Newborn Tongue-tie and Breast-Feeding

To the Editor: I read the article titled "Newborn Tongue-tie: Prevalence and Effect on Breast-Feeding" that appeared the January–February 2005 issue.[1] I am the author of the Assessment Tool for Lingual Frenulum Function (ATLFF) referred to in this article. There are several substantial factual errors in this article that require correction.

1. The authors state that "One of the three investigators examined the tongues of all babies thought by the nurses' initial screening to have the appearance of tongue-tie," and "Although the ATLFF is not designed to be used with normal infants, all the function items and some of the appearance items can be tested on normal infants."

The ATLFF is a *screening tool*. It was designed to be used on ALL infants under three months of age to identify those that are tongue-tied and those that are not.

2. I came to Regions Hospital to provide training; however, the hospital's resources were limited, and I spent less than 2 hours scoring only 2 babies as a demonstration to the researchers. None of the investigators in this study demonstrated proficiency in the use of this screening tool. This hardly constitutes a training standard on which to base an inter-rater reliability study.

3. The scoring parameters are incorrectly stated in this article. A perfect score on the function items is 14, regardless of the appearance item score; an 11 on the function items is acceptable if the appearance item score is 10. A function item score of less than 11 means the infant's tongue function is impaired and the infant is tongue-tied. Treatment recommendations are: when the function item score is less than 11 and the appearance item score is between 8 and 10, frenotomy should be considered if management fails; frenotomy is necessary if the function item score is less than 11 and the appearance item score is less than 8. The function items are considered more important as an indicator of the presence of tongue-tie in this scoring system. Appearance deficits alone are *not* an indicator of the presence of tongue-tie and therefore should *not* be used as a selection criterion for further screening or for treatment!

The authors state that "Twelve of the tongue-tied infants had ATLFF scores of perfect, none had scores of acceptable, and 6 had scores of Function impaired." By definition, no tongue-tied infant can earn a perfect score on this screening tool. If an infant has a perfect scores, he or she is *not* tongue-tied.

4. Because the ATLFF is a *screening tool*, it is insufficient to be used as a predictor of breast-feeding outcomes. I am not surprised that "[t]he ATLFF was not a useful tool to identify which tongue-tied infants are at risk for breast-feeding problems." Breast-feeding is a complex set of behaviors involving 2 people. My tool identifies only the deficits of those babies who have difficulty with one aspect of the breast-feeding relationship: the function of the tongue as a result of tongue-tie.

These substantial factual errors compel one to question the integrity of this study's findings.

Alison K. Hazelbaker, MA, IBCLC
Private practice
Columbus, Ohio

References

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Author's Reply

To the Editor: We appreciate the opportunity to reply to Alison Hazelbaker's letter regarding our article, "Newborn Tongue-tie: Prevalence and Effect on Breast-Feeding" in the January–February issue of JABFP.

1. Four of the 5 appearance items in the ATLFF involve scoring the lingual frenulum. Many newborns have no visible lingual frenulum. We concluded, therefore, apparently incorrectly, that the ATLFF was designed to be used only on infants with the appearance of tongue-tie. We apologize for our error.

2. Because we knew our training time with Ms. Hazelbaker was limited, we videotaped her examining 4 babies (not 2 as stated in her letter.) We reviewed the videotape on later occasions and also contacted Ms. Hazelbaker with scoring questions.

3. The scoring information included in our article is correct but incomplete. Because our study did not include treatment decisions (ie, frenotomy), we did not include the portions of the scoring system related to management in our article. In our study, infants were identified as tongue-tied based on appearance only, as stated under Methods.

4. Ms. Hazelbaker had a copy of our study protocol. One of our study goals clearly was to test the usefulness of the ATLFF in identifying which tongue-tied infants were at risk for breast-feeding problems. She indicated support of our study by spending a day at our hospital educating our nursery nurses, training us, and corresponding with us when we had questions about the ATLFF. We were unaware of any objections to the study goals or methods.

We were surprised and disappointed that the ATLFF did not turn out to be a useful tool. We greatly respect

Ms Hazelbaker and her work on tongue-tie. However, we also stand by the integrity of our study.

Diane J. Madlon-Kay, MD, MS
Lori A. Ricke, MD
Regions Family and Community Medicine Residency Program
Nancy J. Baker, MD
Department of Community Medicine and Family Health
University of Minnesota Medical School
St. Paul

Postvasectomy Semen Analysis

To the Editor: I read with interest the article by Christensen and Maples[1] addressing postvasectomy semen analysis and the low compliance with instructions to confirm azoospermia. It prompted the following questions—when and how often is semen analysis required after a vasectomy, and is it *ever* necessary after a vasectomy? Furthermore, is it necessary to send the excised ends of the vas deferens for histopathological evaluation?

A review of the literature suggests that there is no definite agreement regarding the timing or the frequency of postvasectomy semen analysis. All ejaculates contain potentially fertile spermatozoa immediately after vasectomy, which become rapidly immobile within a few days, and usually by 3 weeks following the procedure.[2] The British Andrology Society guidelines requires patients to wait 4 months or have at least 24 ejaculations before semen analysis.[3] The society also recommends that patients not ejaculate for 48 hours prior to collection, collect semen by masturbation directly into the container, avoid condoms, and deliver the semen within an hour of collection.[3] The World Health Organization has different recommendations—one or 2 semen analyses after 12 weeks or 15 ejaculations.[4]

Azoospermia proven on a single semen analysis at 3 months is probably sufficient grounds for discontinuing other methods of contraception.[5] Further semen analyses should be required only if live sperm are present. Nonmotile sperm are probably not an indication for checking further semen samples.[6] Patient compliance is good if they are required to submit only one sample for analysis but decreases significantly when they are asked to provide a second sample.[5]

I suspect that postvasectomy semen analysis, though logical, is simply not necessary. Perhaps many patients (nearly 40% of my 360) realize this instinctively, wait the specified 3 to 4 months or, in many instances, 12 to 15 ejaculations, before commencing unprotected intimacy with their partners. A small percentage will undoubtedly have unintended issues, but humans gamble on success, and change will be difficult.

There is also no uniformity regarding histologic evaluation of the vasectomy specimens. One series from the United Kingdom showed that only three fourths of the surgeons followed this practice.[6] Provided that the vasa are confidently identified and sectioned, routinely evaluating specimens just adds to the cost. Of the patients requesting vasectomy in my practice, most pay for the procedure themselves, and they can ill-afford this added expense. Hence, I have tended to preserve the vas deferens specimens until azoospermia is established at 3 months, or for 1 year, after which time the specimens are discarded because of space constraints. This is explained to the patients before the vasectomy. I suspect many family physicians practicing in rural communities do the same.

K. Ramakrishnan, MD
Department of Family and Preventive Medicine
University of Oklahoma Health Sciences Center
Oklahoma City

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Author's Reply

To the Editor: Dr Ramakrishnan has raised some very good points. There is no absolute protocol for the number or timing of postvasectomy semen analyses. He suggests that a single 3-month postvasectomy semen analysis would probably suffice, which seems reasonable. My research, however, indicates that less than half the men returned at 3 months (25%) than returned for the 6-week check (58%). Because a semen analysis is the only way to know that one has achieved azoospermia—and that is the purpose of the vasectomy—then this noninvasive sampling is logical.

Our study followed Denniston and Pfenninger,[1] which suggested customary postoperative care, with the exception that we also encouraged a 12-month postoperative semen check, in which only 8% of men participated. I also agree that because 42% of my patients did not return for ANY postvasectomy semen analysis, there are a significant number of risk-takers getting a vasectomy. It has been our practice not to routinely send specimens of excised vas deferens to pathology, because it just incurs more cost and does not determine the success of the vasectomy.

Ronald E. Christensen, MD
Independence Park Medical Associates
Anchorage, AK