NORTH SHORE & SYDNEY PAEDIATRIC SURGERY

ANDREW J A HOLLAND
BSc (Hons) MB BS PhD (Syd)
FRCS (Eng) FRACS (Paed) FACS
Professor of Paediatric Surgery

T 1300 362 278
F 1300 315 668

andrew.holland@sydneypaediatricsurgery.com.au
sydneypaediatricsurgery.com.au

TONGUE-TIE & UPPER LIP-TIE, MUCOUS CYST AND RANULA

What is a tongue-tie?

This is a piece of fleshy tissue running between the under surface of the tongue and the floor of the mouth. It is sometimes called the frenulum. The frenulum is present in most people but when thicker or shorter than normal may restrict movement of the tongue, particularly the ability to stick the tongue out of the mouth. A tongue-tie often causes no symptoms but may cause feeding difficulties, excessive drooling, poor dental hygiene or be associated with speech problems.

What is an upper-lip tie?

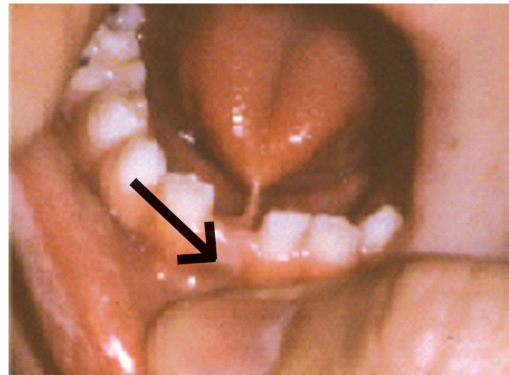
This is a piece of fleshy tissue running between the top gum and the back of the upper lip. It is a normal structure and usually causes no problems. It may be torn during a fall and bleed. Rarely, if it is particularly thick it may cause some separation between the two upper front teeth (central incisors).

What is a mucous cyst or ranula?

These are collections of thickened salivary fluid trapped underneath the soft tissues of the lining of the mouth. They are common close to the lips and under the tongue.

General description

The aim of the procedure is complete release of the tongue-tie and/or lip-tie, or remove the cyst and/ or ranula. The operation is performed as a day case under general anaesthesia and will usually take about 15 to 20 minutes to perform. The procedure is only performed under general anaesthesia to reduce the risk of damage to the tongue together with its associated nerve and blood supply.



Tongue-tie

Preparations

Your child will need to fast for all solids and milk liquids generally for about 6 hours before the start of the procedure. In breast-fed babies or infants this time may be reduced after consultation with the anaesthetist.

Water may be allowed up to 2 hours beforehand. You will be called by the hospital approximately 48 hours prior to surgery to be advised of your admission and fasting times. It is often helpful to bring your child's favourite toy with you on the day.

Anaesthesia

You and your child will meet the anaesthetist prior to the procedure. After talking to you and briefly examining your child, they will take you through to the operating theatre. One parent is welcome to accompany your child until they are asleep. The anaesthetist puts your child to sleep via a face mask (with children 5 years and over there is the option of either a face mask or a needle with numbing cream). You will then be shown to a waiting room. It is very important that you remain available in this area during your child's surgery so that we can quickly contact you in an emergency.

Once your child is asleep, the anaesthetist will insert a 'drip' to allow fluids to be given directly into a vein. Usually this is located in the hand or arm, but occasionally may need to be sited in the leg or scalp.

Procedure

The mouth is cleaned with a mild antiseptic solution. The tongue-tie and/or lip-tie is crushed and then divided using an electrical cautery device, which both releases the tongue-tie and seals any blood vessels in the frenulum. The mucous cyst or ranula will have its ‘roof’ removed to release the fluid. Generally no stitches are required. Local anaesthetic is then applied in the form of a gel to the wound. Rarely one or two dissolving stitches may be required to stop any troublesome bleeding. The local anaesthetic block usually lasts around 2 to 3 hours.

Initial recovery

Once the operation has finished, your child will be taken to the recovery area. When they are awake, you will be called into the recovery ward. Often children appear distressed and a little confused initially - there may be several reasons for this including residual effects of the anaesthetic, hunger, and some discomfort. Generally they will settle quite quickly, especially if offered a drink or feed. The recovery and ward staff are also able to give additional pain relief medication once your child is awake if required. The nursing staff will check the wound and make sure you are happy before you go home. Usually this will be about 2 hours after the surgery.

Post-operative course

Paracetamol (‘Panadol’) should be given on the afternoon and evening of surgery, and in the morning of the following day. After that time, assess your child’s pain to see if further doses are required. Children over 12 months of age may require additional pain relief with ibuprofen (‘Neurofen’). for the first day or so. Follow the manufacturer’s dose instructions for your child’s weight. Paracetamol (no more than 4 doses in 24 hours) and ibuprofen (no more than 3 doses in 24 hours) can be given together if required. There may be a small amount of blood that oozes from the wound in the first 24 hours.

Your child can begin eating when they get home. Start with clear liquids (apple juice, iceblocks) and add solid food slowly and in small amounts. Your child may vomit from the anaesthesia on the day of surgery. This should stop by the morning after surgery.

Return to activity

Your child may return to day care or school when comfortable, usually within 3-5 days.

Call the office if:

- You see any signs of infection: redness along the incision site, increased swelling, foul smelling discharge from incision
- Your child’s pain gets worse or is not relieved by painkillers
- There is bleeding (small ooze of blood in the first day or two is normal)
- Your child has a high temperature
- Vomiting continues on the day after surgery
- You have any questions or concerns

Follow-up

Normally I recommend review with your own local doctor or paediatrician around 2 to 3 weeks after surgery. If there are any special concerns or issues please contact my rooms or clinic to make an appointment. It is normal for there to be moderate swelling of the floor of the mouth for the first week or so after the surgery. Please note that although the wound generally heals very quickly, usually within a week of the procedure, the scar at the floor of the mouth remains pale for several weeks or months. This will not cause any functional problems.

Problems & further surgery

Whilst surgical release of tongue-ties is usually uneventful, there is always a 2-3% risk of bleeding after surgery. Please also be aware that surgical release of a tongue-tie will not always be associated with an improvement in a child with an established speech impairment. Further assessment by your speech pathologist after the surgery is recommended. In around 3 - 5% of cases a mucous cyst or ranula can recur. Generally this will require a second operation to resolve the problem.

FRACS
Fellow of the
Royal Australasian College of Surgeons

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