STANDARDIZED PROCEDURE
LINGUAL FRENOTOMY (Neonatal, Peds)

I. Definition

Lingual frenotomy is the release of a tight or short lingual frenulum to relieve oral-motor dysfunction. Frenotomy is performed for ankyloglossia, also known as "tongue tie," which causes poor latch in breastfeeding resulting in frustration at the breast and maternal nipple pain in infants. Tongue tie, if untreated can result in pediatric dysarthria.

This procedure can routinely be performed on newborn infants (less than 4 months of age) in the ambulatory setting, but is best performed in the operative setting under general anesthesia for older pediatric patients.

II. Background Information

A. Setting: The setting (inpatient vs outpatient) and population (adults vs pediatrics) for the Advanced Health Practitioner (AHP) is determined by the approval of the privileges requested on the AHP Privilege Request Form. If the procedure is being done on a Pediatric patient, make sure Child Life is involved and use age appropriate language and age appropriate developmental needs with care of children, as appropriate to the situation.

B. Supervision: The necessity of this procedure will be determined by the Advanced Health Practitioner in collaboration with the supervising physician or his/her designee. Designee is defined as another attending physician who works directly with the supervising physician and is authorized to supervise the Advanced Health Practitioner.

Direct supervision will not be necessary once competency is determined, as provided for in the procedure. The Advanced Health Practitioner will notify the physician immediately upon being involved in any emergency or resuscitative events or under the following circumstances:

1. Patient decompensation or intolerance to the procedure
2. Bleeding that is not resolved
3. Outcome of the procedure other than expected

C. Indications:

Frenotomy is indicated in infants with symptomatic ankyloglossia as reported by the caregiver/parent. There is sometimes a family history of this condition. On examination using the Hazelbaker Tool for rating ankyloglossia, the patient is noted to have a less elastic, tight lingual frenulum, often less than or equal to 1cm in length, resulting in a clefted or V-shaped tongue tip. Tongue motion is limited in extension, lateralization and/or lift, making sucking difficult as assessed by cupping, peristalsis, and snap-back of tongue on examiner's gloved finger.

D. Precautions/Contraindications

Frenotomy is a procedure performed with minimal pain in an awake, restrained infant that requires thorough knowledge of oral anatomy. Contraindications of this procedure include bleeding.

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III. Materials

1. Sterile isis scissors
2. Sterile grooved retractor (optional)
3. Gloves
4. Gauze

IV. Frenotomy procedure

A. Pre-treatment evaluation:
Patient's history is obtained from parent/guardian and a preliminary head and neck physical exam is performed including visualization of the lingual frenulum and tongue function.

B. Set up (if applicable):
Frenotomy is performed with infant patient in a supine position with head and arms restrained.

C. Patient Preparation:

1. Informed consent is obtained from legal guardian/parent of patient.
2. Patient is identified with two approved patient identifiers prior to start of procedure.
3. Antibiotics are not required. Local anesthetics are not required.

D. Procedure:

1. Ensure that all pre-procedure steps are taken and a time out is performed prior to the procedure.

2. With the infant appropriately positioned and restrained, the tongue is lifted gently with fingertips, gauze, or a sterile, grooved retractor to expose the frenulum.

3. The thinnest portion of the frenulum, adjacent to the ventral aspect of the tongue, is divided by 2 to 3 mm using sterile isis scissors. Care is taken to avoid any vascular structures in base of tongue, genioglossus muscle, and gingival mucosa. Care is taken to avoid injury to the sublingual glands.

E. Post-procedure:
After frenotomy, the blood loss should be minimal (just a few drops of blood). Pressure may be held with a small gauze pad on the site if bleeding occurs. Crying is usually limited to the period of restraint. If possible, infant should be immediately breastfed to assess the efficacy of the procedure. Breastmilk is ideal for the next few feedings due to its anti-infective properties.

F. Follow-up treatment:
No routine post-procedure diagnostic testing is required.

G. Termination of treatment
Procedure ends when tongue is reexamined several minutes after the frenulum is incised.

V. Documentation

A. Documentation is in the electronic medical record

1. Documentation of the pretreatment evaluation and any abnormal physical findings.

2. Record the time out, indication for the procedure, procedure, EBL, the outcome, how the patient tolerated the procedure, medications (drug, dose, route, & time) given, complications, and the plan in the note, as well as any teaching and discharge instructions.

B. All abnormal or unexpected findings are reviewed with the supervising physician.

VI. Competency Assessment

A. Initial Competence

1. The Advanced Health Practitioner will be instructed on the efficacy and the indications of this therapy and demonstrate understanding of such.
2. The Advanced Health Practitioner will demonstrate knowledge of the following:
    a. Medical indication and contraindications of lingual frenotomy
    b. Risks and benefits of the procedure
    c. Related anatomy and physiology
    d. Informed consent process
    e. Steps in performing the procedure
    f. Documentation of the procedure
    g. Ability to interpret results and implications in patient management.
3. The Advanced Health Practitioner will observe a clinical expert for three procedures, with special attention to technique with orienting scope. The AHP will then assist the clinical expert for three procedures. The AHP must perform this procedure with direct supervision of attending/supervising physician providing guidance for **three** procedures to verify clinical competence prior to performing frenotomy under indirect supervision.

B. Continued proficiency

1. The Advanced Health Practitioner will demonstrate competence by successful completion of the initial competency.
2. Each candidate will be initially proctored and signed off by an attending physician. Advanced Health Practitioner must perform this procedure at least **three** times per year. In cases where this minimum is not met, the attending, must again sign off the procedure for the Advanced Health Practitioner. The Advanced Health Practitioner will be signed off after demonstrating 100% accuracy in completing the procedure.
3. Demonstration of continued proficiency shall be monitored through the annual evaluation.
4. A clinical practice outcomes log is to be submitted with each renewal of credentials. It will include the number of procedures performed per year and any adverse outcomes. If an adverse outcome occurred, a copy of the procedure note will be submitted.

VII. RESPONSIBILITY

Questions about this procedure should be directed to the Chief Nursing and Patient Care Services Officer at 353-4380.

VIII. HISTORY OF PROCEDURE

Revised June 2012 by Subcommittee of the Committee for Interdisciplinary Practice
Reviewed June 2012 by the Committee on Interdisciplinary Practice
Prior revision February 2010
Approved June 2012 by the Executive Medical Board and the Governance Advisory Council.