AAMS Dentistry & Oral Sciences
ISSN: 2834-7120 (Print) | eISSN: 2834-7121 (Online)
Volume 07, Issue 10, Pages 1-15
DOI: 10.4103/aams.0498158
ORIGINAL ARTICLE

Dental and Periodontal Conditions During Pregnancy: A Simulated Cross-Sectional Study

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Received: 2026-09-10 · Accepted: 2026-09-29

Abstract

Background: Pregnancy can increase susceptibility to gingival inflammation through hormonal changes that modify responses to dental plaque. Vomiting, dietary changes, and delayed dental attendance may additionally contribute to oral disease. This article presents an explicitly simulated study rather than observations from actual patients.

Objective: To illustrate the distribution of common dental and periodontal conditions across pregnancy and identify practical priorities for antenatal oral healthcare.

Methods: A synthetic dataset represented 120 pregnant adults, with 40 participants assigned to each trimester. Prespecified variables included trimester, gingivitis, untreated cavitated caries, periodontitis, and urgent dental treatment need. Gingivitis and periodontitis were classified separately, while caries could coexist with either condition. Counts and percentages were calculated descriptively; no hypothesis testing or causal inference was attempted.

Results: Gingivitis affected 73 simulated participants, representing 60.8% of the dataset. Its frequency increased from 45.0% in the first trimester to 75.0% in the third trimester. Untreated caries affected 48 participants, or 40.0%, while periodontitis affected 14, or 11.7%. Eight participants, or 6.7%, were classified as requiring urgent assessment for pain or suspected infection.

Conclusion: The constructed findings illustrate how substantial oral treatment needs could coexist during pregnancy. They support a teaching framework emphasizing plaque control, early assessment, and timely treatment, but cannot establish actual prevalence, trimester effects, or associations with birth outcomes. Prospective clinical research is necessary to test these patterns.

Keywords: pregnancy, gingivitis, dental caries, periodontitis, antenatal care, oral health

1. Introduction

Oral health is an important but frequently overlooked component of maternal care. During pregnancy, physiological changes, altered dietary patterns, nausea, and competing healthcare priorities may influence the condition of teeth and supporting tissues. Dental caries, gingival inflammation, periodontal disease, and erosive tooth wear can cause pain, interfere with eating, disturb sleep, and

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reduce quality of life. Although these conditions are not unique to pregnancy, their prevention and timely management deserve particular attention during this period, when women may encounter uncertainty about the safety of dental examination and treatment.

Pregnancy-associated hormonal changes can modify the gingival response to dental plaque, increasing susceptibility to bleeding, swelling, and discomfort. This heightened inflammatory response does not mean that pregnancy inevitably causes periodontal destruction; plaque accumulation, pre-existing disease, smoking, metabolic conditions, and individual susceptibility remain relevant determinants. Likewise, dental caries is a multifactorial disease rather than a direct consequence of pregnancy. Frequent consumption of fermentable carbohydrates, inadequate fluoride exposure, and difficulty maintaining oral hygiene may increase caries risk. Recurrent vomiting or gastric reflux may additionally expose tooth surfaces to acid, while nausea and an exaggerated gag reflex can make toothbrushing less tolerable.

The clinical significance of maternal oral disease extends beyond visible dental lesions. Untreated pain and infection may impair daily functioning and complicate nutritional choices, while persistent gingival symptoms can discourage effective cleaning. Observational studies have also investigated associations between maternal periodontal disease and adverse pregnancy outcomes, including preterm birth and low birth weight. However, shared risk factors, variation in periodontal definitions, and methodological differences complicate causal interpretation. These associations should therefore not be presented as evidence that periodontal disease directly causes obstetric complications or that periodontal treatment necessarily prevents them. The clearest rationale for dental assessment during pregnancy remains the protection of maternal oral health and the management of existing disease.

Despite this rationale, dental attendance during pregnancy may be limited by cost, restricted service availability, fear of procedures, and misconceptions about treatment safety. Some women postpone care until after delivery, even when symptoms are present. Advice from healthcare professionals may also be inconsistent, particularly where oral health is not routinely incorporated into antenatal consultations. Understanding these barriers is essential because disease burden alone does not explain whether women obtain preventive or therapeutic care. Maternal age, educational attainment, socioeconomic circumstances, parity, gestational stage, and previous dental attendance may influence both oral health status and care-seeking behavior.

Locally generated evidence can help identify which conditions and barriers require the greatest attention within antenatal services. Studies combining standardized clinical assessment with information on symptoms, hygiene practices, diet, and dental service use are particularly valuable, although cross-sectional observations cannot establish temporal or causal relationships. Careful distinction between gingivitis, periodontitis, caries, and erosive changes is also necessary to avoid treating clinically different conditions as a single outcome. The present study therefore aimed to assess the prevalence and distribution of dental caries and periodontal conditions among pregnant women attending antenatal care and to examine their associations with selected behavioral, sociodemographic, and pregnancy-related characteristics. A secondary aim was to characterize reported barriers to dental attendance, providing a basis for context-appropriate prevention, referral, and oral health counseling within maternal healthcare. These findings may support more coordinated care without implying that pregnancy itself explains all observed oral disease.

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Figure 2. Figure 1. Medical illustration comparing healthy gingiva with plaque-associated gingival swelling and bleeding during pregnancy.

2. Materials and Methods

A clinic-based cross-sectional study will evaluate dental caries, gingival inflammation, and associated behavioral factors among pregnant women receiving routine antenatal care at two public maternity clinics. Recruitment will occur over six consecutive months. The primary outcome will be the prevalence of gingivitis, defined using full-mouth bleeding on probing. Secondary outcomes will include untreated dental caries, cumulative caries experience, periodontal pocketing, dental pain, and dental service utilization during pregnancy. Associations with gestational stage will be interpreted as cross-sectional differences rather than evidence of changes within individual women.

Pregnant women aged 18–45 years with a documented gestational age and at least six natural teeth will be eligible. Women requiring immediate obstetric assessment, those unable to provide informed consent, and those with medical contraindications to periodontal probing will be excluded. Eligible women excluded because of insufficient dentition will be counted separately to acknowledge potential selection bias. Recent antibiotic exposure, diabetes, vomiting, and dental treatment will be recorded rather than used as general exclusion criteria. Consecutive eligible attendees will be invited by research staff who are not responsible for their obstetric care. Each participant will contribute one assessment.

The target sample will be 320 participants. Assuming an unknown gingivitis prevalence of 50%, a sample of 267 provides an approximate 95% confidence interval with a six-percentage-point margin of error under simple random sampling. Increasing this estimate by approximately 20% allows for incomplete examinations and unusable questionnaires. This calculation prioritizes prevalence estimation; trimester comparisons and adjusted analyses will be considered secondary. Recruitment totals, refusals, and reasons for nonparticipation, when voluntarily provided, will be documented.

Gestational age will be obtained from the antenatal record using the obstetric estimate. Participants will be categorized as first trimester before 14 completed weeks, second trimester from 14 through 27 weeks, and third trimester from 28 weeks onward. A structured interviewer-administered questionnaire will collect age, education, household financial strain, parity, tobacco exposure, toothbrushing frequency, fluoride toothpaste use, interdental cleaning, frequency of sugary snacks, vomiting, and perceived barriers to dental attendance. Dental pain during the preceding four weeks

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and dental visits since conception will also be recorded. Questionnaire wording will be piloted with 15 women who will not enter the analytical sample.

Two calibrated dentists will perform examinations using portable illumination, disposable mirrors, and a standardized periodontal probe. Examinations will be conducted with participants positioned comfortably, avoiding prolonged supine positioning in later pregnancy. No research radiographs will be obtained. Caries will be recorded at tooth level using a cavitation-based visual-tactile threshold, and decayed, missing because of caries, and filled teeth will be summed as the DMFT index. Uncertain reasons for missing teeth will be recorded separately rather than automatically attributed to caries. Untreated caries will be defined as at least one tooth with an untreated cavitated lesion.

Bleeding on probing, probing depth, and gingival recession will be assessed at six sites per tooth, excluding third molars. Bleeding will be recorded within approximately 30 seconds after gentle probing. Gingivitis will be defined as bleeding at 10% or more of examined sites among participants without clinical findings meeting the prespecified periodontitis definition. Periodontitis will require interdental clinical attachment loss at two nonadjacent teeth after excluding identifiable nonperiodontal causes. Because pregnancy-associated enlargement can increase probing depths without attachment destruction, pocket depth alone will not establish periodontitis. Plaque presence will be recorded at four surfaces per tooth.

Before recruitment, examiner agreement will be assessed in 20 nonstudy volunteers. Calibration will target kappa values of at least 0.75 for categorical findings and intraclass correlation coefficients of at least 0.80 for continuous periodontal measurements. Duplicate examinations in 10% of participants will monitor reliability. Examiners will remain unaware of questionnaire responses where practicable.

Analyses will report prevalence estimates with 95% confidence intervals. Modified Poisson regression with robust standard errors will estimate adjusted prevalence ratios, incorporating clinic as a fixed effect. Prespecified covariates will include age, trimester, education, parity, diabetes, tobacco exposure, brushing frequency, plaque, and recent dental attendance. Missingness will be described, with multiple imputation considered when appropriate. Institutional ethics approval will be obtained before recruitment, and written informed consent will be required. Data will be coded and stored securely. Participants with urgent dental findings will receive prompt referral without delaying necessary obstetric care.

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3. Results

The following results describe a simulated dataset constructed to illustrate a plausible study of dental and periodontal disease during pregnancy; they do not represent observations from an actual clinical investigation. The analytic sample comprised 300 pregnant women attending antenatal care, with 100 participants in each trimester. Mean maternal age was 28.4 years (standard deviation [SD], 5.3), and mean gestational age was 23.1 weeks (SD, 10.2). Overall, 126 women (42.0%) were experiencing their first pregnancy, 114 (38.0%) reported household income below the study-defined threshold, and 57 (19.0%) reported nausea or vomiting on at least three days per week. Clinical dental assessments and questionnaire data were complete for all participants.

Gingivitis was the most frequently identified oral condition, affecting 179 participants (59.7%). Untreated dental caries was present in 128 women (42.7%), while 50 (16.7%) met the examination criteria for periodontitis. These conditions were not mutually exclusive. Gingivitis was classified in participants with bleeding on probing at at least 10% of examined sites who did not meet the periodontitis definition. The mean number of decayed, missing, and filled teeth was 5.2 (SD, 3.4), including a mean of 1.4 untreated decayed teeth (SD, 1.9). Seventy-eight participants (26.0%) reported dental pain during the preceding four weeks, and 101 (33.7%) reported gingival bleeding during routine toothbrushing.

Clinical findings differed across trimester groups, as summarized in Table 1. Gingivitis prevalence increased from 46.0% in the first trimester to 72.0% in the third trimester. The proportion of sites with bleeding on probing also increased across groups, whereas the difference in untreated caries prevalence was smaller. Periodontitis was identified more frequently in the third-trimester group, although the absolute number of affected participants remained comparatively low.

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Table 1. Oral health findings by trimester in the simulated study population

Characteristic	First trimester, n=100	Second trimester, n=100	Third trimester, n=100	Overall, n=300
Gingivitis, n (%)	46 (46.0)	61 (61.0)	72 (72.0)	179 (59.7)
Untreated caries, n (%)	38 (38.0)	43 (43.0)	47 (47.0)	128 (42.7)
Periodontitis, n (%)	12 (12.0)	17 (17.0)	21 (21.0)	50 (16.7)
Bleeding on probing, mean percentage of sites (SD)	18.5 (14.2)	25.7 (17.6)	32.1 (20.3)	25.4 (18.4)
Dental pain, n (%)	21 (21.0)	25 (25.0)	32 (32.0)	78 (26.0)

Self-reported preventive practices were variable. Twice-daily toothbrushing was reported by 192 women (64.0%), but only 63 (21.0%) reported interdental cleaning at least once daily. Visible plaque on more than one-third of examined tooth surfaces was recorded in 156 participants (52.0%). Gingivitis was identified in 80 of 108 women brushing less than twice daily (74.1%), compared with 99 of 192 brushing at least twice daily (51.6%). Among women with untreated caries, 74 of 128 (57.8%) reported consuming sugary snacks or beverages between meals at least twice daily, compared with 61 of 172 women without untreated caries (35.5%). These descriptive comparisons were not interpreted as evidence of causation.

In the multivariable logistic model, later trimester and brushing less than twice daily were associated with higher odds of gingivitis after adjustment for the other listed variables (Table 2). The association was greatest for third-trimester participants relative to those in the first trimester. Frequent nausea or vomiting showed an elevated point estimate, but its confidence interval included the null. Maternal age and household income did not show clear independent associations. Because gingivitis was common, the odds ratios should not be interpreted as risk ratios.

Table 2. Adjusted associations with gingivitis in the simulated population

Variable	Adjusted odds ratio	95% confidence interval	P value
Second versus first trimester	1.76	1.00–3.10	0.051
Third versus first trimester	2.83	1.56–5.13	0.001
Brushing less than twice versus at least twice daily	2.18	1.28–3.72	0.004
Daily interdental cleaning versus less frequent cleaning	0.67	0.36–1.24	0.202
Frequent nausea or vomiting versus less frequent symptoms	1.42	0.75–2.69	0.281
Low household income versus higher income	1.28	0.76–2.16	0.354
Maternal age, per additional year	1.02	0.97–1.07	0.438

Dental service use was limited despite the frequency of clinical findings. Seventy-two participants (24.0%) reported a dental consultation during their current pregnancy. Among the 78 women reporting recent dental pain, 24 (30.8%) had sought professional assessment for that episode, leaving 54 (69.2%) without a consultation. Among these 54 women, the principal reported barriers were concern about treatment safety during pregnancy in 23 (42.6%), cost in 17 (31.5%), appointment availability in nine (16.7%), and other reasons in five (9.3%).

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Pain was accompanied by functional limitations in a subset of participants. Of the 78 women reporting pain, 29 (37.2%) described difficulty chewing, 18 (23.1%) reported interrupted sleep, and 12 (15.4%) reported both limitations. Untreated caries was present in 55 women with pain (70.5%), compared with 73 women without pain (32.9%). Nevertheless, pain did not identify all untreated disease: 73 of the 128 participants with caries (57.0%) reported no recent pain. Overall, the findings showed a substantial burden of clinically detectable disease alongside incomplete symptom recognition and limited dental attendance. The trimester comparisons represent differences between participants examined at one time point, rather than demonstrated progression within individual pregnancies.

4. Discussion

Dental and periodontal conditions during pregnancy should be understood within a framework that integrates biological susceptibility, everyday behaviors, and access to care. Pregnancy does not inevitably cause dental disease; rather, physiological changes may modify the response to existing plaque and interact with dietary practices, nausea, and oral hygiene difficulties. This distinction is important when interpreting oral health patterns in pregnant populations because it avoids attributing preventable disease solely to gestation and directs attention toward potentially modifiable factors.

Gingival inflammation is particularly relevant in this setting. Increased estrogen and progesterone concentrations can influence gingival vascularity and inflammatory responses, potentially amplifying bleeding and swelling in the presence of dental plaque. Consequently, clinically evident gingivitis may occur without a corresponding increase in destructive periodontal disease. Gingival bleeding, periodontal pocket depth, and attachment loss should therefore not be treated as interchangeable outcomes. Pregnancy-related enlargement can increase probing depth without indicating irreversible tissue destruction, making careful clinical classification essential to the interpretation of periodontal findings.

Dental caries requires a related but distinct explanation. Frequent consumption of fermentable carbohydrates, altered eating patterns, and difficulty maintaining regular toothbrushing may increase cariogenic exposure. Nausea or an exaggerated gag reflex can make posterior tooth cleaning uncomfortable, while repeated vomiting can expose enamel to gastric acid. Acid-related erosion is not equivalent to caries, although both may contribute to sensitivity and compromised dental function. A plausible interpretation of oral symptoms during pregnancy must therefore consider multiple pathways rather than assuming that pain or sensitivity reflects a single disease process.

The timing of assessment also matters. Differences between gestational stages may reflect cumulative plaque exposure, changing symptoms, or differences in the characteristics of women attending antenatal services at each stage. Cross-sectional comparisons cannot establish that disease progressed as pregnancy advanced. Likewise, untreated carious lesions identified during pregnancy may have developed before conception. Distinguishing prevalent disease from pregnancy-associated changes is necessary before drawing conclusions about the contribution of gestation itself.

Behavioral and social factors provide an equally important context. Lower income, limited oral health literacy, previous negative dental experiences, and competing household demands may influence both preventive practices and treatment attendance. These factors can cluster, making apparently independent associations difficult to disentangle. Dental attendance also requires nuanced interpretation: women with pain may be more likely to seek treatment, so an association between recent attendance and greater disease burden would not necessarily indicate ineffective care. Conversely, low attendance may reflect perceived lack of need as well as practical barriers.

Clinical interpretation should also distinguish maternal oral outcomes from obstetric outcomes. Periodontal inflammation has been investigated as a potential contributor to adverse pregnancy outcomes, but shared risk factors and variation in periodontal definitions complicate causal inference. Associations alone would not justify claiming that dental treatment prevents preterm birth or other obstetric complications. The immediate rationale for addressing oral disease remains the reduction of pain, infection, bleeding, and functional impairment in the pregnant patient.

These considerations support integrating basic oral health assessment into antenatal care. Asking

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about pain, bleeding, difficulty eating, and recent dental attendance can identify women who need evaluation. Counseling should address practical brushing barriers and misconceptions about treatment safety, while encouraging timely professional assessment rather than postponement solely because of pregnancy.

The clinical implications of these findings should be considered within the broader context of antenatal care. Pregnancy provides repeated contact with healthcare services, yet oral health may remain outside routine assessment. Incorporating brief questions about dental pain, gingival bleeding, difficulty eating, and recent dental attendance could help identify women requiring evaluation. Such screening would not replace a dental examination, but it could support timely referral, particularly where symptoms are normalized or treatment is postponed because of concerns about fetal safety.

Counseling should distinguish pregnancy-related susceptibility from the misconception that dental deterioration is inevitable. Hormonal changes can amplify gingival inflammatory responses to plaque, while vomiting, altered eating patterns, and difficulties maintaining oral hygiene may contribute to additional oral health challenges. These mechanisms do not imply that pregnancy independently causes every dental condition observed during gestation. Preventive advice should therefore remain individualized, emphasizing effective brushing with fluoride toothpaste, interdental cleaning, and practical approaches to reducing frequent sugar exposure. Women experiencing recurrent vomiting may also benefit from advice on limiting acid-related damage without immediately brushing acid-exposed teeth.

A further implication concerns communication between maternity and dental professionals. Necessary dental assessment and appropriately selected treatment can generally be undertaken during pregnancy; blanket recommendations to defer care may prolong pain or allow infection to progress. Decisions about procedures and medications should nevertheless account for gestational stage, clinical urgency, maternal comorbidities, and current professional guidance. Clear referral pathways and consistent counseling may be more useful than isolated educational messages, especially when financial barriers, transport difficulties, or uncertainty about service eligibility limit attendance.

Interpretation of the present findings requires caution. Associations between maternal characteristics, oral health behaviors, and dental disease cannot alone establish causation. Socioeconomic circumstances, preexisting disease, smoking, dietary practices, and access to care may influence both reported behaviors and clinical outcomes. Measures based on participant recall are additionally vulnerable to underreporting and social desirability bias. A single assessment during pregnancy, where applicable, cannot reliably separate longstanding disease from newly developed changes or characterize fluctuations across trimesters. Consequently, observed differences should not be attributed exclusively to gestational physiology.

Generalizability also depends on the recruitment setting and the women represented in the sample. Participants attending antenatal services may differ from those with delayed or absent prenatal care, potentially underrepresenting women facing the greatest barriers. Clinical indices capture important aspects of disease but may not fully reflect pain, functional limitation, or perceived treatment need. These limitations favor interpreting the results as evidence to guide locally appropriate prevention rather than as precise estimates applicable to every pregnant population.

Future research should prioritize longitudinal assessment beginning before pregnancy or early in gestation, with repeated standardized dental examinations and follow-up after delivery. Evaluating integrated referral programs would help determine whether improved identification translates into completed treatment, symptom relief, and sustained preventive behavior. Obstetric outcomes should be examined separately and cautiously, because associations with periodontal disease do not establish that dental treatment prevents adverse pregnancy events. Overall, the study supports treating oral health as a component of maternal well-being, while avoiding claims that exceed the observational evidence. Accessible preventive care, timely management of symptomatic disease, and coordinated professional communication offer a practical direction for improving care during pregnancy.

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Figure 1. Figure 2. Medical illustration of antenatal oral assessment, interdental cleaning, and targeted management of dental disease.

5. Conclusion

This study highlights the clinical importance of tooth-related and periodontal conditions during pregnancy and supports integrating oral health assessment into routine antenatal care. Dental caries, gingival inflammation, and periodontal symptoms should not be regarded as unavoidable consequences of pregnancy or concerns that must automatically be deferred until after delivery. Rather, they warrant individualized evaluation, preventive guidance, and timely management according to clinical need and gestational circumstances. Pregnancy-associated physiological changes may increase susceptibility to gingival inflammation, while dietary changes, vomiting, and difficulties maintaining oral hygiene can contribute to an unfavorable oral environment.

The interpretation of pregnancy-related oral disease requires attention to pre-existing dental conditions, socioeconomic circumstances, access to care, and health behaviors. These factors may influence both disease burden and treatment uptake, making it inappropriate to attribute all observed oral changes directly to pregnancy. Similarly, associations between periodontal disease and adverse obstetric outcomes should not be interpreted as evidence of causation. The present conclusions do not establish that dental treatment improves birth outcomes; its immediate justification remains the prevention and relief of maternal oral disease, pain, and functional impairment.

A practical implication is the need for coordinated communication between antenatal and dental services. Brief symptom screening, assessment of recent dental attendance, and clear referral pathways could help identify women requiring further evaluation. Counseling should emphasize twice-daily brushing with fluoride toothpaste, appropriate interdental cleaning, dietary measures to reduce frequent sugar exposure, and seeking care for persistent bleeding, swelling, or toothache. Advice concerning vomiting-related acid exposure should also be incorporated where relevant. Necessary dental care should be planned through individualized assessment rather than postponed solely because of pregnancy.

Further prospective research with standardized clinical examinations and repeated assessments across pregnancy and postpartum is needed to clarify disease trajectories and distinguish pregnancy-associated changes from underlying oral disease. Future studies should also evaluate whether integrated referral and education strategies improve attendance, symptom control, and

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clinically measured oral health, particularly among underserved populations. Overall, maternal oral health deserves recognition as a component of comprehensive prenatal care, with prevention and clinically indicated treatment guided by available evidence, patient preferences, and collaboration between healthcare professionals.

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