Gingivitis ranks among the diseases induced gingival disease, pregnancy gingival diseases. Besides plaque-pregnant women. Pregnancy gingivitis, for instance.1 In more recent studies,2–4 this includes hormonal influences, like puberty, menstruation, pregnancy and diabetes mellitus or even blood disorders. In appearance and form, pregnancy gingivitis does not differ from classic gingivitis, but it does differ in prevalence. Already in 1993, Ziskin et al. spoke of a 90–100 per cent occurrence: In more recent studies, this varied between 88 per cent and 93.7 per cent. Gingivitis has been found to correlate with hormone level and plaque. In the second and third trimester, pregnant women generally notice an increase in gingivitis and bleeding, since the body produces the steroid hormones progesterone and oestrogen more strongly. The more plaque, the higher the risk of gingivitis.

The causes of pregnancy gingivitis, however, seem to be more complicated than previously believed. Even small quantities of plaque in pregnant women lead to an excessive inflammatory reaction in the susceptible tissue. Not only does the immune system change, but so does blood circulation and the cell system. The entire oral mucosa prepares for the birth. The practice team must therefore pay particular attention to the dental hygiene. Pregnancy and oestrogen directly promote the pathogens Prevotella intermedia and Porphyromonas gingivalis. In directly, the soft tissue is more sensitive to bacteria that reach the oral cavity.

Does pregnancy gingivitis lead to premature birth? Generally, science assumes that periodontal inflammation plays an important role in pregnancy complications. Periodontitis as a chronic inflammation is ultimately caused by a bacterial infection and thus represents a potential source of circulating inflammatory biomarkers. These inflammatory mediators spread throughout the entire body and are related to possible negative pregnancy outcomes. In studies on periodontitis in pregnant women, the occurrence of the disease varied between 0.2 per cent and 6 per cent. Clinical studies further suggest that bacteria like P. gingivalis, Treponema denticola, Tannerella forsythia and Fusobacterium nucleatum, from the oral cavity colonise the foetus and the placenta, with blood being the most likely transfer medium. These periodontal pathogens may therefore represent a risk factor for negative pregnancy outcomes, including low birthweight, premature birth and pre-eclampsia (high blood pressure). Actually, there is still no clear proof to support the connection between periodontitis and negative pregnancy outcomes. Some studies indicate that there could be a link. Further studies are needed, however, to understand the complex biological processes. Three facts remain. First, a pre-existing periodontal condition in the woman can exacerbate periodontitis during pregnancy. Second, after the birth, the periodontal status of women with periodontitis improves without active periodontal therapy. However, the disease does not disappear and can even worsen after the birth. Third, pregnancy gingivitis alone does not lead to negative pregnancy outcomes.

Treatment and prevention Whether the mouth is healthy, has gingivitis or even periodontitis, nowadays, organisations and researchers recommend that pregnant women make three visits to the dentist, ideally once per trimester. This way, dentists can advise them comprehensively in the first trimester. The second trimester is suitable for a professional tooth cleaning, and periodontitis treatment. The practice team should use the third trimester for consultation on the dental health of the baby. Ideally, prophylaxis should begin for the child during pregnancy. Different studies show how important it is to educate women during pregnancy and right after the birth in order to reduce the risk of caries in children.

In the dentist’s office, pregnant patients should learn everything important about the development of dental caries, routes of infection and nutrition, however, the emphasis here is not just on the information, but also on targeted, preventative therapy. Expert dentists who become enthusiastic about prophylaxis pass this experience on to their children. This way, prophylaxis for the child, the first primary prophylaxis even before the birth, becomes the focus of dentistry.

Mechanical and professional plaque control Mechanical plaque control has always been the focus of pregnancy prophylaxis. Brushing with a toothbrush with soft bristles and fluoride toothpaste, and using instruments for interdental care and, if necessary, chemical plaque control are key instruments for the prevention of gingivitis and periodontitis even before pregnancy. That is why, for example, Oral-B recommends electric toothbrushes with oscillating rotations. At the same time, every system of mechanical plaque control is suitable in principle, whether manual or electric, as long as the correct technique is used regularly and with persistence (120 seconds). In the case of gingivitis, toothpastes with antibacterial agents such as stannous fluoride are beneficial, and mouth rinsing solutions are suitable as additional therapy. For acute
gingivitis, patients should use chlorhexidine therapeutically for a short time, best in a concentration of 0.1–0.2 per cent or 1 per cent. Different meta-analyses have found that chlorhexidine can be used with confidence during pregnancy. Long-term chemical plaque control is suitable for pregnant women with nausea and poor oral hygiene, particularly in the molar area. Other alternatives, such as tea tree oil and propolis, have not shown any effectiveness in studies.

What to keep in mind with periodontal therapy
If the practice team has to treat pregnant patients for periodontitis, neither has any special procedures to be considered first. Research shows that non-surgical periodontal therapy is safe and sensible during the second trimester. Scaling and root planing are quite possible during pregnancy. Radiographs can be taken and local anaesthesia can be administered without additional risk to the fetus or the mother. Articaine is the agent of choice in this case. Periodontal therapy does not reduce the occurrence of negative pregnancy issues. However, it can lower the frequency of negative pregnancy outcomes in women at high risk of pregnancy complications or who respond better to periodontal treatment.

Modern pregnancy prophylaxis
Professional tooth cleaning as part of modern biofilm management is an indispensable component of gingivitis and periodontal therapy in the context of a prophylaxis session. Professional tooth cleaning, in combination with oral hygiene products and instructions, clearly reduces moderate or severe gingivitis. The second trimester is therefore best suited for professional tooth cleaning. At this point, nausea has usually disappeared and the patient can stay lying down for a whole hour.

An optimal pregnancy prophylaxis also includes nutrition from a dentistry point of view. Here patients should not limit themselves, but enjoy their pregnancy. Nevertheless, patients should forgo acidic foods and beverages. A craving for sour and sweet foods, often in high frequency, also increases the risk of caries or an erosive change in the tooth enamel. In addition, the buffering capacity and rinsing function of the saliva is reduced during pregnancy, the mouth tends to be dry, which promotes the development of dental caries. Even allegedly healthy foods and drinks, like fruits or fruit juices, which are acidic, can quickly damage the tooth enamel.

Speaking of erosion, morning sickness also leads to the production of gastric acid, which can again lead to dental erosion of varying intensity. Toothbrushing should be avoided after an episode. The pellicle needs 2 hours to reform after vomiting. Helpful means of neutralising are the consumption of milk, cheese and, above all, chewing gum. Instead of brushing right after, antibacterial mouth rinsing solutions and fluoride rinsing solutions are suitable first.

Pregnancy is a major challenge with regard to teeth and gingiva. The main task of periodontal treatment during pregnancy is to improve the periodontal and overall health of pregnant women. Oral hygiene training and nutrition advice reduce plaque and gingivitis and thus periodontitis. With respect to affecting negative pregnancy outcomes, intervention even before pregnancy may be more effective. If the practice team controls the gingivitis and so avoids periodontitis, it has made its contribution to a problem-free pregnancy. In all cases, prevention is better than cure and every tooth counts.

Editorial note: A list of references can be obtained from the publisher.

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The next generation toothpaste for Whole Mouth Health - pathway to everyday prevention

Colgate® announces the launch of its next generation Colgate Total® toothpaste designed to proactively protect hard and soft oral tissues - tongue, teeth, cheeks and gums - against the most prevalent oral diseases: gingivitis and caries.

Periodontal disease and caries are both preventable in their early stages (Gingivitis and White Spot Lesions, respectively). Yet, despite the efforts of the dental profession to improve oral hygiene, these diseases continue to be a public health concern worldwide, affecting 50% of the global population estimated to be affected.1 Moreover, patients are looking for guidance and support from their dentist to make sure they are being as proactive as possible for better oral health.

Reducing periodontal disease and caries offers societal benefits

Reducing the incidence and prevalence of caries and periodontal disease has the potential not only to improve health and wellbeing in the general population, but also to reduce the growing financial pressure on publicly funded healthcare systems.

The economic burden of untreated caries is likely to increase due to population longevity which is an important aspect to policy makers.2,3 Attention has focused on controlling bacteria in dental plaque, while the value of Whole Mouth Health has been underestimated.

Whole Mouth Health and the role of dental biofilm

The concept of Whole Mouth Health is based on the importance of achieving more than just healthy teeth - all oral tissues need to be healthy. Teeth, the hard tissue, account for only 20% of oral structures, while the soft tissue, tongue, cheeks and gums represent the 80% majority. To retain a healthy mouth, protection of all surfaces is needed.

Disrupting the cycle

Bacteria can colonize on the teeth, initiating the formation of dental biofilm, but they also adhere to soft tissues in the mouth. From here they colonize on the surface of teeth that have been brushed, rebuilding the dental biofilm causing diseases to reoccur. Protecting the soft tissue and hard surface from bacterial colonization.

Regular fluoride toothpaste® is not enough to achieve Whole Mouth Health - it only protects hard surfaces with fluoride. Regular fluoride toothpaste® does not protect the hard surface from repopulating with bacteria harbored in the soft tissues.

Whole Mouth Health as the new paradigm for prevention

The route to improving Whole Mouth Health is to prevent the build-up of oral biofilm and achieve good bacterial control on all oral surfaces, both hard and soft tissues.

The best way to achieve this is having an everyday prevention routine with the daily use of a toothpaste with proven protection against bacterial - a toothpaste that can strengthen the mouth's natural defenses.

The next generation toothpaste, a clinically proven step forward in the quest for Whole Mouth Health

Decades of research have led to the development of a patented formulation for new Colgate Total®. This advanced toothpaste helps achieve Whole Mouth Health with a new technology that works with dual zinc plus arginine to provide proactive protection to the whole mouth, and prevent the most relevant oral diseases and conditions.

A toothpaste designed to work with the chemistry and biology of the mouth:

The formulation of dual zinc plus arginine effectively controls biofilm, through:

- \( \text{•} \) Weakening to kill bacteria by interfering in bacteria metabolism and reducing their nutrient uptake
- \( \text{•} \) Slowing bacterial growth
- \( \text{•} \) Enhancing soft tissue’s natural defense with a protective barrier that adheres to tongue, teeth, cheeks and gums
- \( \text{•} \) Limiting bacterial adherence to hard and soft tissues for 12 hour protection\(^*\)

Clinically proven whole mouth antimicrobial protection

Studies show that new Colgate Total® reduces bacteria on teeth, tongue, cheeks, and gums (TTGC) by up to 38.3% on Teeth, 39.7% on Tongue, 35.4% on Cheeks, and 25.9% on Gums.\(^**\)

Clinically proven to reduce plaque and gingivitis

New Colgate Total® is clinically proven to reduce plaque (by 30.1%; \( p = 0.001 \)) and gingivitis (by 26.3%; \( p < 0.001 \)) when compared to ordinary non-antibacterial fluoride toothpaste after six months.\(^4\)

Additional benefits:

- \( \text{•} \) Long lasting freshness\(^*\)
- \( \text{•} \) For 12 hours fresh breath\(^**\)
- \( \text{•} \) The fluoride level meets with the international standards for toothpaste efficacy in caries prevention

If you would like more information about the clinically proven benefits and efficacy of new Colgate Total®, visit our website at: www.colgateprofessional.com

References:


* defined as non-antibacterial toothpaste
** after 4 weeks use, 12 hours after brushing
† vs ordinary non-antibacterial fluoride toothpaste
‡ with continuous use, after 3 weeks
New Colgate Total® with Dual-Zinc + Arginine for Whole Mouth Health. Reinvented to proactively work with the biology and chemistry of the mouth.

Protects teeth, tongue, cheeks, and gums

- Superior reduction of bacteria on 100% of mouth surfaces, 12 hours after brushing*¹
- Weakens to kill bacteria
- Creates a protective barrier on hard and soft tissue to protect against bacterial regrowth

NEW | Next generation technology

For better oral health outcomes,† advise your patients about New Colgate Total®

*Statistically significant greater reduction of cultivable bacteria on teeth, tongue, cheeks, and gums with Colgate Total® vs non-antibacterial fluoride toothpaste at 4 weeks, 12 hours after brushing.
†Significant reductions in plaque and gingivitis at 6 months vs non-antibacterial fluoride toothpaste, p<0.001.²