Upper lip-tie, buccal ties and the role of frenotomy in infants

What are the risks of upper labial and buccal frenotomy?

In the absence of relevant studies, we draw on expert clinical experience and anecdotal reports to list risks in order of clinical significance:

1. Haemorrhage if clefts are mistaken (mitigated by use of laser).
2. Unnecessary pain and distress.
3. Wound infection.
4. Oral outcome resulting in worsening feeding problems in the infant with pre-existing breastfeeding or feeding problems.
5. Underlying feeding/breastfeeding problems remain unidentified and unmanaged.
6. Worsened diastema of upper incisors in later childhood due to scarring.

What are the risks of maxillary labial and buccal frenotomy?

In the absence of relevant studies, we draw on expert clinical experience and anecdotal reports to list risks in order of clinical significance:

1. Haemorrhage if clefts are mistaken (mitigated by use of laser).
2. Unnecessary pain and distress.
3. Wound infection.
4. Oral outcome resulting in worsening feeding problems in the infant with pre-existing breastfeeding or feeding problems.
5. Underlying feeding/breastfeeding problems remain unidentified and unmanaged.
6. Worsened diastema of upper incisors in later childhood due to scarring.

What is the functional relevance of the maxillary labial and buccal frenum?

The wide range of maxillary labial and buccal frenum morphologies do not differ from the lip in a way that impacts on function. The infant’s upper lip does not need to be flange for effective breastfeeding. The upper lip participation is in a neutral position in the speech and the lower half of the face when the breastfeeding infant’s face moves symmetrically into the breast. The upper lip is not actively involved in effective milk transfer in breastfeeding and is not visible when optimal intraoral tissue volume and position stabilize the functionality of the infant during breastfeeding are achieved.

How should maxillary labial frenum be classified?

Since the diverse range of labial frenum morphologies do not impact on function, there is no reason to classify variants as “upper lip ties”. The Klotz scale and other systems for classification of the maxillary labial frenum (see Appendix), including the Stanford classification, are of anatomic interest, but lack clinical relevance.

How should buccal frenum be classified?

Since buccal frenum do not impact upon function, there is no reason to classify variants as “buccal ties”. What is the functional relevance of the maxillary labial and buccal frenum?

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How should buccal frenum be classified?

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