



Causes and Treatment of Ankyloglossia

Akira Hiroya*

Department of Dental Sciences, Tokyo Dental College Ichikawa General Hospital, Tokyo, Japan

*Corresponding author: Dr. Akira Hiroya, Department of Dental Sciences, Tokyo Dental College Ichikawa General Hospital, Tokyo, Japan, E-mail: Hiroya@Aki.jp

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Description

Ankyloglossia, also known as tongue-tie, is a congenital oral anomaly caused by an unusually short, thick lingual frenulum, a membrane connecting the underside of the tongue to the floor of the mouth. Ankyloglossia ranges in severity from mild cases with mucous membrane bands to complete ankyloglossia, in which the tongue is tethered to the floor of the mouth.

Ankyloglossia can have a mechanical and social impact on eating, especially nursing, and oral hygiene. Ankyloglossia can also keep the tongue from making contact with the front of the mouth. This can lead to an infantile swallow, which can obstruct the development of an adult-like swallow, resulting in an open bite deformity. It can also cause mandibular prognathism, which occurs when the tongue makes exaggerated anterior thrusts against the mandible's anterior part. The frequency with which ankyloglossia produces issues is a matter of debate. Some experts feel it is rarely symptomatic, while others believe it is linked to a wide range of issues. Messner and Lalakea documented the professional dispute in their study (2000).

Ankyloglossia has both mechanical and social consequences. Lalakea and Messner looked at 15 participants ranging in age from 14 to 68. Questionnaires were administered to the participants in order to assess functional problems related to ankyloglossia. Cuts or irritation beneath the tongue were mentioned by eight individuals, as were difficulties with kissing, licking one's lips, eating an ice cream cone, keeping one's tongue clean, and performing tongue tricks. Seven people also mentioned social repercussions including shame and teasing.

According to the authors, this investigation validated anecdotal evidence of mechanical problems linked with ankyloglossia and shows that the mechanical and social problems reported may be more common than previously considered. Furthermore, some patients may be unaware of the depth of their ankyloglossia-related impairments because they have never had a normal tongue range of motion, according to the authors. The small sample size of this study, which also spanned a wide age range, is a limitation. Mechanical and social repercussions, according to Lalakea and Messner, can arise even if

there are no other symptoms of ankyloglossia, such as speech and feeding issues. Mechanical and social consequences may not manifest themselves until later in infancy, as younger children may not be able to detect or report them. Furthermore, other issues, such as kissing, may not arise until later in life.

Ankyloglossia prevents the tongue from resting in its natural position, on the roof of the mouth. Nasal breathing is enabled when the tongue rests on the roof of the mouth. Chronic mouth breathing is an apparently unrelated side effect of ankyloglossia. Other health problems linked to mouth breathing include enlarged tonsils and adenoids, persistent ear infections, and sleep-disordered breathing.

Ankyloglossia can be difficult to diagnose, according to Horton, because it is not always visible on the underside of the tongue and is often dependent on the range of motion allowed by the genioglossus muscles. Passively elevating the tongue tip with a tongue depressor may disclose the issue in newborns. Making the tongue move to its full range will indicate the tongue tip restriction in older children. The diagnosis can also be confirmed by palpating the genioglossus on the underside of the tongue.

The Academy of Breastfeeding Medicine recommends using a severity scale for ankyloglossia that rates the look and function of the tongue. Ankyloglossia can be treated in a variety of ways. Surgery, such as frenotomy (also known as frenectomy or frenulectomy) or frenuloplasty, is sometimes used to treat ankyloglossia. Soft-tissue lasers, such as the Carbon dioxide laser, can be used to perform this rather routine dental operation. However, it is opposed by authors such as Horton. Surgery can be recommended for patients of any age who have a tight frenulum and a history of speech, feeding, or mechanical/social issues, according to Lalakea and Messner. Adults with ankyloglossia can choose to have the surgery. Waiting and seeing is a possible alternative to surgery for children with ankyloglossia, especially if there are no feeding implications. The frenulum naturally recedes during a child's growth between the ages of six months and six years, according to Ruffoli.