Rebuttal to the Statement of the Australian Dental Association (ADA) on Ankyloglossia

Summary of Rebuttal:

We believe that the development of the consensus statement was flawed from the outset for the following reasons: -

1. None of the members of the committee have extensive experience in the surgical management of ankyloglossia in general and in neonates specifically.
2. None of the members of the committee have declared their conflicts of interest. We believe these could be significant in some cases.
3. The literature review is grossly incomplete with many significant research articles omitted. These articles have been re-published widely, are available freely and without a fee.
4. There was no call for submissions from interested parties with experience around management of ankyloglossia when the ADA initially decided to formulate a consensus paper.
5. There was no opportunity for comment on a preliminary draft of the consensus from members of the dental or other professions.
6. Because a consensus is defined as a general agreement, there are clearly areas of disagreement, and therefore this document is not a consensus at all.

We propose the current consensus statement be retracted and a new statement be released following consideration and application of the above points and the below letter.

The Australian Dental Association (ADA) released a consensus statement on Ankyloglossia and oral frenula on 4th June 2020. This statement has been compiled with an incomplete literature review omitting significant research papers which were published in recent years. There are several unsubstantiated comments and beliefs which have no supportive research. Furthermore, it is bereft of the insights that can be gained from clinical findings in settings where oral frena are treated. The professionals on the panel for this statement are not researchers nor experienced clinicians with treatment of tongue ties. The perspective of panel members lacks insight into current clinical outcomes. The qualifications and experience of the panel members are provided in Appendix A.

Having learned that this statement was in production and that none of the experienced Australian professionals in the field of oral ties were invited to contribute, in August 2019, Dr Marjan Jones met with the president of the Qld branch of the Australian Dental Association - (ADAQ) at the time, Dr Adrian Frick and the CEO, Ms Lisa Rusten. The ADAQ representatives were informed about concerns of the consensus statement being headed by those who have long criticized tongue tie treatment and who would most likely select as their colleagues on the

panel, those whose opinions match their own (thus commencing the project with bias) or whose experience in the field of oral ties is so limited that they have little to contribute to help balance discussions.

As time passed without further news, we approached the Federal ADA president and CEO on 16th May 2020 to request a meeting and for the Federal ADA to consider the contribution of dentists with experience in this area. We sent an extensive letter which included citations of relevant literature to draw attention to potential deficits in a statement that was authored by opponents of tongue tie treatment. We were not provided a meeting and were told that the statement had considered the views of peak bodies rather than individuals with its completion and dissemination being imminent. As members of the ADA each of at least two decades, this disregard of the ADA membership was disappointing but not entirely surprising. The ADA has been on the public record opposing the treatment of ankyloglossia in infants since at least July 2017. For evidence of this, see Appendix B.

In the case of this statement, the ADA have predetermined the outcome of this consensus document in a concerted campaign that commenced in 2017, and selected members of the panel to ensure their historic opposition was not contradicted. This statement has very little merit on a professional or scientific basis and should be seen for what it is - a biased attempt to achieve through its publication what this group of academics, manipulating the ADA against the interests of its members, have failed to do through legitimate methods.

These attempts have the potential of denying mothers and infants the care and assistance they need to overcome the very real challenges they face to sustain that most significant and lifegiving practice of providing sustenance to their infants. These attempts seek to hamper the opportunity for many women to sustain long term breastfeeding – shown in clinical experience and research to aid in development of the jaws and minimise malocclusion. One would imagine the Federal ADA was committed to investigating and promoting procedures that make a difference to the health and life of patients and saving money spent in correction of issues that could be prevented. The ADA could only do this through meeting with and seeking the experience of its members who are consistently seeing positive clinical outcomes in this area and yet for several years has consistently failed to consult its own membership with direct clinical experience in ankyloglossia. We are certain the consensus statement would look very different if experienced practitioners had input into the committee meetings and the final document.

A detailed response to the inaccuracies or omissions in the consensus statement would necessitate an entirely new consensus statement which we are planning to compile in due course if required.

Although most of the available literature is not mentioned or referenced in this consensus document, it is embarrassingly biased with its misinterpretation of the literature which is cited.

For example, on page 8, in the discussion about non-surgical management of tongue tie, a preliminary report by Colaway et al (14) is cited stating that non-surgical management can be effective. However, it does not state that 1 in 3 of the babies in the study went on to have their lip and/or tongue ties surgically treated. In addition, there was only short term follow up of this group of subjects. There was only a 62% success in short-term breastfeeding improvement.

Another example of poor literature review can be found on page 10 where it quotes a paper by Huang et al (15) stating that there is insufficient evidence for the surgical release of labial or buccal frenula. However, this paper is over 25 years old. There have been many papers published since then which offer precisely the opposing view.

Further down on page 10 of the document under the section 'Neonates and infants', the entire section is unreferenced and is just opinion. For example, there is no evidence in the literature, that cold steel frenotomy using scissors is recommended in neonates. This is merely the opinion of the author who is un-named.

On page 13, the section on post-operative care refers to the open wound management or 'stretches'. The authors state that it is not recommended but base this recommendation on one study (27) of ophthalmic surgery which is not related to tongue-tie. The mechanics of the healing of the eye and the tension within the wound are very different to the mechanics of the tongue and the healing of a frenotomy. Extrapolations from the eye study could in fact support the use of stretches for frenotomy patients. We do however agree that more research is required in this area.

The section on page 15 headed 'Is ankyloglossia related to the development of malocclusion?' cites a 2009 paper concluding that there is limited evidence that tongue-tie represents a (co)-factor in the development of malocclusions. However, the authors failed to cite a later study which was published in 2015 by Peres et al 'Effect of Breastfeeding On Malocclusions: A Systemic review and Meta-Analysis.' Acta Paediatr **104**:54-61. These authors analysed 48 studies and concluded that breastfeeding decreases the risk of malocclusion. In their discussion, the authors suggest that the biomechanics of breastfeeding is different from bottle-feeding (and nipple shield) and it is the movement of the lip and tongue which influences the growth and development of the jaws and hence the development of the occlusion. Therefore, we also believe that it is irresponsible of the consensus authors to suggest that use of a nipple shield is an acceptable non-surgical method to resolve breastfeeding issues caused by tongue-tie, as suggested at the end of page 8 of the consensus statement. The benefits of these suggestions by the consensus authors are not supported by any research.

On page 16 in the section 'Does ankyloglossia cause Gastroesophageal reflux disease (GORD)?' the authors of the consensus decided to support an unsubstantiated and poorly researched, minority, opinion paper (38) of one author rather than the world–wide held opinion of many groups and published authors. Furthermore, the authors refer to the study by Siegel (43) of 1000 breastfeeding dyads (mothers and babies) with GORD as subjective and anecdotal and yet it is easily the biggest and most comprehensive study on this subject to date.

The consensus authors decided to omit one of the most cited articles from the literature, namely the study by Ghaheri,B et al "Breastfeeding Improvement Following Tongue Tie and Lip Tie Release : A Prospective Cohort Study" Laryngoscope **127**:1227-1233, (https://onlinelibrary.wiley.com/doi/full/10.1002/lary.26306) in which 237 breastfeeding dyads were studied in this level 2c research paper. It was concluded that there was a significant improvement in breastfeeding outcomes including a reduction in GORD.

It should have been acknowledged by the authors of the consensus that there are various levels of research related to tethered oral tissues and that there are ethical issues associated with undertaking studies which are randomized controlled trials (RCTs). This holds true for all types

of surgery in all fields of medicine and dentistry. And yet, surgeons from all around the world undertake procedures and make decisions based on prospective and retrospective case series studies and studies where the results are based on patient's perceptions which are often subjective. We believe that the research related to tongue and lip tie is at the same level as most other surgical research in medicine and should not be discounted because of the opinion of one or two people. Everyone in the health professions can criticize virtually every research project because of design limitations, restricted subject numbers etc. However, it is misleading for the authors of the consensus to state that there is no evidence or poor evidence when the available evidence is in fact the highest standard of evidence which can be ethically researched.

There are other aspects of the consensus that require re-examination and shall be explored in future write-ups.

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We understand and support the formulation of a consensus statement toward care for and protection of the public and toward helping professions understand issues related to oral restrictions. The mere representation of peak bodies is insufficient to reflect what experienced practitioners may contribute. It is not unreasonable to expect that in the first instance, as a member funded organisation, the ADA would seek input from its members with experience in the area being investigated before seeking to produce a so-called consensus statement.

In a continuing campaign that seems to have a political objective, introducing confirmation bias at the conception of this project, the ADA appear to have gathered predominantly a group people who are either anti-tongue treatment or practitioners with little understanding of the probable hidden agenda of the anti-tongue tie group, seeking to publish the most demonstrably biased "consensus statement".

The result of the exercise is a statement which came together over just two meetings, one via telephone, and which ignores a large swath of evidence to reach the conclusion the ADA Federal and ADAQ branches published in mid-2017, and which includes no practitioners who focus on or regularly treat tongue and lip ties. It's clearly a lot easier to reach consensus when everyone agrees at the outset.

Furthermore, it should be noted that this statement is not signed or co-signed by all of the participant organizations notably the Australian Dental Association itself and the College of Paediatricians who may have been represented by Dr John Sinn. In addition, the statement was co-signed by non-participants namely, the Australian and New Zealand Academy of Periodontists, the Australian Council of Dental Schools, and the Dental Hygienists Association of Australia. (These last 3 organizations would have little to do with the treatment of ankyloglossia and especially so in the treatment of neonates). We feel confident that members of other organizations who are experienced in treatment of patients with oral ties would concur that the opinions expressed in the consensus statement are not representative of the experienced collective despite the implication that their peak body supports the statement.

Finally, any statement such as this should be accompanied with a sunset clause, being a timeline at which point it will be reviewed and revised. A typical period would be two years. This gives a mandatory opportunity for recent research and contemporary opinion to be included in the document. This statement does not make any such declaration. Because this version only

includes some carefully selected research and the personal unsubstantiated opinions of some individuals, and is deficient in inclusion of all research and inclusion of the views of experienced practitioners in all the fields represented, we ask that it be reviewed and edited to reflect current evidence.

We remain disappointed that such a flawed approach was undertaken by the ADA, which surely calls into question its position of public trust, and we call on the Board of the Federal ADA to publicly undertake not to misuse member funds and the ADA's standing in such a fashion in the future.

We welcome the addition of other signatories to this letter, please sign our petition to join us.

Signed,

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APPENDIX A – The qualifications of the panel

Please see below for some background information on the members of the panel who not experts, researchers or experienced clinicians in the field of ankyloglossia. Some are known widely for their opposition to treatment of tongue ties.

Dr Mihiri Silva (Chair of the working group) – Dr Silva's focus has been mainly on hypomineralisation of teeth and decay in children. Her current research involves life course research in large longitudinal cohort studies, with a focus on the interaction between oral health and broader health and well-being, starting from pregnancy. Her research and clinical experience has not been on oral ties and their impact

Professor Laurie Walsh (Australian Dental Association) – while Professor Walsh is a highly experienced academic and researcher, his view on tongue ties was made evident when in an SBS interview, he criticized those that provide education for their comprehensive management and admitted that he had made several appeals to the Dental Board to arrest any developments of education and clinical progress in this arena. His areas of experience and research work are very broad and wide but are mostly focused on lasers and infection control. He is a close contact of a known opponent of tongue tie treatment, Dr Pamela Douglas.

Dr Kareen Mekertichian - Dr Mekertichian's focus is on early intervention paediatric restorative dentistry and he is an advocate for the importance of oral hygiene. He has accomplished a great reputation in these areas and highly regarded with membership in the International College of Dentists. There are no references or history of clinical, research or presenting on the topic of ankyloglossia.

Dr Russell Mottram (Chiropractor) - Dr Mottram focuses predominantly on TMJ and craniofacial pain and practises orofacial myology. His clinical websites display lists of treatments he provides, none of which are tongue ties. His work in the orofacial muscles and TMJ indicate some collaboration with dentists. While Dr Mottram may be an expert in his area, there is no significant experience on the management of ankyloglossia and he is not an expert in their management or treatment.

Ms Lois Wattis (Clinical Midwife and IBCLC) - Ms Wattis is a well-known active opponent of tongue tie treatment and a search on her work indicates a strong affiliation with Dr Pamela Douglas. There are numerous easily sourced articles and blogs on Ms Wattis' strong opinion against "Posterior" Tongue Ties. She only recognises anterior tongue ties as a legitimate restriction and believes any other tie has no impact on feeding. She claims that other equally experienced IBCLCs are misdiagnosing ties and that many tongue tie symptoms can be resolved through changing the position of the infant.

Ms Michelle Simmons (Clinical Midwife Consultant, Westmead) - Ms Simmons has been a certified IBCLC since 2006 and is a member of the LCANZ Board (Lactation Consultants Australia and New Zealand). Her approach as a midwife and IBCLC focuses on postnatal and infant feeding. An easily sourced article written by Ms Simmons displays her comprehensive knowledge in her area of expertise related to breastfeeding. Her experience and connection with oral ties is uncertain, however one of her articles contains data supporting the management and intervention of Ankyloglossia treatment. It is unclear what experience Ms Simmons has in assisting infants with ankyloglossia.

Dr Philippa Sawyer (Paediatric Dentist) - Dr Sawyer is a practicing Paediatric Dentist with around 20 years' experience. An active member of several associations, her focus and articles advocate the importance of diet and oral hygiene toward improving oral health of children. One post shared by Dr Sawyer on her twitter account in February 2018 https://twitter.com/philippasawyerof is a piece on the increase in treatment of tongue ties in Western Australia. This article contains no statistics other than the increase in frenectomy surgeries and provides no information regarding breastfeeding outcomes. In 2018 at the AAPD (Australasian Academy of Paediatric Dentistry) Dr Sawyer conducted an interactive forum on the complications associated with tongue and lip tie releases. Highly regarded in her expertise of restorative dental treatment, there are no associations of her clinical or research experience with ankyloglossia. However, while a member of the NSW Oral Health Committee, a sensationalist style article which published in the ADA newsletter (see Appendix B) warning against the over-treatment of lip and tongue ties.

Ms Eithne Irving (RN, Grad Dip Neuroscience, MBA) – Ms Irving has been an employee of the Australian Dental Association since 2011. With experience in the clinical field of nursing over 20 years ago, Ms Eithne's areas of expertise were not able to be located although, through her Twitter account, she portrays passion about the importance of available dental treatment for all economies and shows interest in diet related to dentistry. It is sourced https://www.ada.org.au/About/Our-Structure/leadership-team she ensures "ADA's voice is heard at all levels". Her experience, clinical or otherwise on the area of tongue ties is not documented anywhere.

Dr Mikaela Chinotti (Dentist) - As a new graduate, Dr Chinotti's area of experience and focus could not be identified. Largely, her work has been as a spokesperson for the ADA. Interestingly there is a comment sourced from https://www.dentalresearch.org.au/News-Media/News-and-Release/Latest-News/Meet-Mikaela-Chinotti,-the-ADA%E2%80%99s-new-Oral-Health-P with Dr Chinotti stating *how "there's little point simply being filled up with a whole lot of theoretical knowledge if there's no practical aspect to it, especially in dentistry where hands-on learning is critically-important."* There is no available data correlating Dr Chinotti with ankyloglossia experience other than this latest ADA statement.

Ms Nicole Stormon (Oral Health Therapist) Ms Stormon is an Oral Health Therapist, associate lecturer and PhD Candidate at University of QLD. She is the Vice-President of the Australian Dental and Oral Health Therapists Association. With 6 years' experience post-graduation, it is evident she has a passion for research. With over 20 journal articles, over 20 conference papers on her topics of interest in dietary related topics to oral health, oral health in aged care and the importance of oral health for people with special needs, she shows a focus on areas general oral health. Her papers hold no relation to tongue ties and her "expertise" in research and clinical field in this specific area remains unclear.

A/Prof David Sherring (Dentist and Oral Maxillo-facial surgeon) - A/Prof David Sherring has an impressive array of experience in his many clinical years as a Dentist and Oral Maxillo-facial surgeon. His proficiency is obvious due to the membership he holds in 8 highly regarded associations not to mention his experience teaching surgical registrars in Oral and Maxillofacial surgery. A/Prof Sherring is certainly an accomplished Oral and Maxillo-facial Surgeon with a focus on dentoalveolar and dental implant surgery, grafting procedures to the jaws or sinus surgery and obstructive sleep apnoea. There is no mention of ankyloglossia as an area of experience or focus.

Ms Heather Gale (IBCLC, Registered Nurse) - Ms Gale has been a certified IBCLC since 1999 with a distinct passion for promoting and offering support for breastfeeding. It is quoted from her "Linked In" account she views "breastfeeding as a National Health Issue." A volunteer for the Australian Breastfeeding Association since 1996 and currently a member of 5 associations related to lactation and nursing. A member of the Australian Society for Tongue and Lip ties for 1 year (2016-2017), Heather's involvement in such associations deems her potentially a suitable and reliable source regarding her opinion of ankyloglossia. Extracted from an online article warning a "dangerous fad of tongue-tie operations" https://www.mamamia.com.au/tongue-tie-operations/ it states Heather's "*experience correcting a tongue-tie had benefits that could last a lifetime."* She further quotes, "*Tongue tie exists, and can have a negative impact on breastfeeding, leading to the cessation of breastfeeding, and all the wonderful benefits. The international body of evidence is astounding, and there are many adults who can contest to the benefits they have experienced since having a 'lived with' tongue tie released."* A concurred opinion of any provider passionate about the treatment of tongue ties while being an advocate for breastfeeding. It is unclear how her previous views can be reconciled with the so-called consensus statement. It is unclear whether she dissented.

Dr Julie Fendall (Osteopath) - Dr Fendall offers over 35 years of experience in Paediatric Osteopathy and antenatal care. Volunteering for the Australian Breastfeeding Association line as a qualified breastfeeding counselor Dr Fendall's involvement in infancy and paediatric care is evident. Her website contains an impressive list of Osteopathic courses she has attended related to pregnancy and paediatric management. Dr Fendall is listed on a parent forum - https://www.themamacircle.com.au/freebies, recommended for her skills in the care of oral restrictions. This is the only specific reference relating her to ankyloglossia although she appears to have some experience in the area of ankyloglossia.

Dr Kelly Oliver (Paediatric dentist) - Practising Paediatric Dentistry since 2012, Dr Oliver has interest in research and teaching her chosen interests. While actively treating in private practice and currently a PhD Candidate in the Department of Paediatrics at The University of Melbourne, her experience over the past 8 years since graduating her chosen specialty is in the area of oral health of children with complex medication conditions, molar incisor, hypomineralisation and the creation of evidence-based clinical practice guidelines for infants and children. While no reference to tongue tie treatment or research is found, Dr Oliver spoke alongside **Philippa Sawyer** at the Australasian Academy of Paediatric Dentistry Annual Meeting in 2018 on the interactive forum on "complications associated with tongue and lip tie releases". No other association, studies or experience with oral restrictions can be found other than this apparent focus on potential adverse outcomes.

Ms Emma Necus (Speech Pathologist) - Ms Necus holds 6 years' experience as an IBCLC in addition to her 15 years as a Speech Pathologist. She conducts training and assistance of oral tethers as a high priority. Sharing a mutual interest of any provider passionate in the care of treating ankyloglossia. It is documented she trains her patients on swallowing dysfunctions and communicative potential as well as care for premature and term infants. She appears to have enthusiasm on the treatment and research of tongue ties. While her name has not been shared among many professional circles working with tongue ties (nor parent forums), she presented a webinar with **Lois Wattis** (above mentioned anti-tongue tie activist) on the assessment and treatment of tongue ties

APPENDIX B – The Stance of the ADA on Ankyloglossia

The ADA is not a disinterested observer on the issue of Ankyloglossia. The ADA has been on the public record opposing of the treatment of ankyloglossia in infants since at least July 2017, when the Federal Branch of the ADA published an article quoting an Oral and Maxillofacial Surgeon at the Royal Melbourne Hospital expressing alarm at the rise in diagnosis and treatment of tongue and lip ties. In their article, the Federal ADA stated *"There has been an alarming surge in the number of referrals to specialists for release of tongue ties, lip ties and buccal ties…there is no scientific evidence to support the release of these ties."* While in concluding the same article, they cite a Cochrane review's conclusion that *"Frenotomy reduced breastfeeding mothers nipple pain in the short term. Investigators did not find a consistent positive effect on breast feeding."* So by lack of evidence, the ADA are ignoring maternal symptoms, and relying on a lack of consistent positive effect on breastfeeding for a procedure they themselves note has only recently increased, begging the question whether sufficient research has been carried out, based on consistent assessment criteria to determine whether it is an effective intervention or not. An early, but not the last claim by the ADA of a lack of evidence.

Just one month after this federal article, the ADAQ (Australian Dental Association Gary Smith) published two columns in the ADAQ News in August, and November-December 2017 critical of general dentists who performed frenectomies, describing them as *"fringe dentistry"* and citing an ADA submission to the Dental Board of Australia which included the statement *"…there are many half-truths and fallacies pushed by those who promote tongue tie surgery for financial gain"*. In the August 2017 article, he quotes a sensationalist opinion piece, by vocal anti-tongue tie doctor, Pamela Douglas (who runs a private clinic specialising in alternative methods for managing difficulties with breastfeeding – although perhaps Dr Smith thinks she does not gain financially from her branded "Gestalt" approach) in which she states *"Since doing these deep cuts by laser and scissors is, to be frank, lucrative for those health professionals who specialise in it…"*, leaving no doubt as to where Gary Smith stands on the issue, especially when he concludes his column stating, *"I think such exploitation of children is unconscionable and must cease"*.

ADAQ CEO, Professor Ian Meyers stated in the September 2017 edition of the ADAQ News, *"Increased incidence of recommendations for lip & tongue tie releases, based on minimal evidence and without appropriate diagnosis and treatment planning by the appropriately trained health practitioner team,"* while providing no evidence as to how he has come to this conclusion, other than the similarly biased statements made by the Federal ADA and ADAQ in July and August 2017. Later in the same article he mentions whether that this increase might be *"driven by the perceived financial reward…"*

The ADA's stance on this appears clear. It seems, as a cohort predominantly of academics, they are opposed to the notion of private dentistry, despite there being no public dentistry for the vast majority of Australians. Unlike doctors and academics, dental practices receive no government funding. All dentistry in Australia is to some degree for *"financial gain"*, unless the authors of these advocate that dentists provide dental care for free or that dental practices should be entirely government funded?

Subsequently, in his final column in the November-December 2017 edition of the ADAQ News, before the leadership was passed to Prof Laurie Walsh (the key driver and instigator of the consensus statement), Dr Smith states *"We are concerned that there is an epidemic of over-diagnosis and over-treatment of the tongue and lip ties in the health sector."* He then goes on to quote the percentage increase in the diagnosis of tongue and lip ties as evidence to support his claim.

With three UQ academics involved in this concerted attack on the diagnosis and treatment of tongue and lip ties in four editions of member-funded publications over a five month period, it would be reasonable that the conclusion reached was more edifying than a suggestion that because the numbers have increased, therefore there must be overdiagnosis and treatment. As they would no doubt instruct their students, correlation is not the same as causality and there are many sound reasons for the increase in diagnosis and treatment, not least of which is increased emphasis on the risks of not breastfeeding which is well documented in the literature, and as demonstrated in an increasing number of studies, increased understanding of the role tongue and lip ties play in breastfeeding difficulties. Mothers are no longer accepting directives from health professionals to switch to artificial formula or that it is normal to have pain. Mothers are seeking a solution and more professionals are aware of emerging evidence both in literature and clinical settings to show that appropriate management of ankyloglossia significantly improves breastfeeding experience and duration.

After this period, during which the Dental Board of Australia did not elect to take up the ADA's concerns expressed in the 2017 submission to limit a procedure the Dental Board has since stated is within the scope of a general dentist, and for which the ADA itself has designated a treatment code (391 – Frenectomy), in 2019 Prof Walsh heavily criticised the diagnosis and treatment of tongue and lip ties in a tabloid news piece aired on Australian television, where he continued the accusations made by the ADA in 2017.

Given the Queensland origins of this dubious undertaking, perhaps it's simply a case of taking a leaf out of Queensland Politician Russ Hinze's book who was fond of quoting Yes Minister's Sir Humphery Appleby's famous line, "…never start an enquiry unless you know what its findings will be."