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# Coverage indicators in the implementation of lingual frenulum assessment in babies at a university hospital

## Indicadores de cobertura na implantação da avaliação do frênulo lingual em bebês em um hospital universitário

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## ABSTRACT

**Purpose:** To evaluate the first six months of implementation of the lingual frenulum assessment in a university hospital. **Methods:** The database of newborns in the hospital during the period of implementation of the lingual frenulum screening was analyzed. Healthy newborns of both sexes and admitted to rooming-in care were included in the study. **Results:** 1151 babies were born during the study period, of which 974 were admitted to rooming-in care and met the inclusion and exclusion criteria. 824 babies underwent lingual frenulum screening. It was possible to observe that the lingual frenulum screening reached, on average, 84.1% of newborns in rooming-in care in the months studied. Of the total evaluations performed, an average of 89.8% of normal cases and 6.6% requiring outpatient reevaluation were observed. The average number of cases identified with ankyloglossia during neonatal screening was 3.5%, and at outpatient follow-up it was 38.5%. The average percentage of absences at reassessment was 28.6%. **Conclusion:** in the first six months of implementation of lingual frenulum screening, it was possible to verify that screening coverage was 84.6% and that there is a need for strategies to expand coverage, as well as for greater engagement of the target population in the proposed procedures, both reassessment and intervention.

**Keywords:** Lingual frenum; Ankyloglossia; Neonatal screening; Newborn; Breast feeding

## RESUMO

**Objetivo:** avaliar os primeiros seis meses da implantação da avaliação do frênulo lingual em um hospital universitário. **Métodos:** análise do banco de dados de recém-nascidos no hospital no período da implantação da triagem do frênulo lingual. Foram incluídos no estudo recém-nascidos saudáveis, de ambos os gêneros e internados em alojamento conjunto. **Resultados:** nasceram 1151 bebês no período estudado; destes, 974 foram internados no alojamento conjunto e cumpriram os critérios de inclusão e exclusão. Realizaram a triagem do frênulo lingual 824 bebês. Foi possível observar que a triagem do frênulo lingual alcançou, em média, 84,1% de recém-nascidos do alojamento conjunto nos meses estudados. Do total de avaliações realizadas, observou-se média de casos normais de 89,8% e de 6,6% com necessidade de reavaliação ambulatorial. A média de casos identificados com anquiloglossia, já na triagem neonatal, foi de 3,5% e no retorno ambulatorial foi de 38,5%. O percentual médio de faltas na reavaliação foi de 28,6%. **Conclusão:** nos primeiros seis meses da implantação da triagem do frênulo lingual, foi possível verificar que a cobertura de triagem foi de 84,6% e que há necessidade de estratégias para ampliar a cobertura, bem como para maior engajamento da população-alvo aos procedimentos propostos, tanto de reavaliação, quanto de intervenção.

**Palavras-chave:** Freio lingual; Anquiloglossia; Triagem neonatal; Recém-nascido; Aleitamento materno

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## INTRODUCTION

In embryonic development, the tongue originates from the first, second, and third pharyngeal arches, around the fourth week of gestation[1]. This structure has, in its lower portion, a fold of mucous membrane, known as the lingual frenulum. The frenulum is developed by apoptosis, which occurs around the seventh week of gestation on the ventral surface of the tongue, separating its anterior two-thirds from the floor of the mouth. At this point, complications may arise in cellular control, and migration may be incomplete or not occur at all, resulting in the condition of ankyloglossia, also known as "tongue-tie"[2].

Ankyloglossia is therefore a congenital anomaly defined by an abnormally short lingual frenulum or one with insertion close to the lingual apex, resulting in restricted movement of the tongue. The cause of the change is still unknown. Certain cases have a hereditary component, but others are not related to the genetic factor[3].

The differential diagnosis of ankyloglossia requires the assessor to have in-depth knowledge of the anatomy of the tongue and its adjacent areas, so that it can be confirmed whether or not the anatomical findings limit the movement of the tongue and, consequently, oral functions[4]. The tongue plays a crucial role in several oral functions, including sucking, swallowing, chewing, and speaking. Changes in the lingual frenulum can have a significant impact in the short, medium, or long term, as any restriction on the free movement of the tongue can result in functional impairment, which may vary according to the degree of change in the frenulum[5].

Several professionals can contribute to the identification and indication of a therapeutic and/or surgical procedure in cases of ankyloglossia. The change must be analyzed based on the functionality of the affected structure[6]. The examination to assess the lingual frenulum in babies usually involves visual observation of the characteristics of the frenulum, tongue movement, non-nutritive sucking, nutritive sucking, and swallowing[7].

To identify changes in the lingual frenulum, Law No. 13,002 was formalized in Brazil in 2014, making it mandatory to assess the lingual frenulum in babies, by a qualified health professional, in all hospitals and maternity wards, in children born on their premises[8]. However, it was only with Technical Notes No. 35/2018 and No. 01/2022 that guidelines were established for health professionals and establishments regarding the early identification of ankyloglossia in newborns (NB) and the determination of the flow of care in the health care network, within the scope of the Unified Health System (SUS)[9,10].

Furthermore, in 2022, Resolution No. 661 of the Federal Council of Speech-Language Pathology was published, which stipulates that speech therapists must be part of the multidisciplinary breastfeeding team. According to the resolution, among other duties, it is the duty and responsibility of this professional to perform oral inspection of the lingual frenulum in newborns and infants, assess the development of orofacial functions, suggest surgical treatment, when necessary, and post-surgical monitoring, when necessary[11].

Early diagnosis of ankyloglossia enables proper and timely attention to orofacial functions, thereby minimizing potential losses. It is described in the literature that changes in the lingual frenulum can harm breastfeeding in the neonatal period, as they can cause pain and trauma to the nipple, ineffective feeding, and low weight gain, in addition to the chance of a decrease in the mother's milk production[12].

Although the law that mandates the implementation of the lingual frenulum assessment protocol in babies dates back to 2014, the implementation of this assessment at the institution where the study originated occurred recently. This delay was due to the difficulty in establishing the flows required by the universal screening procedure. Thus, this study aimed to assess the implementation of lingual frenulum assessment in a university hospital, from February 1, 2022, to July 31, 2022.

## METHODS

This is a longitudinal and descriptive study with a quantitative approach, in which the database of 1,151 newborns in a university hospital was analyzed during the period of implementation of lingual frenulum screening at the institution.

The Santa Maria University Hospital is a leading institution in high-risk pregnancies and neonatal care, serving a population of over one million inhabitants across 43 municipalities in the region. On average, the hospital performs around 1,800 births per year and has 52 obstetrics beds and 25 Neonatal Intensive Care Unit (NICU) beds.

According to the provisions of Resolution No. 466/2012, Chapter IV, this study did not require an Informed Consent Form (ICF), as it utilized secondary data from the project database, which was approved by the Ethics and Research Committee of the institution, under opinion No. 5,869,064. It should be noted that the anonymity of the analyzed records was ensured, guaranteeing the confidentiality of the information. The results were presented in an aggregated form, making it impossible to identify the participants. Furthermore, as it did not involve clinical interventions, the research did not interfere with the individuals' routines, nor did it pose risks or harm to their well-being.

The study used the following coverage indicators as a reference:

- coverage of lingual frenulum screening in rooming-in to the total number of newborn admissions in that unit, each month;
- frequency of typical cases in neonatal screening;
- frequency of ankyloglossia diagnosed in neonatal screening;
- frequency of cases requiring outpatient reassessment due to questionable results in neonatal screening;
- frequency of family attendance at outpatient reassessment;
- frequency of typical cases in outpatient reassessment;
- frequency of ankyloglossia in outpatient reassessment;
- frequency of attendance to perform frenotomy.

Healthy newborns of both genders, born between February 1 and July 31, 2022, and admitted to the hospital's rooming-in were included in the study. Newborns who underwent lingual frenulum screening in the Neonatal ICU were excluded.

Lingual frenulum screening was performed based on the Lingual Frenulum Assessment Protocol in Babies[13] in hospitalized newborns, within the first 48 hours after birth, or upon outpatient return for Neonatal Hearing Screening and

lingual frenulum screening within a maximum of seven days after birth. During the implementation of the lingual frenulum assessment, the team consisted of four qualified professionals, all speech therapists, who had received training and experience with assessment instruments.

According to the protocol, the anatomical and functional assessment of the lingual frenulum is performed by observing the posture of the lips at rest, which may be closed, half-open, or open; the tendency of the tongue positioning during crying, which may be in the elevated midline, in the midline with elevation of the sides, or at the low tip of the tongue with elevation of the sides. The shape of the tip of the tongue when raised during crying or elevation maneuver was also assessed, and it could be rounded, with a slight cleft or with a "heart" shape; finally, the specific item of the lingual frenulum, in which the thickness (thin or thick), the fixation on the tongue, which could be in the middle third, between the middle third and the apex or at the apex, and the fixation on the floor of the mouth, which could be visible from the sublingual caruncles or the alveolar ridge, were verified. Based on this assessment, the results can be categorized as follows: normal (total score between 0 and 4), doubtful (total score between 5 and 6), and altered (total score of 7 or more).

Based on the results obtained in the assessment, the diagnosis and conduct for each case were outlined. In typical results, parents received guidance and had their doubts clarified.

In altered cases, parents were advised on the possible implications of the structural alteration of the lingual frenulum on oral functions. Furthermore, the result was communicated and discussed with the pediatric team for appropriate medical management, which generally involves referral for frenotomy during hospital admission[13].

When the result obtained was doubtful, the baby was referred to for retesting at a Speech Therapy clinic, for reassessment after 30 days of life or more, using the protocol validated for this purpose[14]. On this occasion, the assessment was conducted, and interference of the frenulum in the movements of the tongue was considered in the following situations:

- in the clinical history, when the sum of the items was equal to or greater than 4;
- in the anatomical and functional assessment, when the sum of items 1, 2, and 3 was equal to or greater than 4;
- in the anatomical and functional assessment, when item 4 was equal to or greater than 3;
- in the anatomical and functional assessment, when the total (1, 2, 3, and 4) was greater than 7;
- in the assessment of non-nutritive sucking and nutritive sucking, when the sum of the items is equal to or greater than 2;
- in the clinical examination, when the sum was equal to or greater than 9;
- when the sum of the clinical history and clinical examination was equal to or greater than 13.

In these cases, the baby was referred for lingual frenotomy, performed by an oral and maxillofacial surgeon at the Surgery Clinic of the institution's Dentistry Course.

The study used data from the hospital's Statistics Department to obtain the number of newborns during the period of implementation of the lingual frenulum assessment. Subsequently, data from the screening and reassessment results were analyzed and consulted in internal control spreadsheets of the hospital's Speech Therapy team. Information about babies' attendance at the Surgery Service was analyzed by checking the registration sheets for that service.

The data from this study were analyzed using descriptive statistics.

## RESULTS

Between February 1 and July 31, 2022, 1,151 babies were born at the research institution. Of these, 974 were admitted to the rooming-in and 177 required admission to the Neonatal Intensive Care Unit (Neonatal ICU). Thus, 974 babies met the criteria and were included in the research. Eight hundred twenty-four (84.6%) babies underwent lingual frenulum screening. These data are presented in Table 1, organized by month of birth. A mean coverage of 84.1% of the lingual frenulum was observed during the months studied. The month of birth of each participant was considered for the analysis of screening, reassessment, and attendance at the surgery clinic.

Of the total number of assessments conducted, according to the results described in Table 2, a mean of 89.8% of typical cases was observed. Of the cases that required outpatient reassessment, the mean rate was 6.6%, and among these, the mean attendance rate was 71.4% (Table 3). The mean number of cases identified with ankyloglossia during neonatal screening, in the months consulted, was 3.5%.

At outpatient follow-up, the frequency of ankyloglossia cases that were consequently referred for frenotomy is presented in Table 4. The mean diagnosis of ankyloglossia in the reassessment was 38.5%.

Table 5 describes the frequency of attendance and absence to perform frenotomy at the surgery clinic. The mean attendance was 59.7% in the observed months.

## DISCUSSION

Knowledge of the coverage indicators for lingual frenulum assessment, the frequency of changes, and the need for outpatient reassessment is essential for reflecting on the current flows available in services and planning improvements aimed at the

**Table 1.** Coverage of lingual frenulum screening in rooming-in care compared to the total number of newborn admissions in rooming-in care in 2022 from February to July

| Month of birth (2022) | NB admissions in RC | Lingual frenulum screening n (%) |
|---|---|---|
| February | 158 | 144 (91.1) |
| March | 185 | 179 (96.8) |
| April | 175 | 145 (82.9) |
| May | 168 | 138 (82.1) |
| June | 142 | 134 (94.4) |
| July | 146 | 84 (57.5) |
| Total | 974 | 824 (84.6) |

**Subtitle:** NB = Newborn; RC = Rooming-in care; n = Number of babies; % = percentage

**Table 2.** Frequency of normal cases, need of outpatient reassessment e and ankyloglossia diagnosed in neonatal screening

| Month of birth (2022) | Lingual frenulum screening n | Normal n (%) | Need of Reassessment (%) | Ankyloglossia n (%) |
|---|---|---|---|---|
| February | 144 | 128 (88.9) | 12 (8.3) | 4 (2.8) |
| March | 179 | 159 (88.8) | 10 (5.6) | 10 (5.6) |
| April | 145 | 132 (91.1) | 8 (5.5) | 5 (3.4) |
| May | 138 | 131 (94.9) | 4 (2.9) | 3 (2.2) |
| June | 134 | 120 (89.6) | 9 (6.7) | 5 (3.7) |
| July | 84 | 72 (85.7) | 9 (10.7) | 3 (3.6) |
| Total | 824 | 742 (90.1) | 52 (6.3) | 30 (3.6) |

**Subtitle:** n = Number of babies; % = Percentage

**Table 3.** Frequency of presence or absence of family attendance at outpatient reassessment

| Month of birth (2022) | Forwarded for reassessment N | Presence n (%) | Absence n (%) |
|---|---|---|---|
| February | 12 | 8 (66.7) | 4 (33.3) |
| March | 10 | 7 (70) | 3 (30) |
| April | 8 | 4 (50) | 4 (50) |
| May | 4 | 3 (75) | 1 (25) |
| June | 9 | 9 (100) | 0 (0) |
| July | 9 | 6 (66.7) | 3 (33.3) |
| Total | 52 | 37 (71.2) | 15 (28.8) |

**Subtitle:** n = Number of babies; % = Percentage

**Table 4.** Frequency of normal cases or ankyloglossia cases in outpatient reassessment

| Month of birth (2022) | Presence for reassessment N | Normal n (%) | Ankyloglossia n (%) |
|---|---|---|---|
| February | 8 | 5 (62.5) | 3 (37.5) |
| March | 7 | 3 (42.9) | 4 (57.1) |
| April | 4 | 4 (100) | 0 (0) |
| May | 3 | 1 (33.3) | 2 (66.7) |
| June | 9 | 3 (33.3) | 6 (66.7) |
| July | 6 | 3 (50) | 3 (50) |
| Total | 37 | 19 (51.4) | 18 (48.6) |

**Subtitle:** n = Number of babies; % = Percentage

**Table 5.** Frequency of attendance to perform frenotomy

| Month of birth (2022) | Forwarded for perform frenotomy N | Presence n (%) | Absense n (%) |
|---|---|---|---|
| February | 3 | 2 (66.7) | 1 (33.3) |
| March | 4 | 3 (75) | 1 (25) |
| April | 0 | 0 (0) | 0 (0) |
| May | 2 | 2 (100) | 0 (0) |
| June | 6 | 3 (50) | 3 (50) |
| July | 3 | 2 (66.7) | 1 (33.3) |
| Total | 18 | 12 (66.7) | 6 (33.3) |

**Subtitle:** n = Number of babies; % = Percentage

early identification of ankyloglossia. In the present study, the coverage of lingual frenulum assessment observed varied during the study period, ranging from 57.5% to 96.8%.

In July, the lowest number of newborns who underwent lingual frenulum screening was observed compared to the total number of admissions to rooming-in, which can be attributed to the team's vacation period and a weakness in providing assistance. It is essential to discuss strategies for increasing coverage by expanding the trained team and implementing a well-structured workflow. The demands related to the lingual frenulum require careful attention from hospital management, so that the most significant possible number of newborn assessments can be achieved, including during vacation periods.

The implementation of lingual frenulum screening at the institution was an initiative of the Speech Therapy service. For this reason, speech therapists initially only conducted screenings. However, considering that lingual frenulum screening can be performed by qualified and trained health professionals[8], other

professionals from the health team could be included to perform neonatal screening, which would contribute to increasing coverage of newborns.

According to the literature, the frequency of alteration of the lingual frenulum in babies ranges from 0.8% to 16%[15,16]. In this study, the results showed a frequency of, on average, 3.6% during the studied period, a quantity that is in accordance with the frequency already described. What could justify this frequency variability observed in the literature is the lack of standardization in diagnostic parameters and the different definitions of ankyloglossia, which poses a challenge in conducting well-founded studies, as the results are often limited[3]. Another aspect that may have influenced is the fact that the assessment of the lingual frenulum was recently formalized in Brazil, with the publication of Technical Notes No. 35/2018 and No. 01/2022, which established criteria and guidelines for health professionals and institutions[9,10].

These technical notes serve as guidelines for health services and professionals, ensuring that newborns with alterations or suspected alterations have the right to early diagnosis and treatment when necessary. The objective is that both assessment and intervention are conducted by specialized professionals with experience in the area, so that erroneous results and unnecessary interventions do not occur.

Among the screenings conducted, the number of cases requiring reassessment of the lingual frenulum stands out, specifically those with a doubtful result in the screening, which averaged 6.3% throughout the period. Based on this result, it was recommended that families return for a new assessment when the newborn was 30 days old or older. In the reassessment, the frequency of ankyloglossia was high, reaching 66.7% in May and June. Furthermore, several families were observed to be absent from their return, with a 50% absence rate in April. To improve the flow, it is suggested to consider actively searching for infants who miss reassessment or who do not seek out the surgery clinic. Furthermore, it is recommended that the team improve its communication skills when explaining the diagnosis and implications of ankyloglossia for the development of the stomatognathic system, as family members who are more informed about this condition may have greater adherence to the proposed flowchart. Furthermore, monitoring can be essential in doubtful cases, so that demands arising from breastfeeding and oral motor dysfunctions unrelated to the lingual frenulum can be addressed, thereby avoiding early weaning.

Therefore, guidance must be provided to pregnant women and their families from prenatal care onwards, encouraging them to value the assessment of the lingual frenulum. In addition to the family, the relevance and importance of training health professionals and promoting the integration of the multidisciplinary team is reinforced, which can assist in the diagnosis and indication of surgical intervention[16].

Authors report that after surgical intervention, breastfeeding mothers observe an improvement in the newborn's "attachment" to the breast and a reduction in nipple trauma and pain[17]. It is worth noting that all babies referred for frenotomy and seeking the institution's Surgery Clinic received the intervention, with attendance rates ranging from 50% to 75% during the study period. The literature highlights improvements in oral motor functions and coordination of sucking, swallowing, and breathing after frenotomy; however, clinical monitoring is essential for managing breastfeeding following the procedure. The monitoring stage is not currently foreseen in the hospital's flowchart. It could be implemented to facilitate appropriate adjustments at an opportune time, as breastfeeding promotes the balance of the stomatognathic system, among its numerous benefits for the prevention and promotion of health in early childhood[2]. Hence, it is worth highlighting that post-surgical and/or breastfeeding monitoring by the team is provided for in Technical Note No. 35/2018[9].

It was considered a limitation of the study that data were not collected regarding the duration of breastfeeding among newborns, which is justified by various maternal and newborn aspects that may be related to early weaning in our culture. However, it is suggested that the breastfeeding variable be considered in future studies, provided it is well controlled. Additionally, as a limitation of the study, one can consider the lack of data that may explain the lack of screening in 15.4% of newborns admitted to rooming-in. Given this, it is only possible to infer that this number is related to hospital discharges that occur on weekends, in which patients whose neonatal screenings have not yet been performed are scheduled to undergo them in an outpatient clinic, with the possibility of families not attending or of the screening being conducted in other private services.

The results obtained in this study aim to assist in planning strategies that promote the early diagnosis of ankyloglossia, as well as to raise awareness and inform families of the importance of outpatient assessment and monitoring, when necessary, to implement the recommendations proposed in Law No. 13,002[8].

## CONCLUSION

In the first six months of implementing lingual frenulum screening, it was possible to verify that screening coverage was 84.6%. This indicates a need for strategies to expand coverage, as well as for greater engagement of the target population in the proposed procedures, including reassessment and intervention.

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