



Samaritan InterCommunity Health Network
Samaritan Advantage Health Plan
Sam Choice

CLINICAL PRACTICE GUIDELINE NAME:	Oral Health Care in Pregnancy
ORIGINAL DATE APPROVED BY QMC:	1/10 SHPO
DATES RE-REVIEWED BY QMC:	

GUIDELINE DESCRIPTION:

This guideline highlights the importance of oral health and dental care during pregnancy.

REFERENCES:

1. The guidelines were developed by the University of Washington and the Northwest Center to Reduce Oral Health Disparities.
2. The guidelines have been reviewed by Oregon Health Plan Dental Care Organizations, Oregon Dental Association, Oregon Pediatric Society and the Oregon Chapter of the American College of Obstetrics and Gynecology.
3. The online pdf of “Pregnancy and Oral Health Care Guidelines” can be found at <http://www.oregondental.org/i4a/pages/index.cfm?pageid=3590#P>

"These recommendations are designed to be guidelines but do not guarantee coverage by each plan. For coverage/benefit information please contact our member services department."



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.



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	Acetaminophen (B) Meperidine (B) Morphine (B) Codeine (C)	Lidocaine with epinephrine (2%) (B), considered safe during pregnancy	No evidence that the type of mercury released from existing fillings harms the fetus	30% nitrous oxide can be used when topical or local anesthetics are inadequate		Penicillin (B) Amoxicillin (B) Cephalosporins (B) Clindamycin (B) Erythromycin not in estolate form (B)
	Use neck (thyroid collar) and abdomen shield	Acetaminophen + Codeine (C)	Mepivacaine (3%) (C), use if benefit outweighs possible risk to fetus	Use rubber dam and high-speed evacuation to reduce mercury vapor inhalation	Pregnant women require lower levels of nitrous oxide to achieve sedation		Quinolones (C) Clarithromycin (C)
		Acetaminophen + (Hydrocodone (C) e.g. Vicodin					As prophylaxis for dental surgery: use same criteria for all people at risk for bacteremia
		Acetaminophen + Oxycodone (C) e.g. Percocet					

1 st 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 (14 th week) for dental care.						AVOID: Metronidazole (B)
2 nd Trimester (14-27 weeks)							
3 rd Trimester (28-40 weeks)		NEVER USE 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 1 st and 2 nd trimesters				Caution: CONSULT with prenatal care provider if using anesthesia other than a local block e.g. IV sedation or GA	NEVER USE Tetracycline (D) Erythromycin in estolate form
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*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> Copyright October 2007 by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists