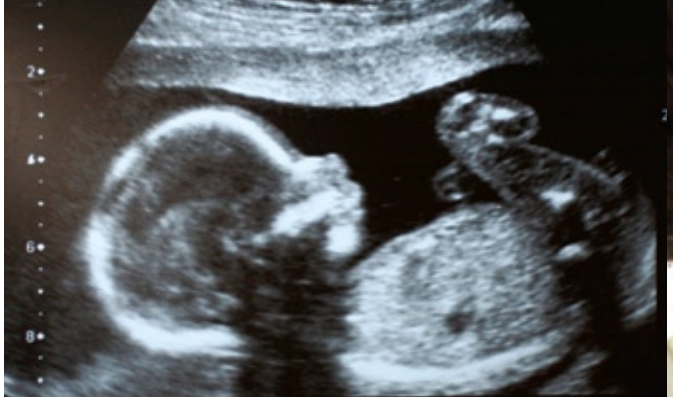

Guidelines for

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 chronic or preexisting hypertension and the development of hypertension during pregnancy, occur in 12–22% of pregnant women. Oral health professionals should be aware of hypertensive disorders because of increased risk of bleeding during procedures. Consult with the woman's prenatal care provider before initiating dental procedures in women with uncontrolled severe hypertension (blood pressure values greater than or equal to 160/110mm Hg).

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 inflammation 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. Heparin increases the risk for bleeding complications during dental procedures. Dental providers should consult with the woman'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. Maintaining a semi-seated position or positioning with a pillow helps avoid nausea or aspiration and can make the woman feel more comfortable

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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 out weighs 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
2nd Trimester (14-27 WEEKS)							
3rd Trimester (28-40 WEEKS)		NEVER USE Ibuprofen					
NEVER & CAUTIONS		NEVER USE Aspirin Consult with prenatal care provider before recommending Ibuprofen (B) or Naprosyn (B) during the 1st and 2nd trimesters. NEVER USE in 3rd trimester.				CONSULT w/ prenatal care provider if using anesthesia other than a local block e.g. IV sedation or GA	NEVER USE Tetracyclines (D) Erythromycin in estolate form (B) Quinolones (C) Clarithromycin (C)

* **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.