



Major considerations of dental care and treatments for pregnant and breast-feeding women: a concise systematic review

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Abstract

Introduction: Dental treatment for pregnant women is still a source of insecurity for many professionals, including those in the dental field. Among the changes present is the increase in the rate of dental caries, acid enamel erosion, and, of paramount importance, a greater predisposition to periodontal disease.

Objective: It was to present the main considerations of dental care and treatment in pregnant and lactating women through a concise systematic review. **Methods:** The systematic review rules of the PRISMA Platform were followed. The search was carried out from December 2022 to February 2023 in the Scopus, PubMed, Science Direct, Scielo, and Google Scholar databases, using articles from 2014 to 2022. The quality of the studies was based on the GRADE instrument and the risk of bias was analyzed according to the Cochrane instrument.

Results and Conclusion: A total of 120 articles were found, 29 articles were evaluated in full and 16 were included and developed in this systematic review study. Considering the Cochrane tool for risk of bias, the overall assessment resulted in 20 studies with a high risk of bias and 32 studies that did not meet GRADE. Drug therapy in pregnant and breastfeeding women, as well as any form of surgical intervention, always requires a careful assessment of the risks potentially involved in this practice. In this way, the dental surgeon must prescribe rationally and responsibly, to avoid the undesirable effects that may be caused by the use of medications. It is of paramount importance, the constantly updating of the professional, through the search for recent information in updated references or specialized centers, about the drugs and their possible harmful effects on the mother and the child.

Keywords: Pregnant women. Breast-feeding women. Dental Care. Dental treatment.

Introduction

Dental treatment for pregnant women is still a source of insecurity for many professionals, including those in the dental field. Since the oral cavity undergoes important changes during pregnancy, maintaining oral health is essential. Among the changes present is the increase in the rate of dental caries, acid enamel erosion, and, of paramount importance, a greater predisposition to periodontal disease [1,2].

Periodontitis is a destructive inflammation of the periodontium and affects about 30% of women of childbearing age. Studies show that when the pregnant woman's oral health is precarious, the risks of having premature and low birth weight babies are greater. There is also a portion of pregnant women who develop problems or injuries because they have pre-gestational comorbidities or acquired at this stage, constituting the group of high-risk pregnant women [2,3]. The association of pregnancy with systemic pathologies requires differentiated care by the dental surgeon, who must know the systemic implications that each pathology has on the general health of pregnant women, in addition to instructing them about the importance of oral health and dental care during this period [4,5].

In this way, it is possible to minimize the risks associated with the mother and the fetus, arising from the poor condition of the teeth and adjacent structures, and allow the performance of any dental procedure with safety and comfort for the patient and the professional. Recent studies show the importance of the dental

professional during pregnancy, a period in which numerous physiological changes occur. Most dental procedures, provided they are correctly performed, do not harm the fetus, especially when performed during the ideal gestational period [5,6].

Thus, this is still the ideal period to motivate and educate pregnant women who are receptive to incorporating healthy habits that benefit their health and that of the baby. It is necessary to train professionals able to provide differentiated care to pregnant women, including preventive and curative actions, to promote the oral health of the mother and, consequently, of the baby [7].

There is a growing body of evidence that drugs can cause damage to the central nervous system (CNS) of the fetus, even in the absence of structural and physiological effects. This is because the fetal CNS is still under development at the time of birth, and according to some authors, this would persist until at least 18 months after birth. Therefore, drugs can interfere with the normal maturation of the CNS and produce abnormalities in the child's mental abilities [7]. Due to the historical scarcity of well-controlled drug studies in human pregnancy, several initiatives emerged in the 1990s. Currently, many of these projects are starting to show results from a simple followup of exposures to a given drug, or study groups of therapeutic classes that have been studied in their entirety, sponsored by consortia of financing companies [1,6,7].

Also, the higher incidence of dental caries in this period is due to the carelessness of women in this phase of change, in which there is a change in eating habits and greater exposure of tooth enamel to gastric acids. Gingival alterations also occur in patients when local irritants are present. Hyperemia, edema, and gingival bleeding are related to factors such as nutritional deficiencies, high hormone levels, the presence of bacterial plaque, as well as the transient state of immunosuppression. It is imperative that the future mother knows and understands the harm that cariogenic and periodontal-pathogenic bacteria can bring to her and her baby [6-9].

Therefore, the present study aimed to present the main considerations of dental care and treatment in pregnant and lactating women through a concise systematic review.

Methods

Study Design

This was followed by a systematic literature review model on the main clinical findings of mandible fractures, according to the PRISMA rules (Transparent reporting of systematic review and meta-analysis-

[HTTP://www.prisma-statement.org/](http://www.prisma-statement.org/)).

Data sources and research strategy

The literary search process was carried out from December 2022 to February 2023 and was developed based on Scopus, PubMed, Science Direct, Scielo, and Google Scholar, using scientific articles from 2014 to 2022, using the descriptors (MeSH Terms): "*Pregnant women. Breast-feeding women. Dental Care. Dental treatment.*", and using the Booleans "and" between the descriptors (MeSH Terms) and "or" between the historical findings.

Study quality and risk of bias

The quality of the studies was based on the GRADE instrument, with randomized controlled clinical studies, prospective controlled clinical studies, and studies of systematic review and meta-analysis listed as the studies with the greatest scientific evidence. The risk of bias was analyzed according to the Cochrane instrument.

Results

Summary of Literary Findings

A total of 120 articles were found. Initially, duplication of articles was excluded. After this process, the abstracts were evaluated and a new exclusion was performed, removing the articles that did not include the theme of this article, resulting in 50 articles. A total of 29 articles were evaluated in full and 16 were included and developed in this systematic review study (Figure 1). Considering the Cochrane tool for risk of bias, the overall assessment resulted in 20 studies with a high risk of bias and 32 studies that did not meet GRADE.

Figure 1. Selection of studies – Flowchart.

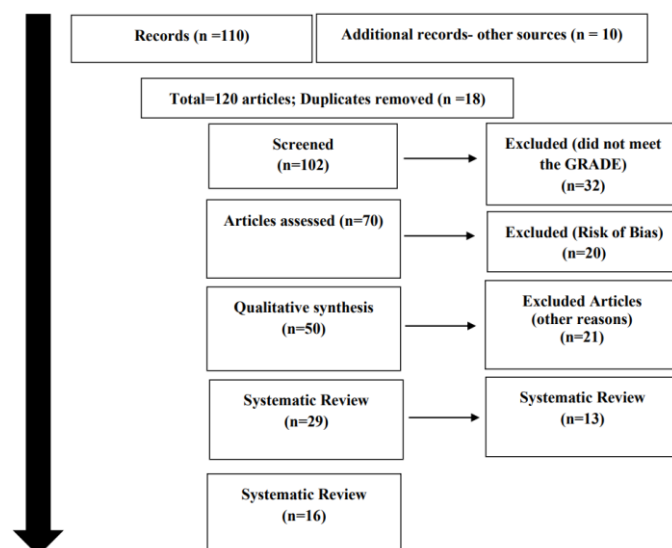


Table 1 shows the main everyday questions and answers about dental treatment for pregnant and lactating women [1,10,11].

Table 1. Main considerations for dental treatment in pregnant and lactating women.

❖ Can a pregnant woman receive dental treatment?
It can be attended at any gestational age, but the second trimester is the most appropriate time, as this is the period of greatest stability.
❖ Are there risks with local anesthesia?
Pregnant women may have an increase in blood pressure and this should be taken into account. Thus, the dentist and gynecologist must choose the appropriate anesthetic.
❖ Can pregnant women be X-rayed?
In the first trimester, radiographs should be avoided. In case of emergency, the lead apron should be used at any stage of pregnancy.
❖ Do they say that teeth "damage" more easily?
Pregnancy is not responsible for the appearance of caries or for the loss of minerals from the mother's teeth to form the baby's calcified structures. Increased cariogenic activity is related to dietary changes and the presence of plaque bacteria caused by inadequate cleaning of teeth.
❖ Does the gum inflame more easily?
Pregnancy does not cause gum inflammation. Despite having a greater vascularization of the periodontium. It is the presence of plaque that causes gingivitis.
❖ Are there special precautions for oral hygiene?
Care is the same as for a woman who is not in the gestational phase.
❖ When do baby teeth start to form?
The "milk teeth" begin to form from the 6th week and the permanent teeth, from the 5th month of intrauterine life. Thus, unfavorable conditions during pregnancy such as the use of medication, infections, and nutritional deficiencies can cause problems in the teeth in the formation and mineralization phase.
❖ Is there any tonic to be taken to ensure good dentition for the future baby?
Fortifiers are part of a balanced diet. If there is a need for vitamins, the gynecologist will determine the necessary prescription.
❖ Should a pregnant woman use fluoride for the baby's teething?
The fact that the pregnant woman takes fluoride during pregnancy does not mean that the baby will have fewer cavities. It is most important after the eruption of teeth, which begins at about 6 months of age.

❖ Is breastfeeding important for baby teeth?

Natural breastfeeding during the first year of life is essential for the prevention of many malocclusions. In addition to the affective and nutritional importance, muscle exercise while sucking on the breast favors nasal breathing and prevents most of the problems of incorrect positioning of teeth and facial structures.

❖ What should a pregnant woman do for her baby to have good teeth?

The level of oral health of the mother is related to the oral health of the child. Parents greatly determine the hygiene behavior of their children. Healthy habits are essential, for example, oral hygiene, and a balanced diet. A good diet also means avoiding sugary products. The natural sugar in food is sufficient for the health of the pregnant woman and the development of the baby.

❖ After birth, when should I take the child to the dentist for the first time?

The first visit to the pediatric dentist should take place around the eruption of the first milk teeth, at which time the parents will receive guidance regarding the causes and transmission of caries, nutrition, cleaning the baby's teeth, and the proper use of fluoride. Health education ensures the chance for the child to grow up without oral problems.

The monitoring of the pregnant patient by a dentist throughout the gestational period is important since many pregnant women neglect their oral hygiene due to various financial and cultural factors. Oral care at this stage then becomes essential because the oral cavity is highly vascularized and physiological and immunological changes can influence its structures [12]. Good oral health protects women's health, improves their quality of life, and has the potential to reduce the transmission of pathogenic bacteria from mother to child. Furthermore, both periodontal disease and caries are typically asymptomatic for long periods, with painful exacerbations occurring as the disease progresses [2,3].

Possible Oral Diseases During Pregnancy

Dental Cavity

The risk of dental caries during pregnancy is due to increased acidity in the oral cavity, increased frequency of ingested carbohydrates, and neglect of oral hygiene. As a corollary to the increase in caries in the mother, children may have cavities, as the disease is transmissible. As an example of confirmation, studies have shown that the baby's perception of sweets occurs around the 14th week of intrauterine life. If the pregnant woman consumes a lot of sugar, the amniotic fluid becomes sweeter, inducing the child to prefer sweetened foods [7,8]. Added to this, the incidence of dental caries

is more linked to factors such as lower stomach capacity and an increase and consequent increase in the frequency of food intake, leading to an increase in carbohydrates in the diet [13].

Acid Erosion

It is estimated that nausea and vomiting during pregnancy affect approximately 70 to 85% of women, leading to dental erosion or decalcification of the tooth enamel, mainly on the palatal and lingual surfaces, in addition to dentin hypersensitivity. Furthermore, changes in salivary composition at the end of pregnancy and during lactation may temporarily lead to enamel erosion [14].

Complications in Gingival and Periodontal Tissues During Pregnancy

It is estimated that periodontal alterations affect between 15 and 30% of pregnant women, with a relatively high proportion of pregnant women. Sexual changes during pregnancy, such as increased estrogen and progesterone, play an important role in periodontal changes, making tissues more susceptible to inflammatory responses. Gingival fluid often contains inflammatory mediators and oral pathogens associated with periodontal disease [1,2].

The mechanisms underlying this destructive process involve both direct tissue damage resulting from bacterial plaque products and indirect damage through the induction of host inflammatory and immune responses in response to bacterial infections. In addition, homeostasis of the periodontium involves multiple factors that can modify the clinical expression of gingivitis, including the amount of bacterial plaque and variations in the production of sex hormones. To corroborate this, clinical studies have revealed an increase in the incidence and severity of gingival inflammation during pregnancy [8].

Added to this, the most accepted theories for periodontal alterations include hormonal effects on the subgingival biofilm, the immune system, vascularization, and specific cells of the periodontium. Thus, the response of the periodontium is not related to a single mechanism, but to a combined effect of factors. According to immune system theory, periodontal tissues become more prone to develop gingival inflammation during pregnancy [15].

By way of discussion, among the most common gingival alterations that may occur during pregnancy, we can mention pregnancy gingivitis and pyogenic granuloma. Pregnancy gingivitis is clinically similar to gingivitis induced solely by biofilm, with reddish, edematous gingiva and sensitivity to brushing. This clinical condition corresponds to an exacerbated

response to the presence of bacterial plaque and its prevalence varies between 35 and 100% of pregnant women. Furthermore, it may disappear a few months after delivery, as long as the local irritants are eliminated by removing the bacterial biofilm, through good oral hygiene or professional prophylaxis [4-7].

In addition, the gravid tumor, or pyogenic granuloma, is a benign lesion that usually appears in the first trimester of pregnancy and affects more than 5% of pregnant women. It can result from repetitive trauma and local irritation on the gingival tissues and occurs preferentially in the anterior region of the maxilla. Thus, studies have indicated that estrogen accelerates tissue healing through the production of neuronal growth factor by macrophages, increasing the granulocyte-macrophage colony-stimulating factor (GM-CSF) in keratinocytes, the fibroblast growth factor (FGFb) and transforming growth factor beta-1 (TGF β 1) in fibroblasts [7,8].

Periodontitis and Premature Birth

About 18% of premature births are related to periodontitis. Periodontitis is an infectious disease caused predominantly by "Gram-negative anaerobes" that colonize the subgingival area. This condition increases the amount of local inflammatory mediators, such as prostaglandins (PG), interleukin 1-b (IL-1b), IL-6, and TNF-a, altering the systemic levels of these mediators. It is therefore suggested that periodontitis has the potential to influence premature birth and low birth weight, involving inflammatory mediators or direct bacterial attack to the amnion [1].

Thus, studies have shown that mothers with satisfactory gingival health have a lower risk of having a premature birth, highlighting the hypothesis that periodontal-pathogenic bacteria, mainly gram-negative anaerobes, can serve as a source of endotoxins and lipopolysaccharides, increasing local inflammatory mediators and systemic [2-5]. In addition, other studies published on the influence of periodontitis on premature birth showed that pregnant women who underwent periodontal interventions during pregnancy had lower rates of premature babies at birth (13.5 %), compared to those who did not. received treatment (18.9%). However, some studies have not found any association between maternal periodontal disease and premature birth of babies and it is not yet confirmed by randomized multicenter studies [7-9].

Exams and General Care

X-rays

X-rays of oral tissues are not contraindicated during pregnancy due to exposure to very low levels of radiation. In addition, radiographs should be used

whenever necessary to complete diagnoses and establish treatment plans. Thus, the dentist must protect against radiation exposure to the pregnant woman's abdomen and neck, placing her arms over her belly to protect against the weight of the lead apron. In addition, a new radiographic dental technology that is also safe during pregnancy is digital radiography, whose radiation is lower than that provided by conventional radiographs [3].

Position of the Pregnant Woman in the Dental Chair

As a reason for attention and primary care with the position of pregnant women, when the pregnant woman is in the prone position, the uterus, in the third trimester, can compress the inferior vena cava and thus prevent a venous return to the heart, which can lead to supine hypotension syndrome, syncope caused by insufficient paravertebral blood circulation, or the vasovagal reflex, due to the decrease in cardiac output. This can be increased by up to 20% when the patient moves from the supine position to the left lateral decubitus position [3,4].

It is estimated that this syndrome only occurs in 15 to 20% of pregnant women and can be avoided during dental treatment by placing the patient in a semi-recumbent position, encouraging frequent changes in position, or placing a wedge under one of your hips to displace the uterus. In addition, a small pillow or folded blanket moves the uterus in such a way as to prevent compression of the vena cava [4].

Pharmacological Treatment

It was believed that the placenta worked as a barrier, protecting the fetus from any pharmacological aggression in the 1950s. Between 1950 and 1960, about ten thousand children were born with important congenital alterations, associated with the use of the drug thalidomide, which was used as a sedative, antiemetic and hypnotic agent. With this, it is known that most drugs cross the placenta and reach the fetus's bloodstream, thus, pharmacological treatment during pregnancy must be administered with care and professional knowledge [2,3].

Besides, teratogenic agents are those that act to alter the growth structure or developmental function of the embryo. To cause a change in development, a teratogen acts during critical periods of embryonic or fetal development. Thus, during organogenesis, fetal tissues begin to differentiate and this is the period of greatest vulnerability to pharmacological agents [1].

Also, neonatal withdrawal syndrome is a common side effect of prolonged use of analgesics, such as paracetamol associated with codeine, hydrocodone,

meperidine, and morphine. Thus, analgesics commonly prescribed in Dentistry should be used for short periods to prevent adverse effects. Added to this, other drugs to be avoided during pregnancy are anxiolytics, including diazepam, since they cause significant respiratory depression, bringing risks to the mother and fetus [2]. The application of lidocaine with epinephrine for dental treatment requires additional care with the amount of anesthetic and inadvertent injections into maternal blood vessels, being safe during pregnancy as long as the technique used is sensible and the volume of the drug is controlled [1].

Dental Treatment During Lactation

As in pregnancy, the fundamental principle of prescribing drugs for lactating mothers is based on the concept of risk and benefit. Thus, knowing the pharmacokinetic and pharmacodynamic characteristics of drugs and their diffusion throughout the body can be useful in identifying the risk and benefits of their use during breastfeeding [1,8,9]. Most drugs given to women during lactation can be detected in breast milk. Fortunately, the concentration of drugs obtained in milk is usually low. However, during lactation, it is best to avoid the use of drugs that do not have available data on their safety [9].

Also, drugs during lactation should be administered conservatively and the dentist should be aware of potentially dangerous drugs for the breastfeeding woman and the baby. The total amount of medicine that the infant should receive per day through breast milk should be less than what would be considered a therapeutic dose. It should be administered 30 to 60 minutes after breastfeeding or 3 to 4 hours before the next feeding. This time interval allows the clearance of many drugs from maternal blood so that concentrations present in milk will be relatively low [1].

Antithrombotic Agents in the Dental Treatment of Pregnant Women

The use of antithrombotics in patients using anticoagulant agents, including heparin and oral anticoagulants, requires certain precautions during dental procedures. During pregnancy, when the administration of anticoagulants is necessary, the drug of choice is heparin, since it is not associated with fetal impairment and its maternal effects can be promptly reversed. Furthermore, concerning antiplatelet agents, aspirin suspension is not indicated for dental procedures. Precautions must be taken to reduce bleeding in patients using antithrombotic drugs. Among the measures, we can mention, evaluating the complete medical history of the patient, minimizing surgical trauma, avoiding the extraction of more than three teeth

per visit, reducing the areas of surgery and periodontal scraping, planning the surgeries at the beginning of the day, and the beginning of the week and request laboratory tests [1].

Thus, control of postoperative bleeding can be prevented by removing non-absorbable sutures within 4 to 7 days, compressing with gauze for 15 to 30 minutes after the surgical procedure, and using coagulating agents such as a gelatin sponge, cellulose, synthetic collagen, tranexamic acid, and suitable synthesis methods to properly coapt the edges [1].

Antibiotic Prophylaxis

One of the most important relationships between oral focus and risk for pregnant women with valvular heart disease is infective endocarditis, in which *Streptococcus viridans* is one of the main etiological agents. Thus, infective endocarditis can affect other structures of the heart, such as the endocardium of interventricular communications and prosthetic valves, causing serious sequelae and often death, making it imperative to maintain oral health during prenatal care until the moment of the child's birth [1].

Thus, antibiotics commonly used for prophylaxis of infective endocarditis (amoxicillin, erythromycin) in dental procedures may interfere with the metabolism of oral anticoagulants, but there is no need to change anticoagulant therapy when a single dose of prophylactic antibiotic is used. Therefore, the recommendations of the American Heart Association - AHA (2014) propose that antibiotic prophylaxis of infective endocarditis be performed in all dental procedures that involve manipulation of the gingival tissue or the periapical region or perforation of the buccal mucosa [7].

Local Anesthetics in Pregnant Women

A local anesthetic that provides the best anesthesia to the pregnant woman should be used to avoid pain and discomfort. Thus, the local anesthetic must contain a vasoconstrictor agent in its composition to delay its absorption, which reduces its toxicity and increases the duration of anesthesia, in addition to reducing local bleeding [1,7]. For example, lidocaine with epinephrine is the most used in the world, as they are not teratogenic and do not have adverse effects in humans, even though they cross the placenta. The American Academy of Pediatrics allows the use of lidocaine during lactation, because, although it is excreted in breast milk, the concentrations are low and do not cause harm to the baby. However, the maximum amount of anesthetic should not exceed two bottles of 2% lidocaine solution [1,13].

Other Medications

Anxiolytics such as bromazepam (Lexotan®), lorazepam (Lorax®), and diazepam (Dienpax®, Valium®) are contraindicated during pregnancy, as it is suspected that these drugs have a reasonable teratogenic power. Most sedatives and hypnotics reach concentrations in breast milk that are sufficient to produce a pharmacological effect in infants. Diazepam can exert a sedative effect on the infant, in addition, it has a prolonged half-life, which can result in significant accumulation of the drug [12,13].

Cardiac and Hypertensive Pregnant Woman Undergoing Dental Treatment

Carrying out dental procedures in cardiac patients is essential, since the presence of infectious foci in the oral cavity (such as periodontal disease, caries, and endodontic lesions) may represent a postoperative complication factor and significantly increase the incidence of bacterial infections. The incidence of heart disease in pregnancy ranges from 1.0 to 7.0%, being the fourth leading cause of maternal mortality and the most frequent non-obstetric cause of death [13].

Dental Treatment in Diabetic Pregnant Women

Dryness and irritation of the oral mucosa decreased salivary flow and changes in the flora, with a predominance of *Candida albicans*, are the most evident oral findings in diabetic patients. Thus, diabetes mellitus (DM) is one of the systemic conditions that aggravate the response of the periodontium to bacterial plaque. In addition, it was observed that patients with improvement in the gingival bleeding index have a decrease in the levels of glycosylated hemoglobin [13].

Dental Treatment in Immunosuppressed Pregnant Women

The most common manifestations in the immunosuppression phase are herpetic infection (46.8%), followed by candidiasis (40.6%), papilloma (9.3%), hairy leukoplakia (6.2%), cyclosporine-induced gingival hyperplasia (6, 2%), tuberculosis (3.1%) and aspergillosis (3.1%). Thus, the diagnosis and treatment of these lesions are of great importance, in addition to eliminating infectious foci before surgery and encouraging oral hygiene [1,13].

Discussion

Dental care during pregnancy is quite common, as pregnant women can present several alterations in the oral cavity, the main ones being hyperplasia and gingival bleeding, resulting from hormonal oscillations, which can occur from the second month of pregnancy and usually disappear after childbirth [1-3]. Thus, based on

the literary findings above on dental treatment in pregnant and lactating women, several physiological changes in pregnancy must be known and considered in dental treatment. The second trimester of pregnancy is the most suitable for dental treatment, however, the pregnant woman should be seen at any time when the required treatment is urgent. The oral diseases that most affect pregnant women are dental caries, acid erosion, and, especially, periodontal disease, which may be associated with several perinatal pathological conditions, including premature birth and the occurrence of low birth weight [3].

Still, the best position to care for pregnant women is lateral decubitus [4]. Amoxicillin and paracetamol are the drugs of choice when necessary, as well as the use of lidocaine with epinephrine in local anesthesia. X-rays are not contraindicated, as long as proper precautions are taken. When the pregnant woman is considered at high risk, basic care must be added to the specific care of each systemic pathology. Dental treatment is important both for oral health and for systemic health, and the association between Dentistry and Medicine is essential during pregnancy [13].

In addition, for a careful drug prescription, the dental surgeon can follow the guidelines of the American Academy of Pediatrics (AAPD) guidelines on Perinatal Oral Health Care, because after selecting the drug treatment and writing the prescription, the prescriber must inform the patient about a) the short- or long-term objectives of the instituted treatment; b) how, when and for how long to take the medication; c) its benefits and risks (adverse reactions, intoxications); d) procedures to be followed if any adverse effects appear; e) how to store the medicines; f) what to do with leftovers [16].

Thus, the dental surgeon will only succeed in administering medication if he acts rationally and responsibly, especially when prescribing for those patients who need special care, such as elderly patients, children, pregnant women, and infants. During dental care for pregnant and lactating women, the dental surgeon is faced with the difficult task of deciding on the conduct to be followed concerning drug therapy, since care with these patients should be redoubled. In this way, always aiming at the best conduct, the professional must know the drugs that can be prescribed for such patients, in addition to their effectiveness and safety [16].

The principle that guides the choice of therapy to be used for pregnant women is based on the risks-benefits for the fetus and the mother. The act of medicating any young woman of childbearing age must always take into account the risk of a possible pregnancy, since the period of greatest fetal vulnerability to drugs is precisely the beginning of

pregnancy, when it has not yet been confirmed pregnancy [1,2].

In this sense, most drugs administered to pregnant women cross the placental barrier and expose the fetus to their pharmacological and teratogenic effects because pregnancy determines several physiological changes. Among the main alterations, we highlight the increase in blood volume and renal plasma flow, in addition to the relative decrease in plasma proteins, which modify several pharmacokinetic characteristics, such as drug-protein binding, distribution speed, and renal clearance of the administered drug [13].

The placenta is not an effective barrier for most drugs and, once they have crossed it, their effects will depend on the ability of fetal tissues to metabolize the substance, as well as on the susceptibility of these tissues to aggression. In this way, the greatest concern of drug administration in pregnant women is the possible passage of the drug through the placental barrier, consequently reaching the fetus and causing harmful effects [7,8].

Conclusion

It was concluded that drug therapy in pregnant and lactating women, as well as any form of surgical intervention, always requires a careful assessment of the risks potentially involved in this practice. In this way, the dental surgeon must prescribe rationally and responsibly, to avoid the undesirable effects that may be caused by the use of medications. It is of paramount importance, the constantly updating of the professional, through the search for recent information in updated references or specialized centers, about the drugs and their possible harmful effects on the mother and the child.

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The authors declare no conflict of interest.

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