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EDITION

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FEATURED READING

TOPIC 3: Ankyloglossia (FEATURED READING) – Identification, Management, and Effect on Breastfeeding

Thomas J, Bunik M, Holmes A, Keels MA, Poindexter B, Meyer A, Gilliland A. Identification and Management of Ankyloglossia and Its Effect on Breastfeeding in Infants: Clinical Report. Pediatrics. 2024 Aug 1;154(2). doi: 10.1542/peds.2024-067605. PubMed PMID: 39069819

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Background

Ankyloglossia is a **congenital variation of normal oral anatomy** in which a restrictive lingual frenulum can limit tongue mobility. Diagnosis and frenotomy rates have risen, raising concerns about **overdiagnosis**. Many infants with exam findings do not develop breastfeeding problems. The goal is to identify **symptomatic cases** and use evidence-based management.

Classification / Key Definitions

Symptomatic ankyloglossia: An infant with physical examination findings consistent with a restrictive lingual frenulum **AND** feeding difficulties that do not improve with lactation support (**both components** must be present).

Frenotomy (frenectomy, frenulectomy): A procedure to release the frenulum.

Critical anatomic points:

- **Appearance alone is insufficient for diagnosis**
- The frenulum **does not connect to the posterior tongue base**, so **"posterior tongue tie"** is **anatomically incorrect terminology** and should not justify intervention
- Feeding ability may **improve over time without intervention**

Assessment and Recognition

Clinical Presentation

Symptomatic ankyloglossia **may present with** maternal nipple pain, poor or ineffective latch, poor milk transfer, inadequate weight gain, or hypernatremic dehydration. These findings are **not specific and overlap** with other breastfeeding problems.

Important limitation: Nipple pain alone is insufficient because pain typically peaks around **day 3** and decreases within **7 to 10 days**.

History

- Prenatal course; intrapartum and postpartum medications
- Maternal breastfeeding history and prior breast surgeries; breast and nipple anatomy
- Family history
- Infant feeding history including **abnormal features** (coughing, choking, color change, bilious emesis, early tiring)
- Breastfeeding difficulties (nipple pain, nipple trauma, prolonged feeding times, difficulty staying attached)

Physical Examination

- Inspect face, jaw, neck, and oropharynx
- Assess for **dysmorphic features, micrognathia or retrognathia, and cleft lip or palate**
- Assess tongue movement and coordination (clean gloved finger exam for suck and palate)
- **Findings that can suggest restriction include** inability to extend tongue over the lower alveolar ridge, inability to lift tongue toward the palate, and heart-shaped tongue on extension

Feeding Assessment

Observe a feeding session. Use **pre- and postfeeding weights** to assess milk transfer. Assess weight gain using **WHO growth standards**. Collaborate with lactation professionals and consider standardized tools (for example, **LATCH score**: Latch, Audible swallowing, Type of nipple, Comfort, Hold).

TABLE 1: OTHER CONTRIBUTORS TO BREASTFEEDING DIFFICULTIES (INFANT VS MATERNAL)

INFANT FACTORS	MATERNAL FACTORS
High intraoral pressure	Nipple variation (generous, inverted, flat)
Early weight loss in birth hospital	Nipple trauma or infection
Prematurity (including early term)	Prior breast surgery or biopsy
Sleepy at breast	Insufficient ductal tissue
Bottle preference (e.g., hospitalization for hyperbilirubinemia)	Medical conditions affecting milk supply (PCOS, gestational diabetes, hypertension)
Other oral anatomic variations (cleft lip or palate, micrognathia)	Delivery complications, retained placenta, or contraception

If poor growth or concerning features, consider: infection, congenital heart disease, congenital adrenal hyperplasia, inborn errors of metabolism, intestinal obstruction

Scoring Tools

Several scoring tools exist to assess ankyloglossia severity, but **none have been validated**. **Do not use scoring tools alone** to diagnose symptomatic ankyloglossia or to decide on frenotomy.

Management

Approach to the Breastfeeding Infant with Suspected Ankyloglossia

- 1 Identify breastfeeding concerns (nipple pain, poor latch, poor milk transfer, poor weight gain)
- 2 Triage through the primary care provider in the medical home
- 3 Perform complete breastfeeding assessment including pre- and postfeeding weights; evaluate for other infant and maternal causes
- 4 If symptomatic ankyloglossia **not confirmed, provide close follow-up** and address other contributors
- 5 If **confirmed** after evaluation and lactation support, **frenotomy may be offered; avoid costly non-evidence-based therapies**

Key AAP Practice Recommendations

- Ankyloglossia is a **variation of normal oral structure**; infants with **normal feeding patterns need no intervention**
- Every breastfeeding mother–infant pair with painful or ineffective patterns should have a **complete breastfeeding assessment before any treatment**
- **Labial and buccal frenae are normal oral structures** unrelated to breastfeeding mechanics; **sucking blisters are a normal newborn finding**
- **"Posterior tongue tie"** is anatomically incorrect terminology and **should not justify surgical intervention**
- **Postoperative stretching exercises are not evidence-based** and are not recommended

Frenotomy

- **Evidence:** Longer-term breastfeeding **benefit is uncertain or inconsistent**; may reduce maternal nipple pain in the **short term**
- **Technique:** Most common approach is **scissor clipping** with or without prior clamping; usually **does not require anesthetic or sutures in newborns**
- **There is no evidence that laser frenotomy is superior to scissor clipping**

Not Recommended / Avoid

- **Postoperative stretching exercises** (not evidence-based; may cause oral aversion)
- Releasing **labial (lip) or buccal (cheek) frenula** (normal structures; no indication for release)
- Using "posterior ankyloglossia" **terminology to justify intervention**
- Frenotomy for infants with **normal feeding patterns**
- Frenotomy to prevent future **speech or OSA**
- **Claiming laser is superior** to scissor clipping
- **Costly non-evidence-based therapies** (craniosacral, myofascial therapy)

Level of Care / Referral Criteria

Newborns with possible symptomatic ankyloglossia need **close monitoring, breastfeeding support** while in the hospital, **early follow-up**, and **weight monitoring** in their medical home.

Coordination between **lactation specialists, feeding therapists, surgeons, and pediatricians** supports best outcomes. For confirmed symptomatic ankyloglossia, frenotomy should be performed by a **trained professional experienced in newborn care** who maintains needed privileges.

JUST IN CASE (CURATED EXAM-DAY SUPPORT)

- [Identification and Management of Ankyloglossia and Its Effect on Breastfeeding in Infants: Clinical Report](#) – AAP Pediatrics
- [Ankyloglossia Management Algorithm Figure](#) – AAP Pediatrics

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