

## Tongue Tied Babies Ref 274

**Dee Bell**

Hi, there. Thank you for having me.

**Steven Bruce**

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 Judy Woodhouse. And she has been kind enough to advertise some of my courses. So the 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 appeal to paediatric osteopath as a kind of ideal sort of partnership with what they do, and also to support infant feeding.

**Steven Bruce**

Woodhouse she's been on the show a number of times before she runs a business called osteo. Biz 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 D is very open to work with chiropractors as well. It just happens that the connection so far has been with osteopaths but it's it's manual therapists isn't it? The so that's where the Yeah, so when I told no go on.

**Dee Bell**

I would totally would house 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 the you know 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**

Tongue ties to me and babies, it just assumed I've got no role to play here. It's, 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, but it seems like loads over the last six months or so who have mentioned that tongue ties are often snipped

unnecessarily and it's 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 being very short 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 the the tongue tie means that the friend Unum which is the 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 friendly limb is further towards the back of the underside of the tongue. And I think the problem is, we all have a friend in them, or 99.5% of people, look, babies are born with friendly limbs. And these friendly limbs 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 it within the NHS, there's a really big, 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**

very primitive, my 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 it was a definitely a tongue tie that needed to be slipped? 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 will what they achieved was better tongue function. So when a friend your lottery 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 awful feet. So it can affect both Buffalo 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 the what interventions should there be done before we're looking at surgery? Right?

### **Steven Bruce**

And how, how have we recognise this PDF? If patients come to me and they're talking about as they do about their children, you know, what, what might give me the clue that this is where they should be going?

### **Dee Bell**

Well, the parents 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 to 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 tongues 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 but 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 friendly limb 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 D latching 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 lateralized 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 cupping are able to wrap the babies you know, 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 by it appears, appears that the baby's tongue isn't functioning as well as it perhaps it could, but caught doing a friendly lottery or doing a surgery procedures not going to do anything to help loosen up the muscles. And it could be something to do with, you know, the 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 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 in that faux tongue tie, you say that the there would there would there certainly wouldn't be an anterior pendulum? No. 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 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. The thing I think the main problem is parents want a quick fix. So if you're told that actually the baby just needs a friend, your love to me, they're keen to have you as you say, this snipped, 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 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 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 at various levels of breastfeeding supporters as well. So the kind of top

**Steven Bruce**

could osteopaths and chiropractors become lactation consultants.

**Dee Bell**

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

**Steven Bruce**

Okay, so that's not that's not going to take an

**Dee Bell**

osteopath. So that won't

**Steven Bruce**

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 osteopath 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 friendly lottery's, which I 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**

So 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, it's 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 friend your tummy, we don't see any downside, but potentially, you could be causing scar tissue. And some parents, I've known parents have to have or 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 to 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, if you know 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 that those sometimes need to be re released. 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 can, you've seen that with the tongue was only able to lift you know that 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.

**Steven Bruce**

How do you encourage that to remain the case after that drastic, friendly, ultimately, the 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 or real exercises. So that would be doing things like sucking onto the parents finger and gently tugging the finger away as the baby cycles allowing the babies 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 lips, 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, you know, doing this. And it should never be anything that 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 sloth breaking the fibres open and doing what we call stretches. But that's not advocated, usually in the UK and not by the tongue, Thai practitioners, you know that the association of dental practitioners?

**Steven Bruce**

Well, all those things you've just said, presumably, they're good after any friendly lottery, not just a fairly drastic one, like that last one. And all of those things are things we could mention to our breastfeeding parents or female parents in passing as part of their own treatment, couldn't we? You've had a term your child's had a friend and ultimately, have you made sure you're doing these things just to make sure the tongue stays mobile? Would that be worth as 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 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 I've had I see when I've been out in the in the high streets or in cafes, and here's why 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 tie should be treated especially post for anatomy for Neurotomy?

**Dee Bell**

So how frequently should they be treated? By the osteopaths? Do you mean

**Steven Bruce**

or the car or the chiropractors? Yeah,

**Dee Bell**

yeah. I would suggest that a baby that's come in and had a significant restriction and then had a friendly lottery performed, I would just want them to be sent for a sort of an MOT. depends kind of on on your opinion, I wouldn't recommend a particular number of treatments, but usually the Osteopath that have been working with me, they would normally see them for maybe three, three treatments after a friend Neurotomy and it's definitely the NHS, the midwives and the tongue tie practice 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 to 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 friend you lie to me, perform the friend you lie to me and then physically You feel them again, and the relaxation, the shoulders coming down, you know release through the fascia through the body could literally be felt, you know, before and after the procedure

**Steven Bruce**

is encouraging. People 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 longer Malaysia, 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, and that kind of traditional cradle hold that often is one of the positions that can cause of the condition to affect feeding sort of more significantly. So a baby sitting up in what we bought while the hold. And also the parent leaning back to feed them is really important. So if you were seeing a baby with Lingam and Asia that 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. lingo Malaysia wonderful. Nikki says she's seen a lot of tongue tie babies more recently with lack of resources and education to resolve it's moved. So resolve within a hospital or shortly afterwards is very clear about the degree of tongue tie and lip tie, which you've 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 tied me 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 Nyepi. 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 that where they're able to treat it. The waiting list to be seen within the NHS 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 a peep of babies dying from Tongue Tied tongue tie on a regular basis.

**Dee Bell**

So what happens is usually they move over to bottle feeding. And because a bottle drips, if you 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 effective, effected, then that doesn't put them as priority,

because 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 that 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, the medical literature used to state that the posterior tongue tie was irrelevant. Is that still the case? Because he's he Simon 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 refer just as simply a friendly limit the back so the left is an anterior tongue tie. Obviously, they're 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 top If 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 it 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 noticed what your one of your viewers mentioned, lip tie, lip tie is this label 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 that for 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 labour, your friend, your limb, 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**

Kirlian 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. So and we also need the tongue to be functioning correctly. So error aphasia 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 are 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. It's most of these things are about correct positioning and attachment. But potentially the baby taking an air can also contribute to them sort of being sick a lot.

**Steven Bruce**



You know, I don't 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, there's cranial osteopaths consider cranial nerves 10 910 and 12. In association with the tongue. Do you also take this into consideration? Would you suggest to cranial osteopathy osteopath first and a surgery later in some cases?

**Dee Bell**

Yeah, for sure. So this is my opinion. So debates debates, 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 parent patients or adult people with a tongue tie have long term sort of health issues sometimes caused by this 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 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 Though we don't know, we don't have the the numbers, the association and 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 friendly limb reforms, because the Phenom 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 also 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 it's very less 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 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 it's in 2018. There's negative research by someone called Nikki mills. And they basically did some studies on cadavers. And those studies showed us that it's 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, you know, for research to come out into the mainstream, and parents are still calling it, you know, or I'm still hearing, you know, a band string. There was it used to be thought that there was a with a posterior that there was kind of a mask as if there was like a kind of a mask. And the the the bit at the front was a sale. And therefore, some people saying that what we were cutting was just the sale of the tongue tie and leaving the mask in place as if it was like a post. And that's now been refuted by Nicky Mills is research showing that the friendly limb is a normal occurring, you know, sort of phenomena. And as I say, 99.5% of people have a friend Unum.

### **Steven Bruce**

And I guess actually, when it comes to doing that sort of research, babies must be quite hard to come by for categoric studies because you don't get many babies that died in infancy do relatively speaking know exactly pretty much at some point.

### **Dee Bell**

Yeah, we have actually got the Nicki Mills study too, that we can share with you for people to have a look at. And I would thoroughly recommend the to 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 of the studies that I read

### **Steven Bruce**

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

### **Dee Bell**

Yeah, so Mike, I teach to one is for coming in from feeding coach. And you can just Yeah, 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 our studios and Cairo's if they've got an appropriate background, they can become a tongue tie assessor as well.

### **Steven Bruce**

Right? That would be really useful. Carol Gregor sends 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 herbs 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 in our 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 are 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, they a lot of trusts have made it that to lactation specialists have to agree and then send the baby

in. Because the person who's actually performing the formula to me 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 refer 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 friendly law to me, 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 health is to 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 as we think they do in the public. So yeah, very difficult, though, it could be that there's financial gain as well. You know, you would hope not within this professional

**Steven Bruce**

people, with 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**

So their knowledge about the the brace 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, the coming through university, now they do some breastfeeding, knowledge, you know, breastfeeding modules, etc. The level that they're trained is, 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 they are consulting, an expert, they often used to say to me, or the breastfeeding ladies come along, and the breastfeeding lady would have been somebody that maybe has had six hours of training. So the training is our health professionals are just not trained to a high enough level in infant feeding. It tends to be a private, 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 it. I think we've just got a few minutes left. But you and I discussed the whole business of adults having resolved 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 tongue tie can cause problems or really, particularly with the back teeth. So often, you'll have in fact, I've had a dad recently, come on, 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 posture, Lee, 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 effect balance, you know, that kind of thing. There was a story about a young lad who, who sort of a bit dis Praxic 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 as after the tongue tie release, tightness is like this, where that 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, lotsa, tuck 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 Cairo's watching can 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 the reason not to resolve a tongue tie one way or the other.

**Dee Bell**

No, sleep, sleep is the other big area, which I don't know whether, you know, the Cairo's 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 apnea is due to tongue tie, not because the tongue is in the airway and not being sitting in the roof of the mouth as it should.

**Steven Bruce**

The only time that we've run out, which is a shame, you're still got loads of questions, and it was fascinating