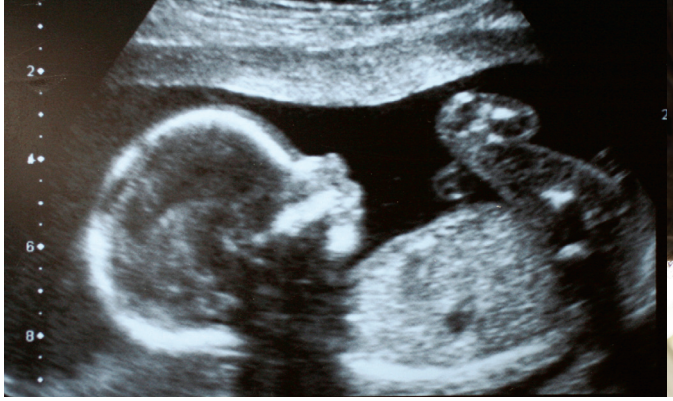

Guidelines for
Oral Health Care in Pregnancy

- Dental care is safe and essential during pregnancy
- Pregnancy is not a reason to defer routine dental care or treatment
- Diagnostic measures, including needed dental x-rays, can be undertaken safely
- Scaling and root planing to control periodontal disease can be undertaken safely; avoid using metronidazole in the first trimester
- Treatment for acute infection or sources of sepsis should be provided at any stage of pregnancy. A number of antibiotics are safe for use
- Treatment, including root-canal therapy and tooth extraction, can be undertaken safely
- Needed diagnosis, preventive care, and treatment can be provided throughout pregnancy; if in doubt, coordinate with the woman's prenatal medical provider
- Emergency care should be provided at any time during pregnancy
- Delay in necessary treatment could cause unforeseen harm to the mother and possibly to the fetus
- For many women, treatment of oral disease during pregnancy is particularly important because health and dental health insurance may be available only during pregnancy or up to two months post-partum

Medical Conditions and Dental Treatment Considerations

Hypertensive Disorders and Pregnancy

Hypertensive disorders, including both preexisting or chronic hypertension and gestational hypertension, occur in 12–22% of pregnant women. Oral health professionals should be aware of hypertensive disorders in pregnancy. Uncontrolled severe hypertension may increase the risk of bleeding during dental procedures. Prenatal care providers should be consulted before initiating dental procedures in women with hypertension to classify the type and severity of hypertension and to rule out preeclampsia if indicated.

Diabetes and Pregnancy

Gestational diabetes occurs in 2–5% of pregnant women in the U.S. It is usually diagnosed after 24 weeks of gestation. Any inflammatory process, including acute and chronic periodontal infection, can make diabetes control more difficult. Poorly controlled diabetes is associated with adverse pregnancy outcomes such as preeclampsia, congenital anomalies, and large-for gestational age newborns. Meticulous control to avoid or minimize dental infection is important for pregnant women with diabetes. Controlling all sources of acute or chronic inflammation helps control diabetes.

Heparin and Pregnancy

A small number of pregnant women with the diagnosis of thrombophilia (a blood disorder) may be receiving daily injections of heparin to improve pregnancy outcome. Additionally, some women may be on low molecular weight heparin products (e.g. enoxaparin). Heparin increases the risk for bleeding complications during dental procedures. Dental providers should consult with their patient's prenatal medical provider prior to dental treatment.

Risk of Aspiration and Positioning During Pregnancy

Pregnant women have delayed gastric emptying and are considered to always have a "full stomach." Thus, they are at increased risk for aspiration. After 20 weeks gestation, they should be maintained in a semi-seated position or a pillow should be placed underneath the right side of the body to allow left lateral uterine displacement off the vena cava. This positioning is generally comfortable and will help avoid hypotension, nausea, and aspiration.

Protecting Your Child's Teeth Begins In Pregnancy

Guidelines for Treatment in Pregnancy

INDICATIONS	RADIOGRAPHS	ANALGESICS (with FDA Category*)	LOCAL ANESTHETIC (with FDA Category*)	AMALGAM PLACEMENT OR REMOVAL	NITROUS OXIDE	ANESTHESIA	ANTIBIOTICS & ANTI-INFECTIVES (with FDA Category*)
Anytime During Pregnancy	Diagnostic x-rays are safe during pregnancy Use neck (thyroid collar) and abdomen shield	Acetaminophen (B) Meperidine (B) Morphine (B) Codeine (C) Acetaminophen + Codeine (C) Acetaminophen + Hydrocodone (C) e.g. Vicodin Acetaminophen + Oxycodone (C) e.g. Percocet	Lidocaine with epinephrine (2%) (B), considered safe during pregnancy Mepivacaine (3%) (C), use if benefit outweighs possible risk to fetus	No evidence that the type of mercury released from existing fillings harms the fetus Use rubber dam and high-speed evacuation to reduce mercury vapor inhalation	30% nitrous oxide can be used when topical or local anesthetics are inadequate Pregnant women require lower levels of nitrous oxide to achieve sedation		Penicillin (B) Amoxicillin (B) Cephalosporins (B) Clindamycin (B) Erythromycin not in estolate form (B) Quinolones (C) Clarithromycin (C) As prophylaxis for dental surgery: use same criteria for all people at risk for bacteremia
1st Trimester (1-13 WEEKS)	Spontaneous pregnancy loss occurs in 10-15% of all clinically-recognized pregnancies in the first trimester. Most losses are due to chromosome abnormalities. Yet, women may prefer to wait until the second trimester (14th week) for dental care.						AVOID: Metronidazole (B)
2nd Trimester (14-27 WEEKS)							
3rd Trimester (28-40 WEEKS)		NEVER USE NSAIDs e.g. Ibuprofen or Indomethacin					AVOID: Sulfonamides (C)
NEVER & CAUTIONS		NEVER USE Aspirin unless prescribed by the prenatal care provider Caution: Consult with prenatal care provider before recommending Ibuprofen (B) or Naprosyn (B) during the 1st and 2nd trimesters				Caution: CONSULT with prenatal care provider if using anesthesia other than a local block e.g. IV sedation or general anesthesia	NEVER USE Tetracyclines (D) Erythromycin in estolate form

* Cat B: No evidence of risk in humans; either animal studies show risk (human findings do not) or, if no adequate human studies done, animal findings negative.

* Cat C: Human studies are lacking and animal studies are either positive for fetal risk or lacking as well; potential benefits may justify the potential risk.

* Cat D: Positive evidence of risk. Investigational or post marketing data show risk to fetus. Nevertheless, potential benefits may outweigh the risk.

Consult with the patient's prenatal care provider with questions and concerns about the use of any medication.

These recommendations have been reviewed with dentists and prenatal care providers—obstetricians, family doctors, nurse practitioners—throughout Oregon. We believe they represent the standard of care in Oregon. If you have questions about individual patients, contact that patient's care provider directly.

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Source material for this document includes Oral Health Care During Pregnancy and Early Childhood: Practice Guidelines. New York, NY: New York State Department of Health, 2006.

ACOG GUIDELINES FOR DENTAL CARE IN PREGNANCY: Caries, poor dentition, and periodontal disease may be associated with an increased risk for preterm delivery. It is very important that pregnant women continue usual dental care in pregnancy. This dental care includes routine brushing and flossing, scheduled cleanings, and any medically needed dental work. Many dentists will require a note from the obstetrician stating that dental care requiring local anesthesia, antibiotics, or narcotic analgesia is not contraindicated in pregnancy. The dentist should be aware that pregnant women's gums do bleed more easily.

Found in Guidelines for Perinatal Care, Sixth Edition, pp 123-124; http://www.acog.org/publications/guidelinesForPerinatalCare/gpc-83.pdf