Tethered Oral Tissues and Infant Oral Assessment

Marsha Walker, RN, IBCLC
Marshalact@gmail.com
Controversy!!
Researchers and clinicians do not always agree on many issues related to tongue-tie, such as:

- The definition of a lingual frenulum
- What a tongue-tie is
- What a labial tie is
- What a buccal tie is
- How to identify tethered oral tissues (TOT)
- What effect they have on breastfeeding, dentition, and speech
- What to do about them, if anything
- How to fix them
- What interventions to recommend following TOT revisions

Tongue-tie is nothing new

- Recognized since the days of Aristotle in third century BC
- Tongue-tie or ankyloglossia from the Greek “agkilos” (curved) and “glossa” (tongue).
- 7th century AD has medical reports of dividing a tongue-tie
- In Middle Ages, competition between midwives who used a sharpened fingernail and surgeons who could use instruments
- Tongue-ties were routinely released through the early 1900s
- When bottle-feeding became the norm in the 1950s, tongue-ties and their division fell out of favor
- Resurgence of breastfeeding caused this to become controversial
- ↑ in diagnosis of tongue-tie in US by 834% from 1997-2012 (Waish et al, 2017)
- Incidence 0.02-12%
Uncertainty and cautions

- An online survey found that professional opinions about tongue-tie varied greatly based on profession and geography
- A study looked at Website quality and trends for ankyloglossia, and found that the quality of Websites is good but many of the published Websites available to patients are opinion pieces without clear sources and with inherent bias toward performing frenotomy for tongue-tie
- Some infants will indeed benefit from frenotomy and others who have multifactorial causes of feeding difficulty may have minimal or no benefit from the procedure.

Definition of lingual frenulum

- Variously defined as “midline submucosal string,” “band,” “mast,” “cord”
- Upon dissection, it was seen as a dynamically layered structure formed by oral mucosa and the underlying fascia covering the floor of the mouth
- Tongue mobilization creates tension in the fascial layer, raising the fascia and overlying mucosa into a midline fold that is recognizable as the lingual frenulum or anterior lingual frenulum (Mills et al, 2019)
Posterior lingual frenulum

- Low attachment of floor of mouth fascia
- Can normally occur in up to 35% of infants without necessarily interfering with breastfeeding
- Martinelli et al, 2016

The posterior tongue

- Base of tongue retracts against posterior pharyngeal wall generating pressure that helps move bolus through back of mouth
- Reduced base of tongue movement could interfere with swallowing
- During breastfeeding, could see nasal regurgitation, gagging, choking, coughing, aspiration
- May be altered in infants with congenital Zika syndrome (Fonteles et al, 2018)
Brooks et al, 2019

Videofluoroscopic swallow study showed reduced base of tongue movement.

Post frenulectomy showed elimination of aspiration, nasal regurgitation and better base of tongue movement.

Upper lip (superior) labial frenulum

- Small, non-muscular triangular fold of connective tissue that extends from the midline maxillary gingiva into the vestibule and central upper lip
- Involved in creating a seal around breast tissue
- Has many morphological components with varying distributions
- Attachment site for maxillary labial frenulum alone is not a sufficient population discriminator for lip tethering
Buccal frena

- Buccal ties are uncommon
- Buccal ties are abnormal mucosal tethers extending from the checks to the gingiva
- Most are small and without medical significance
- Buccal ties can interfere with the gape response, labial seal causing aerophagia (swallowing of air), stabilizing the nipple, creating vacuum
- Possible decrease in suction
Buccal tie


Lingual frenulum assessment

- Assessment Tool for Lingual Frenulum Function (ATLFF)
  - Hazelbaker AK. The assessment tool for lingual frenulum function (ATLFF): Use in a lactation consultant private practice. Pasadena, California, Pacific Oaks College; 1993

- Bristol Tongue-tie Assessment Tool (BTAT)
  - Ingram J et al. The development of a tongue assessment tool to assist with tongue-tie identification. Arch Dis Child Fetal neonatal Ed 2015;100:F344-F348

- Coryllos classification system

- Linguinal Frenulum Protocol with Scores for Infants

- Tongue-tie and Breastfed Babies (TABBY)

- Kotlow
Score of 0-3 indicate severe restriction of tongue function
Showed good correlation with ALTFF
CLINICAL EXAMINATION
(Video to future analysis suggested)

PART I – ANATOMO-FUNCTIONAL EVALUATION

1. Lip posture at rest
   - ( ) closed (5)
   - ( ) half open (1)
   - ( ) open (1)

2. Tongue posture during crying
   - ( ) midline (5)
   - ( ) elevated (3)
   - ( ) midline with the lateral elevated (2)
   - ( ) down (2)

3. Tongue shape when elevated during crying
   - ( ) round (5)
   - ( ) V-shaped (2)
   - ( ) heart shaped (2)

Lingual frenulum protocol with scores for infants

4. Lingual frenulum
   - ( ) visible
   - ( ) not visible
   - ( ) visible with frenum (7)

5. Palate (soft palate) and frenum
   - ( ) midline (5)
   - ( ) midline with frenum (1)

6. Frenulum attachment to the tongue
   - ( ) at the tip of the tongue (6)
   - ( ) through the frenum (1)

7. Frenulum attachment to the floor of the mouth
   - ( ) through the frenum (1)
   - ( ) through the frenum (1)

PART II – EVALUATION OF NON-NUTRITIVE SUCKING AND NUTRITIVE SUCKING

1. Non-nutritive sucking (bite finger suction wearing gloves)
   1.1. Tongue movement
      - ( ) adequate; tongue protrusion, coordinated movements and efficient suction (5)
      - ( ) inadequate; restricted tongue protrusion, uncoordinated movement and late suction start (1)

2. Nutritive sucking during breastfeeding: (when breastfeeding starts, observe infant sucking during 5 minutes)
   2.1. Suction Rhythms (observe groups of suction and pauses)
      - ( ) several suction in a row followed by short pauses (5)
      - ( ) a few suction followed by long pauses (1)

2.2. Coordination among suction; swallowing; breathing
   - ( ) adequate (6) (balance between feeding and suction-swallowing-breathing without stress)
   - ( ) inadequate (1) (rough, choking, dyspnea, regurgitation, hiccups, noises during deglutition)

2.3. Nipple chewing
   - ( ) no (1)
   - ( ) yes (5)

2.4. Clicking during sucking
   - ( ) no (8)
   - ( ) non-systematic (1)
   - ( ) frequent (2)

Non-nutritive sucking and nutritive sucking evaluation scores: Best result = 6, Worst result = 7

HISTORY + CLINICAL EXAMINATION TOTAL SCORES: BEST RESULT=6, WORST RESULT=7
WHEN THE SUM OF HISTORY AND CLINICAL EXAMINATION IS EQUAL OR MORE THAN 8, LINGUAL PRENULM MAY BE CONSIDERED ALTERED.
Kotlow classification

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
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<tbody>
<tr>
<td>I(a)</td>
<td>Total tip involvement</td>
</tr>
<tr>
<td>I(b)</td>
<td>Distal to the midline. The tongue may appear normal</td>
</tr>
<tr>
<td>I(c)</td>
<td>Proximal area with a hump or cupping of the tongue</td>
</tr>
<tr>
<td>II</td>
<td>Bump in the midline area of the tongue</td>
</tr>
</tbody>
</table>

Score of 8=normal function
Score of 6 or 7=borderline
Score of 5 or below=tongue function impairment

TABBY assessment tool

<table>
<thead>
<tr>
<th>TABBY Tongue Assessment Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>What does the tongue-tip look like?</td>
</tr>
<tr>
<td>Where it is fixed to the gum?</td>
</tr>
<tr>
<td>How high can it lift besides open mouth?</td>
</tr>
<tr>
<td>How far can it stick out?</td>
</tr>
</tbody>
</table>

Score of 8=normal function
Score of 6 or 7=borderline
Score of 5 or below=tongue function impairment
Coryllos’ 4-type description

- Type 1 = classical (anterior) lingual frenulum; attachment of frenulum to the tongue tip, usually in front of the alveolar ridge in the lower lip sulcus
- Type 2: 2-4 mm behind the tongue tip and attaches on or just behind the alveolar ridge
- Type 3: Posterior lingual frenulum; tongue-tie is attachment to the mid-tongue
- Type IV: essentially against the base of the tongue; thick, shiny and very inelastic

Coryllos et al. (2004)

Left: Classic, thin anterior tie reducing tongue elevation. Notch in midline of tongue. Notice sucking blisters

Right: Thick posterior frenulum visible as white line on posterior floor of mouth. Palpation reveals taut, firm, “speed bump”
Maxillary frenulum assessment

- Kotlow maxillary lip tie classification
  - Kotlow LA. Diagnosing and understanding the maxillary lip-tie (superior labial, the maxillary labial frenum) as it relates to breastfeeding. J Hum Lact 2013;29:458-464

- Stanford superior labial frenulum classification
  - Santa Maria C et al. The superior labial frenulum in newborns: What is normal? Global Pediatric Health 2017;4:1-6

Kotlow maxillary lip tie classification

- Location of the lip tie is based on the zone of attachment of the lower lip’s mucosa.

  - Class I lip tie
  - Class II lip tie, inserting at the zone of the free and attached gingival tissue
  - Class III lip tie, inserting at the zone between the areas of the future central incisors
  - Class IV lip tie, inserting at the zone extending into the anterior palatal area
Stanford superior labial frenulum classification

Most infants (83%) were Type 2
Poor interrater reliability
Problems with maxillary lip tie classification systems

- Classification may have evaluated older infants, not neonates
- May only be anatomical and not correlated with clinical breastfeeding difficulties
- Classification may not have been validated on a functional basis
- May not be reproducible by clinicians
- Authors and “experts” may have competing interests
- Some practitioners advertise themselves on the web claiming non-existent complication rates and major benefits without supporting evidence

Assessing buccal ties

- Buccal ties can be asymmetrical with some ties on both sides and some on only one side
- May change as child gets older
- Most are small and of no significance
- No measurements or classification systems
- Just because they are visible does not mean they need to be released
- These are very rare and only in severe cases would revision be necessary

http://bfmedaz.com/tongue-tie/
Finger sweep for assessing posterior tongue tie - Dr. James Murphy

- Insert your 5th finger, pad down, into the left side of the infant’s mouth under the tongue
- Advance the finger until meeting firm resistance
- Holding the finger at this depth, move the finger directly to the right side of the infant’s mouth.
- No resistance = no Tongue Tie
- Tongue vibrates only = Small Speed Bump = Small Risk of latch problems
- Tongue moves far to the right then swings back = Large Speed Bump = usually a problem
- Won’t move to the right = a fence = always a problem at some point in life, now or later

James Murphy finger sweep
Finding a posterior tie

- Elevate and push tongue back simultaneously
- Some studies show the occurrence of posterior frenulum at 35%
- May be normal in many infants and not causing problems

Problems with rating and classification systems

- May be too complicated to use in clinical practice
- Nuances or measurements may be slight or difficult to discern without actually measuring the frenulum
- Generally look only at structure or appearance and not function
- Often have very poor interrater reliability
- Should not be only criteria in determining interventions
Signs of frenulum restrictions

- Infant has a high or narrow palate
- Tongue normally rests pressed against hard palate in utero
- Lingual tie prevents tongue from assuming this posture
- Hard palate is maleable and without gentle rounding guidance from tongue, may take the form of high or narrow complicating breastfeeding because tongue cannot press nipple against palate

- Milk leakage out of mouth
- Nasal regurgitation
- May indicate shallow latch, poor tone, lack of recruitment of compensatory muscles
Signs of frenulum restriction

- Sucking blisters on infant’s lips
- Overcompensation of facial muscles to maintain latch
- Infant may still obtain milk in presence of ties due to abundant milk supply, forceful milk ejection reflex


Signs of frenulum restriction

- Milk tongue
- Typically only in center of tongue compared to thrush
- Tongue cannot elevate high enough to clear milk by cleansing against the hard palate


Thrush
Signs of frenulum restriction

- Low tongue posture
- Sides of the tongue are raised
- Front of tongue pulls downward
- Tongue appears flattened against floor of mouth

http://www.cwgenna.com/ttiide
ntify.html

Signs of frenulum restriction

- Aerophagia
- Poor seal around the breast may contribute to excessive swallowing of air
- May see excessive gas in infant, reflux, bloating, excessive spitting up, crying

Nipple deformity

Signs of interference with breastfeeding

<table>
<thead>
<tr>
<th>Infant Signs/Symptoms</th>
<th>Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor latch</td>
<td>Inadequate seal, inability to manipulate nipple/areola into position</td>
</tr>
<tr>
<td>Clicking sound while nursing</td>
<td>Intermittent loss of seal</td>
</tr>
<tr>
<td>Gradual sliding off breast</td>
<td>Inability to maintain hold on nipple/areola</td>
</tr>
<tr>
<td>“Chewing”</td>
<td>Failure to inhibit bite reflex; compensatory use of jaw muscles to maintain</td>
</tr>
<tr>
<td></td>
<td>nipple position</td>
</tr>
<tr>
<td>Ineffective milk transfer</td>
<td>Failure of breast emptying</td>
</tr>
<tr>
<td>Poor weight gain or weight loss</td>
<td>Failure of milk transfer</td>
</tr>
<tr>
<td>Hyperreflexic dehydration (16)</td>
<td>Unrecognized severe failure of milk transfer</td>
</tr>
<tr>
<td>Fussiness and arching away from breast</td>
<td>Infant enrapto to frustration</td>
</tr>
<tr>
<td>Falling asleep at breast</td>
<td>Infant exhaustion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maternal Signs/Symptoms</th>
<th>Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nipple trauma: pain, blister, crack, bleeding,</td>
<td>Localized ischemia from sustained point compression; tissue destruction</td>
</tr>
<tr>
<td>scar</td>
<td>from repetitive crush or nail, excessive vacuum (16)</td>
</tr>
<tr>
<td>Painful breasts</td>
<td>Engagement from failure to empty during primary laktogenesis; infection</td>
</tr>
<tr>
<td>Low milk supply</td>
<td>Failure of secondary lactogenesis from failure to empty</td>
</tr>
<tr>
<td>Plugged ducts</td>
<td>Stasis from failure to empty</td>
</tr>
<tr>
<td>Mastitis</td>
<td>Failure to empty with bacterial ingress from nipple tissue barrier break</td>
</tr>
<tr>
<td>Frustration, disappointment, discouragement</td>
<td>Pain, infant frustration, some of failure because of inability to nourish</td>
</tr>
<tr>
<td>about breastfeeding</td>
<td>infant</td>
</tr>
<tr>
<td>Untimely weaning</td>
<td>Lack of availability of tongue tie diagnosis and remediation</td>
</tr>
</tbody>
</table>

https://neoreviews.aappublications.org/content/neoreviews/11/9/e513.full.pdf
Potential interference with speech

- **Lingual tie**
  - Reduced ability to retract tongue for k, g, h
  - Reduced ability to elevate/depress tongue tip for s, z
  - Reduced ability to elevate tongue tip for t, d, l, n

- **Labial tie**
  - Reduced lip rounding for w
  - Compensatory jaw jutting for f and v

- **Buccal tie**
  - Decreased ability to contract cheeks during production of o, u, w

Tongue placement and breastfeeding

Figure 2. During nursing, the infant's tongue must: 1) protrude over the alveolar ridge to inhibit the larynx, 2) assist the flanged lips in maintaining an airtight seal on the peristalsis, 3) with its pharyngeal function, manipulate the nipple into the proper position (in the depth of the alveolar tip and its proximity to the hard/palatal palate junction), and 4) via distal-to-proximal muscular contractions that end with the bearing of the face of the tongue, produce an internal vacuum, resulting in milk flow.

https://neoreviews.aappublications.org/content/neoreviews/11/9/e513.full.pdf
Tongue placement and breastfeeding


Does TOT revision make a difference?

Geddes DT et al. Pediatrics 2008; 122:e188-e194

- 24 infants with lingual tongue-tie underwent revision with scissors
- Total milk production pre-frenotomy: 455 ± 323 g (16.05 oz ± 11.39 oz)
- Total milk production post-frenotomy: 615 ± 289 g (21.69 oz ± 10.19 oz)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pre-frenotomy</th>
<th>Post-frenotomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milk intake</td>
<td>505 ± 71 g</td>
<td>691 ± 31.9 g</td>
</tr>
<tr>
<td>Milk transfer, ml/min</td>
<td>56 ± 10 g</td>
<td>105 ± 55 g</td>
</tr>
<tr>
<td>LATCH score</td>
<td>79 ± 14</td>
<td>94 ± 89</td>
</tr>
<tr>
<td>Ferr score</td>
<td>36 ± 10</td>
<td>05 ± 12</td>
</tr>
<tr>
<td>Nipple shield, n/N</td>
<td>4/24</td>
<td>1/24</td>
</tr>
</tbody>
</table>

*p < .01, ns < .05,
Does TOT revision make a difference?

- Observational analysis of the ultrasound scans revealed 2 distinct patterns of sucking by the infants before frenulotomy.
- One group of infants (11 of 24 [46%]) placed the nipple close to the HSPJ and pinched the base of the nipple.
- Second group (9 of 24 [37%]) placed the nipple further away from the HSPJ, and the posterior tongue seemed to hump compressing the tip of the nipple to a point.

Ultrasound pre- and post-frenotomy
Pre- and post-frenotomy

- Post-frenotomy shows smoother contour of the back of the tongue which no longer deforms the nipple.
- Probably where much of the nipple pain and damage originates.
Frenotomy Decision Rule for Breastfeeding Infants

Mother with nipple pain or trauma while breastfeeding

AND/OR

inability to maintain latch

AND/OR

poor weight gain in the infant (<15 g/d)

AND

a visible membrane anterior to the base of the tongue, which restricts tongue movement, leading to:

inability to touch the roof of the mouth

OR

inability to cup an examining finger

OR

inability to protrude the tongue past the gum line


Infant identified with possible ankyloglossia

Ensure breastfeeding infant's mouth is wide open present.

Perform standardized measurement of width and functions.

Ankyloglossia confirmed AND breastfeeding difficulty

Ankyloglossia confirmed AND breastfeeding difficulty

Examine tongue and refer feeding infant to exam.

Observe infant while breastfeeding.

Initial intervention for tongue is often effective in regaining oral competency.


Fig. 2. Ankyloglossia flow chart.
Making the decision

- Is restriction present
- Check both appearance and function
- Does tongue/lip/cheek alteration interfere with breastfeeding
- Might the restriction also interfere with speech
- What are maternal and infant signs and symptoms
  - Nipple pain/damage
  - Infant weight gain issues
  - Excessively long feeding sessions
  - Milk production problems
- Do parents wish to initiate corrective procedure
- Do parents understand the risks of the procedure and that it may not always fix the problem, at least not immediately
- Is mother ready to abandon breastfeeding
- Better breastfeeding outcome noted when tie revision done by 72 hours postpartum

Todd & Hogan. Breastfeeding Review 2015; 23:11-16

Procedure
(Pros and Cons)

Scissors
- Less pain
- Promotes hemostasis
- Creates clear surgical site
- Reduces post-surgical edema
- Avoid excising nerves, muscles, lingual glands
- Needs specialized equipment and providers

Light scalpel CO₂ laser (diode, Erbium)
- Hospital or office procedure
- Pediatrician or ENT

Pros
- Less pain
- Promotes hemostasis
- Creates clear surgical site
- Reduces post-surgical edema
- Avoid excising nerves, muscles, lingual glands
- Needs specialized equipment and providers

Cons
- Less pain
- Promotes hemostasis
- Creates clear surgical site
- Reduces post-surgical edema
- Avoid excising nerves, muscles, lingual glands
- Needs specialized equipment and providers
Maxillary lip tie release

Pre-frenotomy activities

- Many protocols and suggestions with little research, consistency, or validation
- Some say to delay procedure for up to several weeks to engage in pre-frenotomy activities
- Accustoms the infant to how things about the mouth are supposed to move
- Prepare and re-pattern tongue function
- Strengthen intrinsic and extrinsic tongue muscles
- Offer tummy time opportunities

Pre-frenotomy activities
www.Drghaheri.com

- Suckling exercises
  It’s important to remember that you need to show your child that not everything that you are going to do to the mouth is associated with pain. Additionally, babies can have disorganized or weak sucking patterns that can benefit from exercises. Starting these exercises from the moment you make your appointment can speed up your recovery after the procedure. The following exercises are simple and can be done to improve suck quality. Aim for 4x/day leading up to the day of your procedure.

- Slowly rub the lower gumline from side to side and your baby’s tongue will follow your finger. This will help strengthen the lateral movements of the tongue.

- Let your child suck on your finger and do a tug-of-war, slowly trying to pull your finger out while they try to suck it back in. This strengthens the tongue itself. This can also be done with a pacifier.

- Let your child suck your finger and apply gentle pressure to the palate. Once the baby starts to suck on your finger, just press down with the back of your nail into the tongue. This usually interrupts the sucking motion while the baby pushes back against you. Listen for a seal break and then put your finger back up into the palate to re-stimulate sucking. Repeat as tolerated.

- With one index finger inside the baby’s cheek, use your thumb outside the cheek to massage the cheeks on either side to help lessen the tension.

Post procedure exercises

- Controversial

- Some say no exercises needed

- Some say stretching exercises for 6 weeks

- Dr. Ghaheri-4 weeks
  - Stretches 6x/day for 3 weeks, then 4th week taper down to end at 4 weeks, not going more than 6 hours between stretches

- Dr. Baxter
  - Stretches 6x/day for 3 weeks
Are there contraindications or cautions?

- Should check with pediatrician prior to any procedures
- Any airway compromise which could worsen with increased tongue mobility
  - Macroglossia
  - Small mandible
  - Pierre Robin Sequence
  - Laryngomalacia
  - Tracheomalacia
- Genetic anomalies of a more complex nature
- Familial bleeding history
- Infection/fever
- Illness
- Questionable ability for follow-up

What if it doesn’t work?

- Should the revision be revised
- Infant may have other issues (mandible position, ...
- Most but not all revisions result in improved breastfeeding, reduced nipple pain and damage
- Some studies show up to 22% of revisions do not result in better breastfeeding
- Some studies and clinicians postulate that the longer the revision is delayed the less likely the procedure will be successful
- Infant may have recruited other muscles and altered sucking patterns to compensate for tethered oral tissues
Other muscle involvement

- Tongue composed of 8 muscles
- Intrinsic originate and attach within the body of the tongue
- Extrinsic originate outside the body of the tongue and attach within it
- Muscles work in pairs, unequal contraction, weakness or strength, may cause the tongue to still not work as desired
- Other breastfeeding issues may also be in play

Bodywork

- Bodyworkers locate areas of the body impacted by restriction, tightness, decreased mobility, asymmetry and mobilize these areas
- May be helpful whether or not revision is successful
- Orofacial myology
- Chiropractic
- Craniosacral
- Osteopathic
- Speech and Language Pathologist (SLP)
- Occupational therapy
- Physical therapy
When parents decide against revision

- Is breastfeeding uncomfortable/painful but still effective?
- Is breastfeeding comfortable but ineffective?
- Is breastfeeding comfortable and effective
- Is breastfeeding uncomfortable and ineffective?
- All of this can change over time and may require long term follow-up
- Some mothers may have particular breast/nipple or milk ejection characteristics that allow successful breastfeeding in presence of TOT

Considerations when revision will not be done

- 1. Monitor infant weight
  - Some infants rely on an ample milk supply and strong milk ejection to gain weight in the early days and weeks
  - This may change as baby gets older and must rely on generating vacuum to maintain milk production
- 2. Maintain milk production
  - Create an overabundance of milk
  - May need to pump milk several times per day
Considerations when revision will not be done

- 3. Manage nipple discomfort/pain/damage
  - Can try nipple shield
- 4. Try different nursing positions
  - Ventral or prone positioning may use gravity to bring tongue forward
- 5. General sucking exercises to strengthen tongue muscles bilaterally
  - Finger tug
  - Lateral tongue stimulation
- 6. Consider bodywork and referrals such as:
  - Myofacial/myofunctional therapy
    - Exercises to strengthen and maintain range of motion for jaw, lips, cheeks, and tongue
  - SLP referral for impact on speech and feeding
  - Chiropractic, cranio-sacral

Resources

- International Affiliation of Tongue-tie Professionals (IATP)
  - https://tonguetieprofessionals.org/
- International Association of Orofacial Myology
  - https://www.iaom.com/
- Ankyloglossia Bodyworkers
  - http://www.ankyloglossiabodyworkers.com/