven Bruce
Or the chiropractors.

Dee Bell
Yeah. I would suggest that a baby that's come in and had a significant restriction and then had a frenulotomy performed, I would just want them to be sent for a sort of an MOT. Depends kind of on your opinion, I wouldn't recommend a particular number of treatments, but usually the osteopaths that have been working with me, they would normally see them for maybe three treatments after a frenulotomy, and it's definitely the NHS, the midwives and the tongue tie practitioners are very pro body work now, particularly in private practice. I know that they're referring to chiropractors and osteopaths as follow up,

and then we would take your opinion as to whether or not the baby needed, you know, one or more treatments. But there's definitely things, if a baby's had a very, very restricted tongue tie like the picture I showed you before, I would want somebody to check that baby over, check the hyoid, you know, check how the sort of all the bones are functioning after the release. And in our clinic, as part of the course we had them check the baby before the frenulotomy, perform the frenulotomy and then physically you feel them again, and the relaxation, the shoulders coming down, you know release through the fascia through the body can literally be felt, you know, before and after the procedure.

Steven Bruce
That is encouraging. Pip also asked if there's anything you would do to help babies with a floppy larynx?

Dee Bell
No, we don't. So no feeding advice. So in terms of if somebody was seeing a baby that had laryngomalacia, then we would always look at the positioning that the baby is actually fed in. So it improves the milk transfer, when a baby is lying on their back, in that kind of traditional cradle hold, that often is one of the positions that can cause the condition to affect feeding, sort of more significantly. So a baby sitting up in what we call koala hold and also the parent leaning back to feed them is really important. So if you were seeing a baby with laryngomalacia that's struggling to feed, then again, I would recommend a referral to an IBCLC or an infant feeding coach, and they can go through positions that are going to improve it but there isn't anything that we can do to actually improve the condition.

Steven Bruce
I'd say my medical vocabulary is growing rapidly today. Laryngomalacia, wonderful. Nikki says she's seen a lot of tongue tie babies more recently with lack of resources and education to resolve within hospital or shortly afterwards, is very clear about the degree of tongue tie and lip tie, which if not dealt with, causes a lot of distress for infant and parents. It causes overmedication, giving up on breastfeeding, etc, speech and eating challenges when the baby is older. So that's not a question. Nikki's just sending in her own opinion about how this is affecting children. Is it your experience as well that the NHS is getting worse at treating tongue ties, I don't mean worse in terms of what they can do, just in their ability to do it?

Dee Bell
Yeah, so what's happening is it's being noted or picked up by the parents or by the midwife who does the sort of the baby check, which is called the NIPE. The parents are sort of told that the baby has a tongue tie, but then the hospital often doesn't have the facilities or a clinic running where they're able to treat it. The waiting list to be seen within an NHS clinic is some sort of between two and six weeks. And if a parent is struggling to feed the baby, whether that's breast or bottle feeding, obviously, a six-week wait is too long. And that's why a lot of parents are having to be seen privately. The other problem is, as you said before, too many people are being told the baby has a posterior tongue tie. And therefore, they're being referred to the NHS clinics and then blocking the appointments. So a baby with a really severe anterior tongue tie may not get treated.

Steven Bruce
In which case, presumably that baby's going to have problems receiving the nutrition that he or she needs. that potentially has dire consequences. So what in reality does happen, because I don't hear of babies dying from tongue tie on a regular basis.

Dee Bell
So what happens is usually they move over to bottle feeding. And because a bottle drips, they may have to try several bottles, but they will usually be able to bottle feed. The other thing is that the baby may feed very frequently. I've seen bottle feeding parents having to give the baby an ounce sort of every hour, because the baby's too tired to carry on. They're even sort of almost squeezing the bottle, you know helping the baby get the milk. And if the baby's weight isn't affected, then that doesn't put them as priority, and the parents are actually compensating for the baby's feeding issues. And also, if a baby's on formula, they often don't qualify to be seen in the NHS because they're not breastfeeding. And in that case, they would have to see a private practitioner. And private practitioners will see babies that are bottle feeding or breastfeeding, as long as the tongue tie seems to be impacting the baby's feeding ability.

Steven Bruce
Right. Simon's just sent in his observation that the medical literature used to state that the posterior tongue tie was irrelevant. Is that still the case? Because he thinks it's very relevant.

Dee Bell
Yeah, so I've just got a slide on my screen now that shows you actually what I would call a true posterior tongue tie. So, as opposed to just simply a frenulum at the back, so the left is an anterior tongue tie, obviously, the very classic one that everybody can diagnose because you can't help but see it. But on the right, you would have to lift this baby's tongue and you can see the tension through the mucosa, and fascia in that baby's tongue tie there, and this baby was a baby that I treated, who was really struggling to breastfeed, mum was compensating by feeding several times an hour. And we were able to release that frenulum and then the baby to feed significantly better almost immediately. So there is something, definitely a true posterior tongue tie, and it definitely impacts on feeding. I think the problem is, parents getting a diagnosis from people that aren't, you know, aren't qualified to give that diagnosis. And it's also very, very big on social media. Parents are following a lot of people on social media who are, I know two accounts, one account that's called Released The Ties, which is a mum campaigning for all ties to be cut. And then I also, conversely, another account, sort of basically saying it's barbaric, and they should all be stopped. Also, I noted what one of your viewers mentioned, a lip tie. A lip tie is this labial frenulum here, and we don't treat lip tie in the UK at all. And as a lactation consultant and midwife of over 20 years, I've only ever seen about four true lip ties where the lip was actually fused, and therefore it would cause a problem with feeding. The rest of them are just a labial frenulum, which is normal. And I think this is the thing, it's about practitioners that are looking, understanding the difference between normal anatomy and something that's actually causing a problem.

Steven Bruce
Caroline has asked what the link is between tongue ties and reflux?

Dee Bell
Well, there's some research that links the two, for different reasons. One is because obviously the tongue is the beginning of digestion in the body. And we also need the tongue to be functioning correctly. So aerophagia may be another kind of sort of contribution. So if the baby's taking in a lot of air, either at the breast or particularly on the bottle, then air going down into the stomach can cause reflux. There are some practitioners, reflux specialists or reflux practitioners, who are very much blaming tongue tie for it. I tend to err on the side of, the diagnosis of babies with reflux is a massively over diagnosed thing. And if we look at the feeding and correct positioning and attachment first, the reflux rates will go down. You know, it's the same with colic, most of these things are about correct positioning and attachment. But potentially, the baby taking in air can also contribute to them sort of being sick a lot.

Steven Bruce
You know, I don't imagine there's any topic in the world which doesn't have polar camps on social media, one campaigning violently and vigorously for one thing, while the others do exactly the same in the opposite direction. It's a shame when it might affect the health of a baby, of course. Nikki says cranial osteopaths consider cranial nerves 9, 10 and 12 in association with the tongue. Do you also take this into consideration? Would you suggest to cranial osteopath first and a surgery later in some cases?

Dee Bell
Yeah, for sure. So this is my opinion, so depends, when a baby has an anterior tongue tie, I personally would recommend that that is released with or without bodywork, because it isn't just the immediate, it can go on to cause problems with eating solids, speech, later life orthodontics and also even adult patients or adult people with a tongue tie have long term sort of health issues sometimes caused by the restriction. So when there's a really, really restrictive frenulum, I would recommend that that is released and then they have body work. If a posterior tongue tie has been suggested, then I would definitely 100% look at what we can do sort of physically first without doing an invasive procedure because I believe that's why the rates are so high. We're going in with surgery straight away. And if you only look at do the surgery, then the parents are going to be disappointed by the outcome because that's when they start saying that it didn't work, or it wasn't cut properly. Because they haven't seen the benefits that they want.

Steven Bruce
Lucy's asked, how likely the frenulum is to reattach. She says she's seen kids who've needed it to be redone, which you've mentioned already. And she also asked about the exercises. We talked about the exercises. Is it common that they reattach?

Dee Bell
So, we don't know, we don't have the numbers, the Association of Tongue Tie Practitioners estimate around 4% of the cases that we see need to be rereleased. The reason we don't know is because we can't follow up all the parents, a lot of us try to follow up our own caseload, but we'll send an email, we'll send a message, we give them a call. And because of the postnatal, you know, the nature of life at that time, they often don't get back to us. So it's very hard to get really good hard data on the improvement. Anecdotally, when I see babies again, the frenulum reforms, because the frenulum is just the floor of the mouth and the mucosa. And it's actually a fold. It's not a band or a chord, which is what people used to think, it's a fold of the underside of the mouth. And when that sort of ulcer forms and the new surface,

you know, repairs, it's going to cause a new fold, but what we're looking for is for that fold to be further back and less restrictive. So unless we saw all the babies again ourselves to reassess them, we don't know how many reform. But it's said that those exercises or it's thought that those exercises will help, but I don't think that we can actually directly influence it. It depends on the cell programming and how that individual baby heals.

Steven Bruce
I did say to people before we came on air in my sort of email earlier on today, or the one that went out earlier on today that there was new evidence in this and that was it. I think the new evidence that it isn't a band of tissue, isn't a band of fascia is actually a fold. How recently was that discovered? Because it seems like a strange thing to come to light recently.

Dee Bell
So in 2018, research by someone called Nikki Mills. And they basically did some studies on cadavers. And those studies showed us that it's a fold, not a band. And that's really changed everything. So that was published in 2019. But as we know, it takes a really, really long time for research to come out into the mainstream, and parents are still calling it, or I'm still hearing a band string. It used to be thought that with a posterior that there was kind of a mast and the bit at the front was a sail. And therefore, some people saying that what we were cutting was just the sail of the tongue tie and leaving the mast in place as if it was like a post. And that's now been refuted by Nikki Mills' research showing that the frenulum is a normal occurring, you know, sort of phenomena. And as I say, 99.5% of people have a frenulum.

Steven Bruce
And I guess actually, when it comes to doing that sort of research, babies must be quite hard to come by for cadaveric studies because you don't get many babies that die in infancy, do yiou, relatively speaking, pretty much everybody else dies at some point.

Dee Bell
Yeah, we have actually got the Nikki Mills study too, that we can share with you for people to have a look at. And I would thoroughly recommend those two papers and in fact, I've just got them up on my other screen. So one of them is called What is a Tongue Tie - Defining the Anatomy of In-situ Lingual Frenulum and the other one is Defined the Anatomy of The Neonatal Lingual Frenulum. And I would really recommend those two studies are read.

Steven Bruce
Well, we've got quite a lot of references I know that you've shared with us which we'll send them out by email after the show. So everybody's got the opportunity to do that. And Curleen actually asked how one gets onto your course to become a lactation consultant. I imagine we'll be sending out links for that as well.

Dee Bell
Yeah, so I teach to, one is to become an infant feeding coach. And you can just contact me on Instagram, which is the Infant Feeding Academy, or through the links that we've shared. And then the other one after becoming an infant feeding coach, it's kind of a postgraduate to become a Tongue Tie Assessor, or we

will have osteos and chiros if they've got an appropriate background, they can become a tongue tie assessor as well.

Steven Bruce
Right. That would be really useful. Gregor sent in quite a long comment here. It says it's so brilliant to have this topic explored just now. As a cranial osteopath specialising in obs and peds, it would be ideal to share her own insights of the pandemic versus referrals for tongue tie, there's a correlation apparently, referrals for tongue tie have also now shifted from midwife consultant based to now lactation consultants and breastfeeding specialists and midwives, which is great, but the criteria for assessment appears to have shifted as well. And quite often private practice midwives are diagnosing and carrying out the procedure simultaneously without the option for referral or a second opinion. Does that ring bells with you?

Dee Bell
Yeah, absolutely. So to reduce the numbers that were being sent into, by midwives, a lot of trusts have made it that two lactation specialists have to agree and then send the baby in. Because the person who's actually performing the frenulotomy only has perhaps 15 minutes. So they're not going to be the person who's doing the, you know, who's checking, positioning and attachment, checking to see whether or not the baby's got torticollis, all that kind of thing. So the two lactation specialists are supposed to kind of have vetted the case and then referred them in so the person performing it can just go ahead and perform them. In reality, that doesn't actually happen. I happen to know that, you know, they may get the two referrals, but one person didn't even get the baby out of the car seat. So that doesn't necessarily work. But that is the ideal. In private practice, as you say, there are some private practitioners that are the person that are assessing and can perform the frenulotomy, I would be very concerned if that private practitioner isn't also a lactation consultant. So the level that you want from your tongue tie practitioner is somebody who is a lactation consultant, or infant feeding coach, and ideally, usually a midwife or healthist as well. If they're a private midwife, in theory, they have the knowledge, but in my experience in teaching on the courses that I teach now, the midwives don't have as high a level of knowledge about infant feeding as we think they do in the public. So yeah, very difficult, it could be that there's financial gain as well. You know, you would hope not within this profession.

Steven Bruce
So, the people more likely to have that knowledge, are they going to be the nurses who visit parents as a follow up after, you know, after they've gone through their childbirth and so on?

Dee Bell
Sorry, the knowledge about how to support breastfeeding?

Steven Bruce
All of this actually, the whole business of breastfeeding, about recognising tongue ties and so on, is that something that nurses are specifically trained in?

Dee Bell
No, so this is the problem. Within the NHS, coming through university now, they do some breastfeeding knowledge, you know, breastfeeding modules, etc. The level that they're trained is a lot lower than you would think. Maternity support workers are often being sent on courses to improve their knowledge. And each hospital should have BFI which is the Baby Friendly Initiative as a minimum standard, but many hospitals are not even going for this standard. So whilst parents think that they are consulting an expert, they often used to say to me, oh, the breastfeeding ladies come along, and the breastfeeding lady would have been somebody that maybe has had six hours of training. So our health professionals are just not trained to a high enough level in infant feeding. It tends to be a private thing. And many trusts don't employ lactation consultants, they don't see the need. Unfortunately, even though when you do have services that have quite a high level of training for their staff, breastfeeding rates nationally are still only going up very, very slowly. We only have the breastfeeding rate of 1% at six months that are still exclusively breastfeeding.

Steven Bruce
Right. Okay, well, it's perhaps disappointing, but thank you. Evan has brought up a topic which I was hoping we'd get round to. I think we've just got a few minutes left. You and I discussed the whole business of adults having unresolved tongue ties. Are you aware of the impact it can have on an adult's life?

Dee Bell
Yeah, so various studies that have been done, again, we don't have really good sort of evidence in this, but we know that a tongue tie can cause problems orally, particularly with the back teeth. So often, you'll have, in fact, I've had a dad recently, come and I said, have you got any problems? And he said, no, I said, you didn't have any problem with your teeth? And he said, no, I've had them out. So I think that kind of proves my point. So if you can't take the tip of your tongue round your jaw to clean your teeth, which most of us naturally are able to do, it can cause problems with the back of the teeth. It caused problems often with a jaw thrust and posturally, like a compensation because the tongue isn't moving freely, people often overuse the jaw. And then also, you know, you've got that kind of neck posture coming forward. It's also, there's more kind of research coming out, showing that it can affect balance, you know, that kind of thing. There was a story about a young lad who was a bit dyspraxic and had difficulties and had a tongue tie released at the age of about six or seven, and then was able to ride his bike and he hadn't been able to do so. Because the fascia under the tongue goes all the way through the body, right, you know, right down to the toes. And it can really affect the posture. And what I've seen in the babies is after the tongue tie release, tightness is like this, where their shoulders and everything is able to come down. So the other thing is speech. Only really, the anterior tongue ties are something that obviously we might see with problems with speech, because of saying, la, sa, ta, all of those positions of the tip of the tongue, but many people will compensate by overusing the jaw to make, you know, to make the sounds. So again, more research is needed. But it definitely affects adults, and also for teenagers socially, kissing, sticking your tongue out at people, that kind of thing. So it definitely has effects, you know, sort of going through the different ages.

Steven Bruce
And I'm sure there are some chiros watching can work out quite a few of the potential complications of not being able to move your tongue that way. And personally, I'm thinking as a first aid instructor, actually

has one benefit that presumably your tongue can't fall back and block your airway if you're unconscious. So I'm not suggesting that's a reason not to resolve a tongue tie one way or the other.

Dee Bell
Sleep is the other big area, which I don't know whether, you know, the chiros and osteopaths would sort of see patients for so sleep disordered breathing, because the tongue is supposed to sit in the roof of the mouth. And sitting in the roof of mouth means that it widens the palate. When the tongue can't widen the palate, you get a high arched palate and narrow airways. And there's so there's been sort of quite a link towards like sort of snoring and sleep apneas due to tongue tie, because the tongue is in the airway and not sitting in the roof of the mouth as it should.

Steven Bruce
Dee, we haven't got any time left, we've run out, which is a shame, still got loads of questions, and it was fascinating. And I probably ought to apologise to the audience that I asked a whole lot of questions myself beforehand, before getting to theirs. Can I send a few of these through to you on email? So I can answer them in my email out to the audience later, because we've had 370 people watching. So it's clearly a popular lunchtime topic, this one.

Dee Bell
Yeah, absolutely.

Steven Bruce
I'll do that and I'll send the links that you gave us as well. And we'll hopefully that'll be useful for the audience. But thank you very much for joining us. That is today's 45 minutes of CPD done, I'm afraid. I hope you found it interesting. I certainly did, as well as useful for your own clinic work. I mentioned that we've set up a new course with Laurie Hartman for April, it's taken us a while to sort things out with him for various reasons, which I'm not going to go into. But he's agreed to run this next one on the first and second of April. That's a weekend, I'm sure I don't need to tell you just how popular his courses are and what a brilliant instructor he is. So I would urge you to get on that course as soon as you can. You can't quite do it yet, because we haven't set up the webpage. But I'll send out the details of that tomorrow with the email about Dee's discussion today. I do appreciate that it's Christmas. And with all the expense that entails we've set up four things to make it easy for you to get on the Laurie Hartmann course. First of all, there's an early booking discount of 48 pounds, which is available till the end of the month, there's a member’s discount of 50 pounds. And third to secure a place you only need to pay a deposit of 75 pounds up front. The final thing is that the rest of it can be paid in two instalments because I'm personally very keen to get as many people as possible on Laurie Hartman's course because it is so good for osteopaths and chiropractors. Don't forget we're also running the hypo pressives course in February, more maternal stuff, really because this can be life changing stuff, particularly for those postnatal ladies with the problems that often go with that. We ran a show on the topic a few months back that was called something like treatment for leaky ladies. And the awful thing that struck me out of that was that most women just put up with problems like incontinence because they assume that nothing can be done. So, like I say, this course can be life changing for the 1000s of ladies in that position. So very helpful for you as a practitioner. We have got two shows left for you before the Christmas break. They're both going to be fantastic Claire Minshull, Serena Simmons, they will be joining me in the studio on Wednesday evening

this week and we'll be talking about the psychological aspects of patient compliance. I've said it before, but Claire is a real live wire, Serena Simmons likewise, you can expect some real fun from that broadcast as well as more evidence-based clinically relevant CPD, which will definitely help you and your patients. Next week, the final broadcast on Tuesday evening. It's a very welcome return for Nick Burch and John Graham, Nick, the spinal consultant with a brain the size of a planet. John, a superb rehab physio, they're going to be talking about the latest approaches to treating chronic pain and neurofeedback training, and we're going to be demonstrating some kits in the studio which I guarantee You will not have seen before. So there'll be a whole heap of really useful practical stuff in there. All evidence based as usual. I haven't got time to go through everything else that's in the calendar maybe I should just mention, there's an online first aid course in February, but you can check all this out on the app or on our website. But we will be delivering a huge range of stuff from autogenic training, mindfulness to shoulder treatments and much more in the new year. I've waffled on long enough. Hope to see you again on Wednesday evening, but for now, good afternoon.