Letters to the Editor

Send letters to Kenneth W. Lin, MD, MPH, Associate Deputy Editor for *AFP* Online, e-mail: afplet@aafp.org, or 11400 Tomahawk Creek Pkwy., Leawood, KS 66211-2680.

Please include your complete address, e-mail address, and telephone number. Letters should be fewer than 400 words and limited to six references, one table or figure, and three authors.

Letters submitted for publication in *AFP* must not be submitted to any other publication. Possible conflicts of interest must be disclosed at time of submission. Submission of a letter will be construed as granting the American Academy of Family Physicians permission to publish the letter in any of its publications in any form. The editors may edit letters to meet style and space requirements.

Letters on Preconception Counseling and Care

Original Article: Recommendations for Preconception Counseling and Care

Issue Date: October 15, 2013

Available online at: http://www.aafp.org/afp/2013/1015/p499.html

TO THE EDITOR: I applaud the advice given by Drs. Farahi and Zolotor about preconception counseling. In addition, oral health should be part of a comprehensive approach to preconception care, because it can have a major impact on health outcomes for women and their children.

Recently, the American College of Obstetricians and Gynecologists recommended that medical professionals "advise women that oral health care improves a woman's general health through her life span and may also reduce the transmission of potentially caries-producing oral bacteria from mothers to their infants."[1] National consensus guidelines agree with this message, and outline the evidence for treating oral conditions in pregnant women and the safety of such treatment.[2]

Although there is evidence that periodontitis can affect birth outcomes (e.g., low birth weight, preterm birth), studies also show that interventions to manage the disease during pregnancy (e.g., deep root scaling) do not improve these outcomes. Therefore, dental experts have speculated that treating periodontal disease during pregnancy is too late.[3] This is yet another reason for family physicians to focus on oral health screenings, advice, and referrals during the preconception period.

Drs. Farahi and Zolotor discuss preconception counseling for women who are obese or have diabetes mellitus. Evidence indicates that addressing oral health and treating periodontitis can improve glycemic control and reduce obesity rates.[4] As part of the patient-centered medical home initiative, we need to integrate oral health screening, hygiene counseling, diet advice, and dental referrals into routine care.[5]

HUGH SILK, MD, MPH, FAAFP
Worcester, Mass.
E-mail: hugh.silk@umassmed.edu

Author disclosure: No relevant financial affiliations.

REFERENCES

1. American College of Obstetricians and Gynecologists Women's Health Care Physicians; Committee on Health Care for Underserved Women. Committee opinion No. 569: oral health care during pregnancy and through the lifespan. *Obstet Gynecol.* 2013;122(2 pt 1):417-422.
2. National Maternal and Child Oral Health Resource Center. Oral health care during pregnancy: a national consensus statement. http://www.mchoralhealth.org/PDFs/OralHealthPregnancyConsensus.pdf. Accessed October 20, 2013.
3. Boggess KA, Edelstein BL. Oral health in women during preconception and pregnancy: implications for birth outcomes and infant oral health. *Matern Child Health J.* 2006;10(5 suppl):S169-S174.
4. Genco RJ, Grossi SG, Ho A, Nishimura F, Murayama Y. A proposed model linking inflammation to obesity, diabetes, and periodontal infections. *J Periodontol.* 2005;76(11 suppl):2075-2084.
5. Brownlee B. White paper: oral health integration in the patient-centered medical home (PCMH) environment. Case studies in oral health centers. September 10, 2012. http://www.qualishealth.org/sites/default/files/white-paper-oral-health-integration-pcmh.pdf. Accessed October 20, 2013.

TO THE EDITOR: I was surprised that this article did not mention screening women of Ashkenazi Jewish descent for inherited disorders. These disorders are prevalent, and the option for screening should be included in any comprehensive conversation with women of Ashkenazi Jewish descent.

LAURA OPPENHEIM, MD
Philadelphia, Pa.
E-mail: lauraopp@gmail.com

Author disclosure: No relevant financial affiliations.

IN REPLY: These letters raise two important points about preconception care. Oral health is an essential part of a woman's overall health, and counseling regarding preventive oral health care and treatment of periodontal disease and dental caries should be part of care for all patients throughout the life ▶

span.[1] Studies have demonstrated that children of mothers who had interventions to prevent caries developed fewer cavities than children of mothers who did not have interventions.[2] Although several studies have shown a link between periodontal disease and pregnancy outcomes,[3,4] evidence to demonstrate that preventive oral health care during the preconception period decreases rates of preterm labor or low birth weight is lacking. We agree with Dr. Silk that prevention and treatment of periodontal disease should be a part of comprehensive care for women with type 2 diabetes before, during, and after pregnancy.

In regard to screening for genetic disorders in women of Ashkenazi Jewish descent, we appreciate Dr. Oppenheim raising this issue. Screening for carrier status of heritable conditions is an important part of preconception care. We recommend family genetic history and targeted screening in women with increased risk.

As Dr. Oppenheim points out, certain heritable conditions are more common among persons of Eastern European (Ashkenazi) Jewish descent; Gaucher disease and Tay-Sachs disease are the most common, affecting one per 900 and one per 3,000 of these persons, respectively.[5] A more detailed discussion of screening for heritable conditions based on racial and ethnic risk would also need to focus on other common conditions, such as sickle cell disease (affecting one in 300 African Americans)[6] and cystic fibrosis (affecting one in 2,500 persons of European descent, especially French Canadian).[7]

NARGES FARAHI, MD
ADAM ZOLOTOR, MD, DrPH
Chapel Hill, N.C.
E-mail: narges_farahi@med.unc.edu

Author disclosure: No relevant financial affiliations.

REFERENCES

1. American College of Obstetricians and Gynecologists Women's Health Care Physicians; Committee on Health Care for Underserved Women. Committee opinion No. 569: oral health care during pregnancy and through the lifespan. *Obstet Gynecol.* 2013;122(2 pt 1):417-422.
2. Kohler B, Andréen I, Jonsson B. The effect of caries-preventive measures in mothers on dental caries and the oral presence of the bacteria *Streptococcus mutans* and lactobacilli in their children. *Arch Oral Biol.* 1984;29(11):879-883.
3. Offenbacher S, Katz V, Fertik G, et al. Periodontal infection as a possible risk factor for preterm low birth weight. *J Periodontol.* 1996;67(10 suppl):1103-1113.
4. Jeffcoat MK, Geurs NC, Reddy MS, Cliver SP, Goldenerg RL, Hauth JC. Periodontal infection and preterm birth: results of a prospective study. *J Am Dent Assoc.* 2001;132(7):875-880.
5. American College of Obstetricians and Gynecologists Committee on Genetics. ACOG Committee opinion No. 442: preconception and prenatal carrier screening for genetic diseases in individuals of Eastern European Jewish descent. *Obstet Gynecol.* 2009;114(4):950-953.
6. American College of Obstetricians and Gynecologists Committee on Obstetrics. ACOG practice bulletin No. 78: hemoglobinopathies in pregnancy. *Obstet Gynecol.* 2007;109(1):229-237.
7. American College of Obstetricians and Gynecologists Committee on Genetics. ACOG committee opinion No. 486: update on carrier screening for cystic fibrosis. *Obstet Gynecol.* 2011;117(4):1028-1031.

Clarification

Updated USPSTF and CDC recommendations, and incorrect Cochrane review data. Based on new and additional recommendations, we are updating the article "Update on Prenatal Care" (February 1, 2014, p. 199). The U.S. Preventive Services Task Force (USPSTF) updated their recommendations in January 2014 regarding screening for diabetes mellitus in pregnant women. Therefore, the third to the last sentence in the abstract (p. 199), the ninth statement in the SORT table (p. 206), and text in the second paragraph under the "Gestational Diabetes" header (p. 206) have been revised to indicate that the USPSTF recommends that all pregnant women be screened for diabetes between 24 and 28 weeks' gestation. Based on 2012 recommendations from the Centers for Disease Control and Prevention (CDC), the third row in Table 5 (p. 205) should not have included cefixime (Suprax) as a treatment option for gonorrhea. Because incorrect data from a Cochrane review (reference 66) were cited, the last three sentences of the first paragraph under the "Postterm Pregnancy" header (p. 207) should have updated rates of perinatal death and operative vaginal delivery. The online version of this article has been corrected.

Correction

Incorrect statement regarding etidronate's effect on hip fractures. In the Practice Guideline "ACP Releases Guideline on Treatment of Low Bone Mineral Density or Osteoporosis to Prevent Fractures" (May 1, 2009, p. 808), the first sentence of the second paragraph (p. 808), which described the effects of etidronate (Didronel) on hip fractures, contradicted data presented in Table 1 (p. 811). Etidronate has not been shown to reduce the risk of hip fracture and should not have been included in the list of drugs discussed. This error also appeared in the summary section of the original American College of Physicians (ACP) clinical guidelines. The sentence should have read as follows: "Bisphosphonates, including alendronate (Fosamax), zoledronic acid (Reclast), and risedronate (Actonel), have been shown to reduce vertebral, nonvertebral, and hip fracture risk." Another statement indicating that etidronate reduces vertebral fractures should have been added. The online version of this Practice Guideline has been corrected. ■