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Review Article

Pregnancy and oral health: Safe practices for managing dental conditions

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Abstract

Pregnancy is a transformative phase in a woman's life, marked by significant physiological, hormonal, and emotional changes. These changes also influence oral health, making pregnant women more vulnerable to conditions such as gingivitis, periodontitis, and dental caries. Dental care during pregnancy is crucial for maintaining both maternal and fetal health, as poor oral health can be associated with adverse pregnancy outcomes, including preterm birth and low birth weight. However, dental treatment for pregnant women requires special considerations, including the timing of interventions, the use of medications, and the management of common oral conditions. This review explores the essential aspects of providing dental care to pregnant women, with a focus on best practices for safe and effective treatment, the importance of collaboration between dentists and obstetricians, and preventive strategies to improve oral health during pregnancy. The article also reviews the evidence-based guidelines for the use of medications, dental radiography, and treatment protocols across the three trimesters of pregnancy. Numerous references have been included to provide a comprehensive understanding of the topic.

Keywords: Pregnancy, Oral health, Dental treatment, Safe antibiotics, Pain management, Gingivitis, Periodontitis.

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1. Introduction

Pregnancy induces a host of systemic changes in a woman's body, significantly impacting various aspects of her health, including oral health. Hormonal fluctuations during pregnancy, particularly increases in estrogen and progesterone, can lead to conditions such as pregnancy gingivitis and pyogenic granulomas. Additionally, morning sickness and changes in dietary habits during pregnancy contribute to the development of dental caries. Dental care during pregnancy is not only important for the mother's oral health but also plays a crucial role in preventing complications that can affect the developing fetus. Research has demonstrated a correlation between maternal periodontal disease and adverse pregnancy outcomes, such as preterm birth and low birth weight.[1]

This article aims to provide a detailed review of the considerations for providing dental care to pregnant patients. It will examine the physiological changes that occur during pregnancy and their impact on oral health, discuss the timing of dental treatments across the trimesters, review the safety of medications used in dental care, and highlight the importance of preventive measures. The review also emphasizes the necessity for dentists to collaborate with obstetricians to provide optimal care. By addressing these aspects, this article aims to equip dental professionals with

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the knowledge required to manage pregnant patients safely and effectively.

In a retrospective review of 150 pregnant women visiting the dental outpatient department over the past 12 months, the most commonly reported complaints included bleeding gums (58%), toothache (43%), and halitosis (22%). Among them, 65% had not undergone any dental check-up in the previous year. These statistics highlight the urgent need to increase awareness about oral health during pregnancy and integrate dental evaluations into routine antenatal care.

2. Physiological Changes during Pregnancy and their Impact on Oral Health

Pregnancy triggers numerous hormonal changes that affect the entire body, including the oral cavity. Increased levels of estrogen and progesterone during pregnancy can lead to gingival inflammation and exacerbate the body's response to plaque accumulation. As a result, pregnancy gingivitis, characterized by swollen, tender, and bleeding gums, is common and affects about 60-70% of pregnant women.[2] This condition typically manifests during the second trimester and can worsen if oral hygiene is not maintained. While pregnancy gingivitis often resolves after delivery, if left untreated, it can progress to periodontitis, a more severe form of gum disease associated with tooth loss.

In addition to gingivitis, some pregnant women develop pyogenic granulomas, also known as "pregnancy tumors." These benign, hyperplastic lesions typically appear on the gingiva and are often associated with poor oral hygiene and hormonal changes. Although pyogenic granulomas are non-cancerous and usually resolve postpartum, they can cause discomfort and bleeding, particularly during eating or brushing.[3] In some cases, surgical removal may be necessary if the lesion interferes with daily activities.

Another oral health issue associated with pregnancy is dental erosion caused by frequent vomiting due to morning sickness. The repeated exposure of teeth to stomach acid can erode enamel, increasing the risk of dental caries.[4] Furthermore, the craving for sugary foods during pregnancy can exacerbate this issue, as increased sugar intake promotes bacterial growth in the oral cavity, leading to tooth decay. This can have serious implications, as untreated dental infections in pregnant women have been linked to adverse pregnancy outcomes, including preterm birth and low birth weight.

Pregnancy also affects the salivary composition, reducing its flow and buffering capacity, which can further contribute to the risk of dental caries and other oral health issues. Understanding these physiological changes is crucial for dental practitioners to provide appropriate care and prevention strategies to pregnant patients.

Patient data from a clinical review of 150 pregnant women further emphasizes the high prevalence of oral complaints, reinforcing the importance of tailored dental care during pregnancy.

3. Optimal Timing for Dental Treatments during Pregnancy

Dental treatment for pregnant women should be carefully timed to minimize any risks to the developing fetus. The timing of dental interventions is categorized by the three trimesters of pregnancy, each with specific considerations.

3.1. First trimester

The first trimester is a critical period for fetal development, as organogenesis occurs during this time. Dental care during this stage should be limited to emergency procedures only, as elective treatments pose a higher risk to fetal development. Non-emergency procedures should be postponed until the second trimester when fetal development is more stable. In cases where urgent dental treatment is required, the use of local anesthesia is considered safe, but care must be taken to avoid medications that may interfere with fetal development.

Patients may also experience morning sickness during the first trimester, which can complicate dental treatment. The dentist should advise patients to rinse their mouths with water or a fluoride mouthwash after vomiting to protect the enamel from acid erosion.

3.2. Second trimester

The second trimester is considered the safest period for dental treatment. At this stage, the fetus is more developed, and the risk of teratogenic effects is reduced. Elective procedures, such as fillings, professional cleanings, and even extractions, can be performed during this time with minimal risk to the fetus.[5] This is also an ideal time to address oral health issues such as pregnancy gingivitis, as treating gum disease during this period can prevent complications later in pregnancy.

During the second trimester, pregnant women are generally more comfortable lying in the dental chair, making it easier for the dentist to perform necessary treatments. However, patients may begin to experience discomfort when lying flat for extended periods, so dentists should monitor the patient’s position and adjust as necessary to ensure comfort and safety.

3.3. Third trimester

As pregnancy progresses into the third trimester, patients may experience more discomfort when lying in a supine position due to the size of the uterus, which can compress the inferior vena cava and lead to supine hypotensive syndrome. This condition can cause a drop in blood pressure, leading to dizziness and fainting. To prevent this, dentists should position the patient in a semi-reclined or side-lying position during treatment.[6]

During the third trimester, elective treatments should be postponed, as the increased physical and emotional stress of

dental procedures can trigger premature labor. Only emergency procedures should be performed, and care must be taken to minimize discomfort and stress for the patient.

4. Safe use of Medications in Dental Treatment for Pregnant Patients

The use of medications during dental treatment requires careful consideration to ensure the safety of both the mother and the fetus. Many commonly used dental medications, such as antibiotics, analgesics, and local anesthetics, are safe for use during pregnancy, but some should be avoided due to their potential teratogenic effects or risks to fetal development.

4.1. Analgesics

Pain management is an essential aspect of dental care, but not all analgesics are safe for use during pregnancy. Nonsteroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen, are contraindicated, especially in the third trimester, as they can cause premature closure of the fetal ductus arteriosus. Acetaminophen (paracetamol) is the preferred analgesic for pregnant women, as it is considered safe for both the mother and fetus.[7] However, it should be used at the lowest effective dose for the shortest duration possible.

NSAIDs should be used with caution, especially after the second trimester, as they can cause complications such as premature closure of the ductus arteriosus in the fetus. Following NSAIDS can be used in dental practice:

1. Acetaminophen (Paracetamol)
    a. Indication: Preferred option for pain and fever in dental practice.
    b. Dosage: 500–1000 mg every 4–6 hours, up to 4000 mg/day.
    c. Safety: Safe throughout pregnancy (Pregnancy category B).
2. Ibuprofen
    a. Indication: Mild to moderate pain and inflammation in early pregnancy.
    b. Dosage: 200–400 mg every 6 hours, maximum 1200 mg/day.
    c. Safety: Avoid in the third trimester (Pregnancy category B in first and second trimesters, category D in the third trimester).
3. Naproxen
    a. Indication: Moderate pain management in early pregnancy.
    b. Dosage: 250–500 mg every 12 hours, maximum 1000 mg/day.
    c. Safety: Avoid in the third trimester (Pregnancy category B in the first and second trimesters, category D in the third trimester).

4.2. Antibiotics

Antibiotics may be required to treat infections, and certain antibiotics are considered safe for use during pregnancy. Penicillin, amoxicillin, and clindamycin are commonly prescribed antibiotics that pose minimal risk to the fetus. However, tetracyclines should be avoided, as they can cause permanent discoloration of the fetus's developing teeth and inhibit bone growth. If antibiotics are necessary, the dentist should consult with the patient's obstetrician to ensure that the selected medication is safe for use during pregnancy.

Following Antibiotics can be used in dental practice:

1. Penicillins (e.g., Amoxicillin, Penicillin V)
    a. Indication: Dental infections such as abscesses or periodontitis.
    b. Dosage: Amoxicillin 500 mg every 8 hours for 7–10 days.
    c. Safety: Considered safe (Pregnancy Category B).
2. Cephalosporins (e.g., Cephalexin)
    a. Indication: Dental and skin infections, suitable for patients allergic to penicillin.
    b. Dosage: Cephalexin 500 mg every 6 hours for 7–10 days.
    c. Safety: Generally safe (Pregnancy category B).
3. Clindamycin
    a. Indication: Used for serious dental infections, particularly in penicillin-allergic patients.
    b. Dosage: 300 mg every 6–8 hours for 7–10 days.
    c. Safety: Safe in pregnancy (Pregnancy category B).
4. Erythromycin
    a. Indication: Alternative for penicillin-allergic patients.
    b. Dosage: 250–500 mg every 6 hours for 7–10 days.
    c. Safety: Safe, but avoid erythromycin estolate (Pregnancy category B).
5. Azithromycin
    a. Indication: Second-line treatment for dental infections in penicillin-allergic patients.
    b. Dosage: 500 mg on day 1, followed by 250 mg once daily for 4 days.
    c. Safety: Safe during pregnancy (Pregnancy category B).
6. Metronidazole
    a. Indication: Anaerobic infections (e.g., periodontal infections).
    b. Dosage: 500 mg every 8 hours for 7 days.
    c. Safety: Generally safe after the first trimester (Pregnancy category B).

4.3. Drugs to avoid in pregnancy

Certain antibiotics and NSAIDs should be avoided during pregnancy due to potential harm to the developing fetus:

a. Tetracyclines (e.g., Doxycycline): Causes tooth discoloration and inhibition of bone growth in the fetus (Category D).
b. Quinolones (e.g., Ciprofloxacin): Can cause damage to fetal cartilage and joints (Category C).
c. Sulfonamides: Risk of neonatal jaundice and kernicterus (Category D).
d. NSAIDs in the third trimester: Avoid ibuprofen, naproxen, and aspirin due to the risk of premature closure of the ductus arteriosus and bleeding.

When prescribing medications during pregnancy, it is essential to consider the potential risks and benefits carefully. Antibiotics such as penicillins, cephalosporins, and certain macrolides (like erythromycin and azithromycin) are generally safe. Acetaminophen is the preferred NSAID, while ibuprofen and naproxen can be used with caution in the early stages of pregnancy.

4.4. Local anesthetics

Local anesthetics are commonly used in dental procedures to provide pain relief. Lidocaine, with or without epinephrine, is the most frequently used local anesthetic in dental practice and is considered safe for use during pregnancy when administered in appropriate doses. However, high concentrations of epinephrine should be avoided, as they can cause vasoconstriction and reduce placental blood flow. Dentists should always use the lowest effective dose of local anesthetic to minimize any potential risks to the fetus.

5. Radiation Exposure from Dental X-rays

The safety of dental radiographs during pregnancy is a common concern for both patients and practitioners. While excessive radiation exposure can pose risks to fetal development, the use of modern dental X-ray equipment, combined with proper shielding, makes dental radiography safe for pregnant women.

According to guidelines from the American Dental Association (ADA), dental X-rays can be performed safely during pregnancy when necessary precautions are taken. The use of a lead apron and thyroid collar significantly reduces radiation exposure to both the abdomen and the thyroid gland, protecting the fetus from harmful effects.[8] Digital radiography, which emits lower doses of radiation compared to traditional film radiography, is the preferred option for pregnant patients. Dentists should limit the use of X-rays to situations where they are essential for diagnosis and treatment planning and should always consult with the patient's obstetrician if there are concerns about radiation exposure.

6. Managing Common Oral Health Issues in Pregnancy

Pregnant women are more susceptible to certain oral health conditions due to hormonal changes and altered immune responses. The following are the most common oral health issues encountered during pregnancy and their recommended management.

6.1. Pregnancy gingivitis

Pregnancy gingivitis is one of the most common oral health issues affecting pregnant women. It is caused by increased levels of estrogen and progesterone, which amplify the inflammatory response to plaque. Symptoms include red, swollen, and bleeding gums. Maintaining good oral hygiene, including regular brushing and flossing, is the most effective way to prevent and manage pregnancy gingivitis. Dentists should provide professional cleanings and emphasize the importance of oral hygiene education to minimize the risk of progression to periodontitis.[9]

6.2. Pyogenic granulomas

Pyogenic granulomas, or pregnancy tumors, are benign growths that can develop on the gingiva due to increased hormonal levels and irritation from plaque. While these lesions typically resolve after delivery, they can cause discomfort and bleeding. If the lesion is small and asymptomatic, no treatment is necessary. However, if the lesion interferes with daily activities, surgical excision may be required.[10]

6.3. Dental caries and erosion

Pregnant women are at higher risk for dental caries due to changes in diet and the effects of morning sickness. Frequent snacking, especially on sugary foods, and vomiting can increase the acidity in the mouth, leading to enamel erosion and caries formation. To reduce the risk of caries, dentists should recommend the use of fluoride toothpaste and encourage patients to rinse their mouths with water or a fluoride mouthwash after vomiting. Dietary counseling to reduce the intake of sugary foods can also help prevent caries.[11]

7. Collaboration between Dentists and Obstetricians

Collaboration between dental professionals and obstetricians is crucial to ensuring comprehensive care for pregnant patients. Dentists should maintain open communication with the patient's obstetrician to confirm the safety of dental procedures and medications. This collaboration is particularly important when managing patients with high-risk pregnancies, as certain conditions may require modifications to dental care.

Obstetricians can play a key role in encouraging pregnant women to seek dental care and maintain good oral hygiene. Many pregnant women avoid dental visits due to concerns about the safety of treatment during pregnancy. By

educating patients about the importance of oral health and dispelling myths about dental treatment during pregnancy, obstetricians can help ensure that pregnant women receive the necessary dental care to maintain their health and prevent complications.[12]

8. Chair Posture for Pregnant Females during Dental Treatment

When providing dental care to pregnant women, special attention must be paid to their comfort and safety, particularly in terms of chair positioning. As pregnancy progresses, changes in posture, circulation, and pressure on internal organs can affect the well-being of both the mother and the fetus. Here's how to ensure proper chair posture during dental treatment for pregnant women:

1. First trimester (1–13 weeks)

During the first trimester, most pregnant women can tolerate regular dental chair positions. However, since nausea and fatigue are common, keeping the chair in a semi-reclined position is advisable.[13]

a. Positioning:
   i. A semi-reclined or slightly upright position can help prevent nausea and provide comfort.
   ii. This reduces pressure on the abdomen and avoids exacerbating any morning sickness.

b. Considerations:
   i. Keep sessions short to minimize fatigue.
   ii. Be cautious about reclining too quickly, as sudden position changes may cause dizziness.

2. Second trimester (14–27 weeks)

The second trimester is the most comfortable period for dental treatment. However, as the uterus enlarges, adjustments in chair positioning become necessary to avoid pressure on major blood vessels like the inferior vena cava, which can lead to a condition known as supine hypotensive syndrome (reduced blood pressure due to lying flat).[14]

a. Positioning
   i. A semi-reclined position (45 degrees) is recommended to reduce the risk of compressing the inferior vena cava.
   ii. Tilt the chair slightly to the left using a small pillow or rolled-up towel under the right hip. This helps shift the uterus away from the inferior vena cava, improving blood flow and preventing dizziness or fainting.

b. Considerations
   i. Encourage frequent position changes and allow breaks if necessary.
   ii. Monitor the patient's comfort and watch for signs of dizziness or lightheadedness.

3. Third Trimester (28–40 weeks)

In the third trimester, the size of the uterus is substantial, and lying flat can easily compress the vena cava, leading to supine hypotensive syndrome. The mother's comfort and safety become even more critical during this period.[15,16]

a. Positioning
   i. Avoid the fully supine position. Instead, the chair should be adjusted to a semi-reclined (30 to 45 degrees) position.
   ii. Use a left lateral tilt by placing a pillow or cushion under the patient's right hip or back to rotate the body slightly to the left, preventing vena cava compression.
   iii. Keep the patient's head higher than her feet to further reduce compression risks.

b. Considerations:
   i. Keep the appointments as short as possible.
   ii. If the patient experiences any discomfort, dizziness, or light-headedness, adjust the position immediately.
   iii. Ensure regular breaks during longer procedures and allow the patient to sit up between treatments if necessary.

8.1. General recommendations throughout pregnancy

1. Short appointments: Limit the duration of dental procedures to reduce physical strain.
2. Frequent breaks: Allow the patient to sit up or take breaks to prevent discomfort or dizziness.
3. Communication: Continuously monitor the patient's comfort level. Encourage the patient to alert the dentist if she feels unwell.
4. Patient's history: Be mindful of any pre-existing conditions such as high blood pressure, preeclampsia, or gestational diabetes, as these may necessitate even more careful positioning.
5. Patient complaints and data entry practices.

Efficient data entry and accurate record-keeping are essential for monitoring trends in oral health among pregnant women. A review of clinical entries from the dental department revealed that gingival bleeding and tooth sensitivity were among the most common patient-reported complaints. Digital record systems should capture the trimester of pregnancy, primary oral complaint, previous dental history, and any medications being taken. Standardized forms and software integration can improve continuity of care and enhance interdisciplinary collaboration between dentists and obstetricians.

Key points:

1. Avoid flat supine positioning after the first trimester.
2. Tilt the patient slightly to the left using pillows to prevent compression of the inferior vena cava.
3. Keep the patient in a semi-reclined position throughout the second and third trimesters.
4. Prioritize comfort, minimizing treatment time, and providing frequent breaks during long procedures.

By carefully adjusting chair posture, dental practitioners can ensure a safer, more comfortable experience for pregnant patients, minimizing risks and promoting both maternal and fetal health.

9. Preventive Strategies for Maintaining Oral Health during Pregnancy

Prevention is the cornerstone of maintaining oral health during pregnancy. Educating patients about the importance of good oral hygiene and regular dental visits can significantly reduce the risk of oral health issues. The following preventive strategies are recommended for pregnant women:

1. Oral hygiene education: Dentists should emphasize the importance of regular brushing, flossing, and the use of fluoride toothpaste to prevent pregnancy gingivitis and dental caries.
2. Dietary counseling: Pregnant women should be advised to limit their intake of sugary foods and beverages, as these can increase the risk of dental caries. Eating a balanced diet rich in calcium and vitamins can help maintain strong teeth and gums.
3. Fluoride treatments: The use of fluoride toothpaste and professional fluoride treatments can help strengthen enamel and prevent dental caries, especially in women with a high risk of caries due to frequent vomiting or dietary changes.
4. Regular dental visits: Pregnant women should be encouraged to continue routine dental check-ups and cleanings throughout pregnancy. Early detection and treatment of oral health issues can prevent complications later in pregnancy.
5. Managing morning sickness: For women experiencing morning sickness, rinsing the mouth with water or a fluoride mouthwash after vomiting can help neutralize stomach acid and protect the teeth from erosion.

By incorporating these preventive strategies into their care, dentists can help pregnant women maintain optimal oral health and prevent complications during pregnancy.

10. Conclusion

Dental care during pregnancy requires special consideration due to the physiological changes that occur during this time. By understanding the impact of pregnancy on oral health, dentists can provide safe and effective care to pregnant patients. Preventive strategies, careful timing of treatments, and collaboration with obstetricians are essential for ensuring the health and well-being of both the mother and the developing fetus. This review highlights the importance of maintaining good oral health during pregnancy and provides evidence-based guidelines for the safe management of dental issues in pregnant patients.

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12. Conflict of Interest

None.

References

1. Silk H, Douglass AB, Douglass JM, Silk L. Oral health during pregnancy. *Am Fam Physician*. 2008;77(8):1139–44.
2. Russell SL, Huang SS, Bird C, Heyman RE, Kang M, Yang C. Addressing challenges of prenatal oral health care: It is time for pregnant people to have the oral health care they deserve. *J Am Dent Assoc*. 2025;156(3):177–9. https://doi.org/10.1016/j.adaj.2024.12.012.
3. Adeniyi A, Donnelly L, Janssen P, Jevitt C, von Bergman H, Brondani M. A Qualitative Study of Health Care Providers' Views on Integrating Oral Health into Prenatal Care. *JDR Clin Trans Res*. 2021;6(4):409–19. https://doi.org/10.1177/2380084420961998.
4. Xiong X, Buekens P, Fraser WD, Beck J, Offenbacher S. Periodontal disease and adverse pregnancy outcomes: a systematic review. *BJOG*. 2006;113(2):135–43. https://doi.org/10.1111/j.1471-0528.2005.00827.x.
5. Russell SL, Mayberry LJ. Pregnancy and oral health: a review and recommendations to reduce gaps in practice and research. *MCN Am J Matern Child Nurs*. 2008;33(1):32–7. https://doi.org/10.1097/01.NMC.0000305655.86495.39.
6. Hersh EV, Moore PA, Grosser T, Polomano RC, Farrar JT, Saraghi M, et al. Nonsteroidal Anti-Inflammatory Drugs and Opioids in Postsurgical Dental Pain. *J Dent Res*. 2020;99(7):777–86. https://doi.org/10.1177/0022034520914254.
7. Abdollahi M, Tehrani H, Mahdizadeh M, Nemati-Karimooy A, Gholian-Aval M. Perceptions and determinants of oral health care among Iranian pregnant women: a qualitative study. *BMJ Open*. 2024;14(1):e080033. https://doi.org/10.1136/bmjopen-2023-080033.
8. Davison JM. Renal disorders in pregnancy. *Curr Opin Obstet Gynecol*. 2001;13(2):109–14. https://doi.org/10.1097/00001703-200104000-00002.
9. Spencer M, Idzik SK. Dental Screening and Referral during Prenatal Care. *MCN Am J Matern Child Nurs*. 2023;48(6):320–5. https://doi.org/10.1097/NMC.0000000000000957.
10. Daneshvar S, Ghazanfari Z, Hoseiny-Rad M, Aivazi N, Aivazi AA. Oral Health Among Pregnant Women at Ilam, Iran: A KAP Study. *J Health Rep Technol*. 2023;9(2):e130772. https://doi.org/10.5812/jhrt-130772.
11. Rayburn WF. Recommending medications during pregnancy: an evidence based approach. *Clin Obstet Gynecol*. 2002;45(1):1–5. https://doi.org/10.1097/00003081-200203000-00003.
12. Al Jallad N, Vasani S, Wu TT, Cacciato R, Thomas M, Lababede N, et al. Racial and oral health disparity associated with perinatal oral health care utilization among underserved US pregnant women. *Quintessence Int*. 2022;53(10):892–902. https://doi.org/10.3290/j.qi.b3095001.
13. American College of Obstetricians and Gynecologists. Oral health care during pregnancy and through the lifespan. Committee Opinion No. 569. *Obstet Gynecol*. 2019;122(2):417–22.

14. Yenen Z, Ataçağ T. Oral care in pregnancy. *J Turk Ger Gynecol Assoc*. 2019;20(4):264–8. https://doi.org/10.4274/jtgga.galenos.2018.2018.0139.
15. Hemalatha Vt, Manigandan T, Sarumathi T, Aarthi Nisha V, Amudhan A. Dental considerations in pregnancy-a critical review on the oral care. *J Clin Diagn Res*. 2013;7(5):948–53. https://doi.org/10.7860/JCDR/2013/5405.2986.
16. Gallagher-Cobos G, Almerich-Torres T, Montiel-Company JM, Iranzo-Cortés JE, Bellot-Arcís C, Ortolá-Siscar JC, et al. Relationship between Periodontal Condition of the Pregnant Woman with Preterm Birth and Low Birth Weight. *J Clin Med*. 2022;11(22):6857. https://doi.org/10.3390/jcm11226857.

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