Misconceptions After Conception:
Debunking Myths About Oral Health During Pregnancy

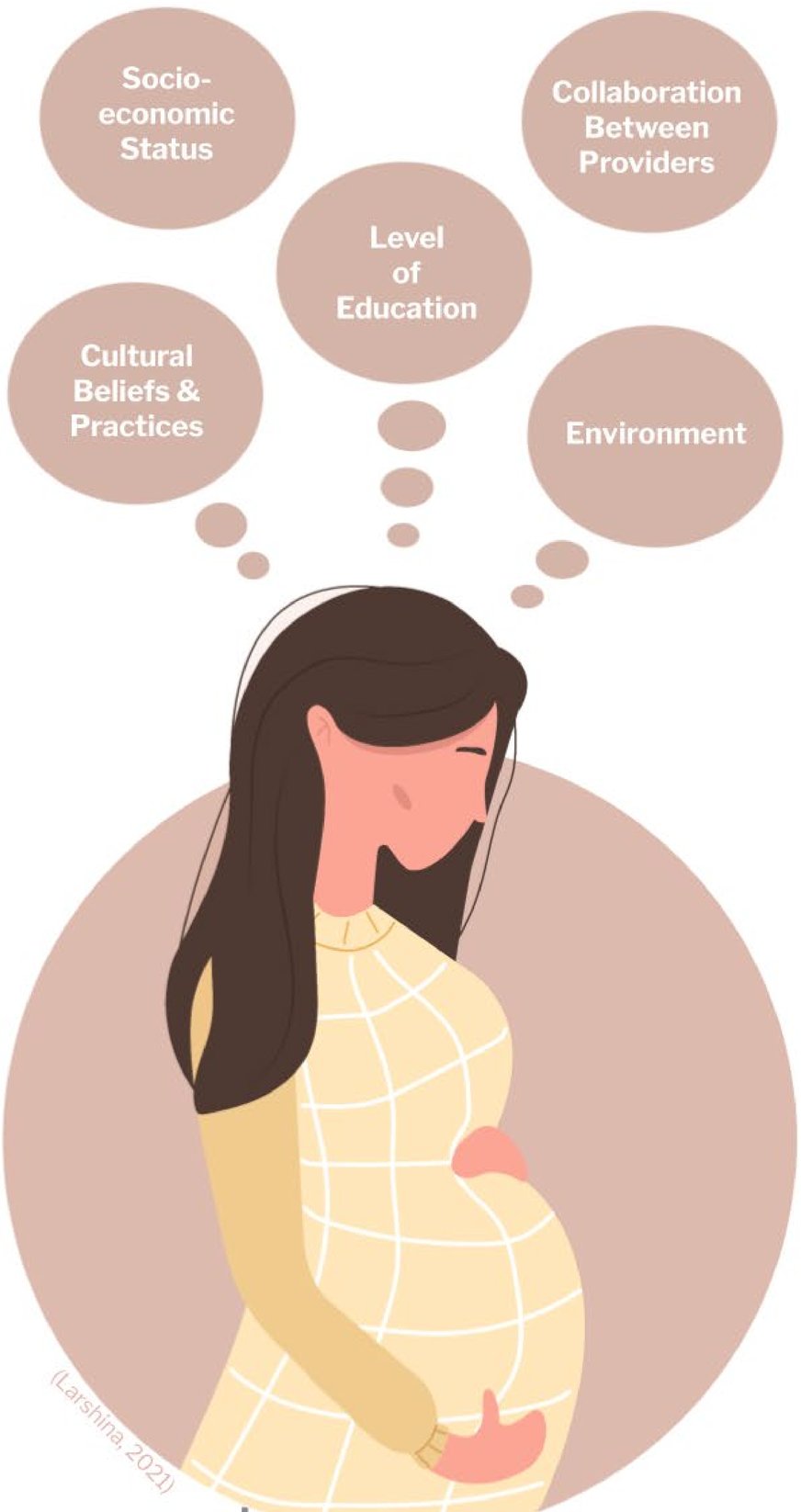
Chelsea Borsack, Ana Baquero, Adiola Hisa
Farmingdale State College Department of Dental Hygiene

INTRODUCTION

- While dental professionals are likely well versed in the connection between pregnancy and oral health, research has shown that pregnant women hold many different misconceptions regarding oral homecare and professional dental treatment during fetal development.
- Research suggests that pregnant women's oral health literacy is limited. Such limitations may contribute to behaviors that promote negative pregnancy outcomes, including preterm birth and low birth weight.
- It is important that the dental hygienist is familiar with the oral-systemic link as it pertains to pregnancy so they can provide informed oral hygiene instruction (OHI) to patients who are pregnant or trying to become pregnant.

ORAL HEALTH LITERACY

- The American Dental Association defines oral health literacy as "**the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate oral health decisions**" (ADA, 2022).
- A pregnant woman's oral health literacy is determined by many factors, including their culture, education, and socioeconomic status coupled with the oral health knowledge of their prenatal providers and whether there is collaboration between these providers and the patient's dental treatment team.
- A study conducted by Vamos et al. (2019) showed that a majority of pregnant patients did not receive any oral health information from their prenatal providers.
- A significant number of pregnant women also reported that they did not seek dental treatment during pregnancy due to fear that it was unsafe for the developing fetus despite 72.3% reporting at least one oral health problem (Hans et al., 2019).
- In a survey of 200 gynecologists, 48% reported that they did not know about "oral manifestations caused by hormonal changes, which are specifically related to pregnancy" (Paneer et al., 2019).



PROFESSIONAL DENTAL TREATMENT AND HOMECARE MYTHS

MYTH: It is unsafe for radiographs to be exposed on a pregnant woman.
FACT: Diagnostic radiographs may be performed after the first trimester and are low-risk to the developing fetus. The risk of disease progression outweighs the minimal risk of radiation. High doses of radiation (>0.5 Gy) should be avoided (Favero, 2021).

MYTH: Pregnant women should avoid dental visits until after their baby is born.
FACT: Dental treatment should be sought regularly regardless of pregnancy status. Periodontal disease is a risk factor for low birth weight, preterm birth, preeclampsia, and other pregnancy complications so oral health should be monitored regularly (Bi et al., 2021).

MYTH: Substances such as local anesthesia, fluoride, and antibiotics may be harmful to the developing fetus.
FACT: Certain antibiotics can be used in case of infection. Anesthesia is considered safe for use during pregnancy when necessary. Nitrous Oxide should not be used (Favero, 2021). Use of fluoride mouthrinse and dentifrice is considered safe, whereas systemic fluoride may be related to negative pregnancy outcomes (Spittle, 2021).

MYTH: Increased bleeding while brushing or flossing is a normal symptom during pregnancy.
FACT: Increased bleeding may occur due to hormonal changes, but only in the presence of existing gingival diseases. In most cases, good oral hygiene should reduce or eliminate bleeding gums regardless of pregnancy status (Gare et al., 2021).

MYTH: Pregnant women should brush their teeth immediately following vomiting from morning sickness.
FACT: Morning sickness is common, affecting 70-80% of pregnancies, and often involves vomiting, which introduces acid to the oral cavity. Brushing immediately after vomiting can increase acid-induced erosion of tooth enamel by pushing acid into the tooth structure. Pregnant patients should instead be advised to rinse following vomiting (Favero, 2021).

MYTH: Only the mother's oral health can affect the baby.
FACT: Pathogenic bacteria may be introduced to the vaginal canal through the orogenital route of transmission (Gare et al., 2021).

CONCLUSION

Pregnant women face many barriers to receiving proper oral healthcare. This is due, in part, to the limited oral health literacy of pregnant women and of the healthcare professionals involved in their prenatal care. Limited oral health literacy and social determinants of health have led to the development of many myths about oral health during pregnancy. Dental hygienists should be familiar with common misconceptions and the oral health literacy levels of their patients to develop and provide appropriate patient education and OHI that promotes good pregnancy outcomes.

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