Don’t Fight It Tooth and Nail: Your Dentist is on Your Side during Pregnancy!

By Beth Conover, APRN, CGC MotherToBaby Nebraska, UNMC

“There are so many risks to the baby if I go for dental work, right?” “What about x-rays?” “I don’t like going to the dentist anyway, so I’ll probably just wait until my baby is born. That should be fine, right?” Worries, excuses, we’ve heard it all at MotherToBaby when it comes to dental procedures during pregnancy. We often receive questions from women wondering whether dental care is safe. In short, the answer is….yes! What better time to talk about the reasons why it’s ok than during June – typically the month the American Dental Association dubs as “Oral Health Month.”

Routine dental care is low risk, and most emergency procedures can be done as well.
Good oral health improves your overall health, and increases your chances of a good pregnancy outcome. However, when you are scheduling a dental appointment and are pregnant (or trying to get pregnant), let the office know so that they can be prepared to make decisions about which procedures are safe for your baby. In some cases, you or your dentist may want to wait until after delivery for elective (non-necessary) procedures.

Here are some commonly asked questions we get from pregnant women:

- **When I brush my teeth, my gums have started to bleed. Is this normal? What should I do?**

Bleeding gums is a common problem during pregnancy. Pregnant women have hormonal changes that can increase their chances of getting gum problems such as gingivitis (puffy and tender red gums that bleed easily). Your dentist will want to monitor this so that it does not progress to a more serious gum disease. Periodontal disease is a bacterial infection of the gums and jaw bones that support the teeth, and can increase your chances of having a smaller baby, delivering early, and having other pregnancy complications. Dentists recommend that you floss daily, and get your teeth cleaned on a regular basis during pregnancy (consider having it done more frequently, if you are having pregnancy gingivitis).

- **It seems like pregnancy is causing me to get more cavities in my teeth…am I right?**

Pregnancy can contribute to women having more cavities. This is in part due to changes in diet such as frequent snacks including sugary foods. To prevent cavities, eat a healthy diet and brush your teeth after eating sweets. In addition, if you have morning sickness, the acid from your stomach can affect your tooth enamel and make cavities more likely. Rinse your mouth with water or mouthwash after morning sickness episodes. If your toothpaste is making your morning sickness worse, ask your dentist for the name of a bland-tasting toothpaste.

- **What if I need to get a cavity filled or a tooth pulled? Can I have a local anesthetic?**

Agents like lidocaine which are injected into your gums are low risk for your baby. In one study, researchers compared pregnant women who received lidocaine injections as part of dental treatment with women who did not, and found no significant increase in risk for miscarriage, prematurity, or birth defects. If you need a pain medication, your dentist will take into account where you are in your pregnancy so as to make a choice that is safest for your baby.

- **Are dental x-rays safe in pregnancy?**

You may choose to have routine X-rays done prior to pregnancy, or to delay them until after you deliver – talk to your dentist about the best options for you. However, if you have a dental emergency and need to have them done, don’t

hesitate. Advances in technology have made dental X-rays safer, and they do not involve as much radiation or may not involve radiation at all. Your dental office will cover your neck and abdomen with a lead apron, which lessens the exposure to your baby even more.

- **What else can I do to ensure dental health?**

Schedule a visit to your dentist before you are pregnant. Get teeth cleaned, gums examined, and any dental issues addressed prior to pregnancy.

Brush your teeth at least twice a day and floss once a day. This helps reduce plaque, the sticky film that covers your teeth and can make gums inflamed and increase your risk for periodontal disease.

I hope I've given you a few good tips to chew on – Your teeth and baby will thank you. Have a healthy pregnancy!

Beth Conover, APRN, CGC, is a genetic counselor and pediatric nurse practitioner. She established the Nebraska Teratogen Information Service in 1986, also known as MotherToBaby Nebraska. She was also a founding board member of the Organization of Teratology Information Specialists (OTIS). In her clinical practice, Beth sees patients in Pharmacogenetics Clinic and Genetics Clinic at the University of Nebraska Medical Center. Beth has provided consultation to the FDA and CDC.

About MotherToBaby
***MotherToBaby** is a service of the Organization of Teratology Information Specialists (OTIS), suggested resources by many agencies including the Centers for Disease Control and Prevention (CDC). If you have questions about exposures during pregnancy and breastfeeding, please call MotherToBaby toll-FREE at 866-626-6847 or try out MotherToBaby's **new text information service** by texting questions to (855) 999-3525. You can also visit **MotherToBaby.org** to browse a library of fact sheets about dozens of viruses, medications, vaccines, alcohol, diseases, or other exposures during pregnancy and breastfeeding or connect with all of our resources by downloading the new MotherToBaby free app, available on **Android** and **iOS** markets.*

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My baby sister was 35 years old and pregnant with her first child. As a family, we were ecstatic. The family was expanding, and I was about to be an aunt for the third time. She was in her 3rd trimester and very pregnant, but she was up there in the choir singing and dancing her heart out at a memorial concert. I, along with many others, was shocked at how energetic and agile she was that far into pregnancy. However, when the concert was over, I looked at her feet and they were very, very swollen. I was concerned and told her to speak with her doctor immediately. Three days later, she got a call from her doctor to check in to the hospital, 6 days before her actual due date. Unbeknownst to me, she had dropped off a urine sample the day before the concert. Test results revealed that she had preeclampsia (a type of high blood pressure that is specific to pregnancy) and they needed to deliver the baby. Left untreated, preeclampsia can be very dangerous for mom and baby. My sister scrambled to get everything together and rushed to the hospital, and baby Jordan, my nephew, was born. My sister is a strong, educated, physically fit African American woman, and thank God her story ended well. However, that is not always the case. It could have gone a very different way.

Hypertensive disorders of pregnancy (HDP) are a group of medical conditions that involve high blood pressure during pregnancy. High blood pressure, also known as hypertension, is a condition where the force of the blood against the walls of the arteries is too high. This can damage the arteries and increase the risk of heart attack, stroke, and other serious health problems. Hypertensive disorders of pregnancy are a leading cause of maternal death and can put both mother and baby at risk for serious complications during pregnancy.

There are four main types of hypertensive disorders of pregnancy:

- **Chronic hypertension**: High blood pressure that occurs before pregnancy or before 20 weeks of gestation, or that persists longer than 12 weeks after delivery.
- **Gestational hypertension**: High blood pressure that develops after 20 weeks of gestation, without signs of organ damage or protein in the urine.
- **Preeclampsia**: High blood pressure that develops after 20 weeks of gestation, with signs of organ damage or protein in the urine.

- **Preeclampsia superimposed on chronic hypertension**: Chronic hypertension that worsens or causes organ damage or protein in the urine during pregnancy. This means that you have two problems with your blood pressure.

Chronic hypertension affects approximately 85,000 births (2.3%) in the United States each year. Unfortunately, the number of pregnant women diagnosed with HDP is increasing and more maternal deaths are occurring due to complications from these conditions in pregnancy. On top of that, the rates between white people and other racial groups are widening, especially among black pregnant women during pregnancy. According to a Centers for Disease Control and Prevention (CDC) report, HDP affected at least 1 in 7 delivery hospitalizations in the United States from 2017 to 2019, and about a third of those who died during hospital delivery had some form of HDP. Some of the other key findings of the report were that:

- HDP affected more than 1 in 5 delivery hospitalizations of Black women and about 1 in 6 delivery hospitalizations of American Indian and Alaska Native women, compared to 1 in 8 delivery hospitalizations of White women.
- Black women had higher odds of entering pregnancy with chronic hypertension and developing severe preeclampsia.
- Black women and American Indian and Alaska Native women had higher rates of maternal death due to HDP than White women.

The causes of hypertensive disorders of pregnancy are not fully understood, but some risk factors include obesity, diabetes, kidney disease, family history, multiple pregnancies, and advanced maternal age (over age 35) and the rates are higher among communities of color compared to white people. In general, more than 50% of black women have hypertension, compared to 39% of non-Hispanic white women and 38% of Hispanic women. The symptoms of hypertensive disorders of pregnancy may vary depending on the type and severity, but some common ones are headaches, swelling, blurred vision, stomach pain, and reduced amounts of urine than usual.

HDP can be dangerous for both you and your baby, but it can be prevented and treated with proper care and attention. To reduce the chance of HDP, pregnant women and those planning for pregnancy can take the following steps:

- Get early and regular prenatal care. They can check your blood pressure and screen for any signs of HDP[1].
- Take your blood pressure medication to lower your blood pressure and prevent complications. They may also advise you to take a low-dose daily aspirin after 12 weeks of pregnancy to reduce the risk of preeclampsia[2].
- Maintain a healthy weight and lifestyle. Try to lose weight before you conceive and gain weight gradually during pregnancy according to your doctor's guidelines. Exercise regularly, eat a balanced diet, avoid smoking, limit

alcohol and salt intake, and manage stress[23].

- Monitor your blood pressure at home. Your doctor may suggest that you use a home blood pressure monitor to keep track of your blood pressure between visits.

MotherToBaby has helpful fact sheets on smoking, alcohol, stress and exercise, and low-dose aspirin. You can also contact us for information on medications that may be recommended by your healthcare provider for treatment. We are a free service that is available for everyone. The heart of the matter is that you do what is best for you and your baby and we are here to help you through all stages of pregnancy from the time you hear a heartbeat on a monitor and until the time your baby captures your heart.

Resources:

American Heart Association. (2023, February 27. Black women of childbearing age more likely to have high blood pressure, raising pregnancy risks. Accessed February 7, 2024 Read More

Ford, N. D., et al., (2022). Hypertensive Disorders in Pregnancy and Mortality at Delivery Hospitalization – United States, 2017-2019. ***MMWR. Morbidity and mortality weekly report***, ***71***(17), 585–591.

Hoover, C., (2023, August 30). Addressing Hypertension Is Critical for Lowering the Black Maternal Mortality Rate. The Century Foundation . Read More

Kalinowski, J., et al., (2021). Stress interventions and hypertension in Black women. ***Women's health (London, England)***, ***17***, 17455065211009751.

Leonard, S. A., et al., (2023). Chronic Hypertension in Pregnancy and Racial-Ethnic Disparities in Complications. ***Obstetrics and gynecology***, ***142***(4), 862–871.

Margerison, C. E., et al., (2019). Pregnancy as a Window to Racial Disparities in Hypertension. ***Journal of women's health (2002)***, ***28***(2), 152–161.

Sharma, G., et al., (2022). Social Determinants of Suboptimal Cardiovascular Health Among Pregnant Women in the United States. ***Journal of the American Heart Association***, ***11***(2), e022837.

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Dealing with constipation can be challenging, and the struggle intensifies during pregnancy. The struggle is real, and I know it firsthand! I have struggled with constipation ever since I was a teenager. But once I started college, the stress of my day-to-day life intensified my symptoms which led me to suffer from chronic constipation. Once I found out I was pregnant, I knew it was only a matter of time until I experienced the discomfort, pain, and bloating all over again. But I knew that, while this might be disheartening, I was not alone. Up to 38% of pregnant individuals experience constipation in the first trimester (***Trottier et al., 2012***).

This common issue has even earned its own ICD-10 code (used for medical billing), emphasizing the need for attention and solutions. Let’s explore the reasons behind pregnancy-related constipation and discover effective ways to manage and alleviate it. Our Constipation Resource Hub is a great way to access all the information that MotherToBaby experts have for you related to this topic, but let’s go over some specifics first!

Understanding the Causes of Constipation in Pregnancy:

Constipation during pregnancy can be attributed to various factors, including an unbalanced diet, insufficient fiber intake, inadequate hydration, and a lack of physical activity. Hormonal changes, particularly an increase in progesterone, also play a significant role. Additionally, medications used to combat nausea and vomiting in pregnancy (NVP) and supplements like iron and calcium may contribute to constipation.

Navigating Treatment Options during Pregnancy:

While constipation is common during pregnancy, suffering needlessly is not acceptable. Explore different treatment options, but keep in mind that there is no one-size-fits-all approach. Understanding the complexities of your individual situation is crucial.

Nutrition Adjustments:

- Incorporate 4-5 cups of fresh fruits and vegetables daily.

- Aim for 25-30 grams of fiber daily.
- Stay hydrated by drinking plenty of water.
- Engage in 150 minutes of moderate exercise per week (consult your healthcare provider before starting any new exercise routine during pregnancy).

Medication Considerations:

- Laxatives can be an option, they are medications used to soften stool or stimulate the bowel, but it's essential to be informed. Explore our fact sheet on laxatives here https://mothertobaby.org/fact-sheets/laxatives/. Here's a brief run-down of some of these options:

- Bulk-forming laxatives (fiber supplements) like psyllium
  - Osmotic laxatives
  - Stool softener laxatives
  - Stimulants, and lubricants

Prescription medications

- Prucalopride (Motegrity®) for the treatment of functional constipation, also known as chronic idiopathic constipation. Read our fact sheet here.

Managing Underlying Conditions that May Make Constipation during Pregnancy Worse:

Some individuals may face constipation due to underlying conditions such as Irritable Bowel Syndrome (IBS-C) or

Functional Constipation (FC). Consult your healthcare provider for a proper diagnosis and follow their recommendations. Explore our informative fact sheet on Functional Constipation here. https://mothertobaby.org/fact-sheets/functional-constipation/ .

Stress can exacerbate constipation, especially for those with IBS-C. Be kind to yourself and explore stress management techniques. Learn more about stress during pregnancy in our fact sheet here https://mothertobaby.org/fact-sheets/stress-pregnancy/ .

For those with **Gestational Diabetes** or a predisposition to Type 2 Diabetes Mellitus, regulating blood glucose levels is crucial. Explore our blog on diabetes during pregnancy here https://mothertobaby.org/baby-blog/diabetes-and-pregnancy-the-not-so-sweet-story/ .

In conclusion, constipation during pregnancy is a shared experience, but it shouldn't be endured without seeking relief. I certainly looked for options that helped me during my pregnancy, just like I did, so can you! Open a conversation with your healthcare provider to explore solutions. By making dietary adjustments, staying active, and managing stress, you can navigate constipation more comfortably during this transformative time. For personalized information about medications or conditions, or to volunteer for the **study on constipation** (https://mothertobaby.org/ongoing-study/constipation/) in pregnancy, reach out to our experts at MotherToBaby—they're here to answer your questions and provide support throughout your pregnancy journey.

We want to enroll all individuals who took Motegrity® at any point in their current pregnancy or while breastfeeding. If you, or someone you know has been exposed to this medication, please report use to our team.

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Sara contacted us on the MotherToBaby live chat service after being referred by her OB/GYN who had told her that the Paxil (drug name paroxetine) she was taking could cause a heart defect. She was 14 weeks along and wanted to learn more, but was confused because all her genetic testing results had come back normal. She asked: “How could my baby have a heart defect if my non-invasive prenatal testing (NIPT) was negative?”

During pregnancy, there are many tests done to check on the health and development of your baby. It can be difficult to keep track of what they are all looking for and why they are important. To understand these tests, it can be helpful to know the differences between a birth defect and a chromosomal abnormality and what they each mean for the health of your baby.

All pregnancies have a background risk for birth defects of 3-5%, but certain exposures can increase the risk of birth defects above this background estimate. Most birth defects occur during the first trimester while the baby is growing and developing. A certain body part – such as the heart, brain, or limbs – might not develop correctly, and the baby’s body may look or function differently than it should. You may have heard of a baby being born with a hole in the heart, or with something called a cleft lip. These are two examples of birth defects that can occur during pregnancy. Birth defects can range from mild to severe, and the health of the baby will be dependent on where the birth defect occurs and how severe the problem is.

Certain tests done during pregnancy can look at your baby to see if there are birth defects. For example, most pregnant individuals will go in for an anatomy scan between 18 and 22 weeks where the healthcare provider will look at the baby using an ultrasound. Most people know this as the time when they can learn the gender of the baby, but the ultrasound will also take a detailed look at the baby’s organs and body parts, including the heart, brain, face, and stomach, to check for birth defects. While this is an important screening test, it is not perfect, and more minor defects may go unnoticed until birth.

Chromosomal abnormalities are changes in the baby’s DNA that happen at the time of conception. The best way to understand DNA is to think of it like a recipe book that holds all the recipes for the growth and development of different body parts. If a certain recipe calls for one stick of butter, but the printed book accidentally says two sticks of butter, the recipe will turn out different. In the same way, sometimes people have extra or missing amounts of DNA that can cause changes in development. For example, people who have a chromosomal abnormality known as Down syndrome have three copies of their 21st chromosome rather than only two. This extra amount of DNA is what causes the developmental differences in individuals with Down syndrome.

During your pregnancy, your healthcare provider may suggest that you meet with a genetic counselor to have non-invasive prenatal testing, or NIPT, performed. This test can be done as early as 10 weeks. During pregnancy, some of the baby’s DNA enters the pregnant woman’s bloodstream. By taking a small blood sample from mom, a lab can take a look at the baby’s DNA and tell if they have certain chromosomal abnormalities, such as Down syndrome. When you meet with a genetic counselor, they will go over all of the pros and cons of this test as well as your family history, and will meet with you again to review the results.

Back on the live chat service, Sara asked: “So because my NIPT results were normal, the baby is unlikely to have a chromosomal abnormality. However, a birth defect still could have happened in the first trimester, and I need to wait until my anatomy scan to get those results, is that right?” That’s exactly right, I replied. I then went on to explain that

although Paxil (paroxetine) has been shown to increase the risk for heart defects in some studies, other studies do not suggest a risk, so the overall chance of the baby being affected is low.

As we ended our chat, Sara shared that she was feeling much more knowledgeable about the difference between a birth defect and a chromosomal abnormality. She was able to breathe a sigh of relief that her NIPT results came back normal, indicating a low risk for conditions like Down syndrome. She also felt much more confident heading to her anatomy scan in a few weeks knowing that this test, while not perfect, would be the best way to identify birth defects before her baby is born.

If you have any questions about birth defects or exposures during pregnancy, speak with a MotherToBaby specialist via phone, text, live chat, or email. For any questions regarding genetic testing in pregnancy, or to find a genetic counselor in your area, visit the Find a Genetic Counselor page on the National Society of Genetic Counselors website: https://findageneticcounselor.nsgc.org/

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By: Kirstie Perrotta, MPH and Becky Spencer, PhD, APRN, PMHNP-BC, IBCLC, PMH-C, FILCA

Shannon was newly pregnant and had been referred to MotherToBaby by her doctor. She was taking 50 mg of sertraline per day for general anxiety and her doctor thought that she may need to wean off the medication now that she was 5 weeks pregnant. Shannon had been taking the medication for 3 years and was feeling great on her current dose, so she had some concerns about this plan. On the MotherToBaby website’s live chat service, Shannon was

connected with me, a teratogen information specialist, where she asked “Do I really need to stop my anxiety medication, or could I just continue on a lower dose?”

I started by addressing the importance of weighing the risks vs. benefits of taking any mental health medication during pregnancy. Sertraline is very well studied and has not been associated with a risk for birth defects, but does have the potential to cause neonatal adaptation syndrome or withdrawal approximately 10-30% of the time and persistent pulmonary hypertension in less than 1% of exposed infants. On the other hand, we know that untreated anxiety can also cause problems for the pregnancy, including an increased risk for preterm delivery. For many patients, the benefits of staying on a medication like sertraline outweigh the potential risks, but each case is unique and ultimately the patient needs to decide what they are most comfortable with.

Getting to Shannon’s next question about dose, I shared that although many pregnant women feel they need to decrease their dose once they get a positive pregnancy test, the opposite is in fact true. During pregnancy, there are many changes that occur including weight gain, increased blood volume and enlargement of the kidneys. On the outside, things won’t look much different, but research shows these changes happen soon after conception. This means that medication doses that previously worked well to control a condition become “diluted,” in a sense, and may not be as effective. In some cases, women need to actually increase their dose to continue to control the disease.

To learn more about how bodily changes during pregnancy impact medication dosing, we turn to Becky Spencer, PhD, APRN, PMHNP-BC, IBCLC, PMH-C, a psychiatric nurse practitioner who specializes in perinatal mental health at Texas Women’s University with some more questions about this fascinating phenomenon.

Q. Can you tell us a little more about what is happening in the body during pregnancy and why medications become less effective?

Becky Spencer: You are correct, Kirstie, that pregnancy has a significant impact on drug absorption, which is how a drug is transported into the bloodstream, drug distribution, which is the disbursement of a drug as it moves through the blood and tissues of the body, and drug metabolism, which is the process by which the body breaks down and eliminates drugs or other substances. During pregnancy, especially later in pregnancy, drug absorption from the stomach into the bloodstream is decreased due to slower gastric emptying and slower movement of the bowel and colon, so it can take longer for a medication to be absorbed and get to work.

A pregnant woman’s blood volume almost doubles during pregnancy which impacts drug distribution. With the dilution effect there is a lower concentration of medication in the blood plasma which results in less medication reaching the target tissues. Most drugs are metabolized in the liver or kidneys. During pregnancy, the increased blood flow to the kidneys results in an increased glomerular filtration rate (GFR), which means that medications are cleared from the bloodstream quicker, meaning the drug stays in the body less time. Similarly, hormone levels increase during pregnancy which increases the activity of various metabolic enzymes in the liver that metabolize drugs. When the liver metabolizes a drug more quickly there is less drug that reaches the target tissues.

What these changes mean for pregnant women who take medication for mood and anxiety disorders is that the dose of medication that they were taking before pregnancy may have a decreased effect during pregnancy, because the biological changes effectively decrease the amount of medication reaching the target tissues, in this case, the brain. Pregnant women may have an increase in mood and anxiety symptoms that they interpret as a worsening condition when, in fact, the decrease in circulating medication is the cause for an increase in symptoms.

Q. In your practice, how often do you see women increasing their mood medication dose? Does the dose need to be increased substantially?

Becky Spencer: That is a great question. The answer is that it depends on the type of medication, the specific condition (depression, anxiety, obsessive compulsive disorder, bipolar, etc.), and the severity of symptoms. Psychiatric providers typically increase medication dosages in gradual amounts until the patient has symptom relief or desired therapeutic effect. If a patient is experiencing a partial response to a medication (some improvement in mood and anxiety symptoms) best practice is to increase the dose of that medication before considering adding an additional medication.

Another question that I hear is whether or not dosages of medication should be based on achieving a specific blood plasma concentration level. The short answer is, for most medications, no. We don't routinely check blood plasma concentrations of most antidepressants because valid and reliable therapeutic plasma concentration ranges do not exist. Some mood stabilizing medications like valproate or lithium do require blood plasma monitoring both during pregnancy and outside of pregnancy. Euthymia, or stable mood, is the goal of medication dose adjustments for mood and anxiety disorders during pregnancy.

Q. What about after delivery? Does the dose need to be decreased right away?

Becky Spencer: It depends on the type of medication, and, to some extent, the symptoms that the patient is experiencing. The postpartum period is a vulnerable time for mood and anxiety disorders for several reasons including the significant hormonal shift that occurs after birth, lack of sleep, role adjustment to caring for a baby, and for some new parents, lack of necessary social and emotional support. Decreasing antidepressants too quickly after birth could exacerbate mood and anxiety symptoms during that very vulnerable time. The decision to decrease dosages of any medication prescribed for mood and anxiety disorders should be a collaborative decision between the patient and the provider. If decreasing mediation dose is desirable, it should occur gradually and any change in mood and anxiety symptoms should be reported to the provider. The one exception to this rule is for patients taking lithium. If lithium dosages were increased during pregnancy, they must be decreased to pre-pregnancy dosages after delivery.

Q. Shannon is asking about sertraline, an anti-anxiety medication, but are there other drugs that women need to also increase their dose of during pregnancy?

Becky Spencer: Any medications used to treat mood and anxiety disorders, including antidepressants, mood stabilizers, antipsychotics, and anti-anxiety medications, may need dose increases during pregnancy. The most important point is for pregnant women to monitor their mood and anxiety symptoms and report them to their provider. The decision to increase doses of medication should always be a collaborative decision between the patient and the healthcare prescriber.

Q. How should patients approach this conversation with their healthcare provider?

Becky Spencer: The decision to take any medication during pregnancy must be based on a discussion between healthcare providers and patients that takes into consideration the available research on the risks of specific medications AND the risks of untreated or undertreated mental conditions for both the pregnant woman and the baby. The risks of not treating mood and anxiety disorders during pregnancy are well documented and significant. Untreated or undertreated mood and anxiety disorders during pregnancy are associated with hypertension, preterm delivery, low birth weight, and long-term negative impacts on motor and cognitive development of the baby. Mental health conditions are the leading cause of maternal mortality in the United States. Effective treatment for mood and anxiety disorders in the perinatal period will literally save lives.

My top three tips for having a discussion with healthcare providers about medications for mood and anxiety disorders in the perinatal period include:

- Make an appointment with a psychiatric provider who specializes in perinatal mood and anxiety disorders or reproductive psychiatry. The provider directory on the Postpartum Support International website is a great place to find specialists in your state, and many provide telehealth services.

- If your obstetric provider is hesitant to treat your mood and anxiety symptoms, recommend that they make an appointment to speak with a psychiatric provider who specializes in treatment of perinatal mood and anxiety disorders during pregnancy at the Postpartum Support International Psychiatric Consult Line. This free service is staffed by perinatal psychiatrists who are available to share their skills and expertise and provide guidance to fellow medical professionals on prescribing medications during pregnancy and lactation.

- MotherToBaby Fact Sheets are an excellent resource and a great way to start a conversation with your provider about specific medications for mental health during pregnancy and lactation. I recommend that pregnant and lactating women who are taking medications for mood and anxiety disorders access and print out the MotherToBaby Fact Sheets for the medications that they are taking or are interested in learning more about, read them, jot down questions, and take them to their obstetric and/or psychiatric providers to start the conversation. Remember that you are your own best advocate for you and your baby's health.

Thanks so much for sharing your insight, Becky. It's always great to learn more about this topic.

Ultimately, Shannon decided to stick with her current dose for the first few weeks of pregnancy and make an appointment with her psychiatrist to discuss increasing her dose in a few weeks. In the meantime, she was planning to monitor her mood to make sure the anxiety remained well controlled.

If you have questions about mental health medications, dose, or any other exposures in pregnancy or lactation, please feel free to reach out to a MotherToBaby specialist via phone, chat, text, or email for more information. Additionally, you can visit our Mental Health Resource Hub to access fact sheets, blogs, and podcasts on mental health conditions and the medications used to treat them during pregnancy and breastfeeding.

References:

- Cook, N., Ayers, S., & Horsch, A. (2018). Maternal posttraumatic stress disorder during the perinatal period and child outcomes: A systematic review. ***Journal of Affective Disorders, 225***, 18–31. doi:10.1016/j.jad.2017.07.045

- Davenport, M. H., Meyer, S., Meah, V. L., Strynadka, M. C., & Khurana, R. (2020). Moms Are Not OK: COVID-19

and Maternal Mental Health. ***Frontiers in Global Women's Health***, 1. doi:10.3389/fgwh.2020.00001

- Deligiannidis, K. M., Byatt, N., & Freeman, M. P. (2014). Pharmacotherapy for mood disorders in pregnancy: a review of pharmacokinetic changes and clinical recommendations for therapeutic drug monitoring. ***Journal of Clinical Psychopharmacology***, ***34***(2), 244-255. doi: 10.1097/JCP.0000000000000087

- Grigoriadis, S., Graves, L., Peer, M., Mamisashvili, L., Tomlinson, G., Vigod, S. N.... Richter, M. (2018). Maternal Anxiety During Pregnancy and the Association with Adverse Perinatal Outcomes. ***The Journal of Clinical Psychiatry***, 79(5). doi:10.4088/jcp.17r12011

- Hussein W, Lafayette RA. Renal function in normal and disordered pregnancy. Curr Opin Nephrol Hypertens. 2014 Jan;23(1):46-53. doi: 10.1097/01.mnh.0000436545.94132.52. PMID: 24247824; PMCID: PMC4117802.

- Hutner, L. A., Catapano, L. A., Nagle-Yang, S. M., Williams, K. E., & Osborne, L. M. (Eds.). (2021). ***Textbook of women's reproductive mental health***. American Psychiatric Pub.

- Prakash, C., & Nagle-Yang, S. (2019). Postpartum psychosis: Protecting mother and infant. ***Current Psychiatry***, ***18***(4), 12-21.

- Rusner, M., Berg, M., & Begley, C. (2016). Bipolar disorder in pregnancy and childbirth: a systematic review of outcomes. BMC Pregnancy and Childbirth, 16(1). doi:10.1186/s12884-016-1127-1

- Sachdeva P, Patel BG, Patel BK. Drug use in pregnancy; a point to ponder! Indian J Pharm Sci. 2009 Jan;71(1):1-7. doi: 10.4103/0250-474X.51941. PMID: 20177448; PMCID: PMC2810038.

- Shay, M., MacKinnon, A. L., Metcalfe, A., Giesbrecht, G., Campbell, T., Nerenberg, K. ... Tomfohr-Madsen, L. (2020). Depressed mood and anxiety as risk factors for hypertensive disorders of pregnancy: a systematic review and meta-analysis. ***Psychological Medicine***, 50(13), 2128–2140. doi:10.1017/s0033291720003062

- Slomian, J., Honvo, G., Emonts, P., Reginster, J.-Y., & Bruyère, O. (2019).

- Consequences of maternal postpartum depression: A systematic review of maternal and infant outcomes. ***Women's Health, 15***, 174550651984404. doi:10.1177/1745506519844044

- Trost, S. L., Beauregard, J. L., Chandra, G., Njie, F., Berry, J., Harvey, A., Goodman, D. (2023). Pregnancy-Related Deaths: Maternal Mortality Review Committees in 36 states, 2017–19. https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html