

Use of *Paxil CR Tablets* or *Paxil Tablets* During Pregnancy

This response may include reference to information about Paxil CR® (paroxetine HCl) Controlled-Release Tablets; Paxil® (paroxetine HCl).

SUMMARY

- Epidemiological studies of pregnancy outcomes following maternal exposure to antidepressants in the first trimester have reported an increase in the risk of congenital malformations, particularly cardiovascular (ventricular and atrial septal defects), associated with the use of paroxetine. The data suggest that the risk of having an infant with a cardiovascular defect following maternal paroxetine exposure is approximately 1/50, compared with an expected rate for such defects of approximately 1/100 infants in the general population. There have been reports of premature birth in pregnant women exposed to paroxetine or other SSRIs, although a causal relationship with drug therapy has not been established.
- Neonates exposed to *Paxil CR Tablets*, *Paxil Tablets*, and other SSRIs or serotonin and norepinephrine reuptake inhibitors (SNRIs), late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. Such complications can arise immediately upon delivery. There have also been postmarketing reports of premature births in pregnant women exposed to paroxetine or other SSRIs.
- Two large case-control studies using separate databases, each with >9,000 birth defect cases and >4,000 controls, found that maternal use of paroxetine during the first trimester of pregnancy was associated with a 2- to 3-fold increased risk of right ventricular outflow tract obstructions. In one study the OR was 2.5 (95% confidence interval, 1.0 to 6.0, 7 exposed infants) and in the other study the OR was 3.3 (95% confidence interval, 1.3 to 8.8, 6 exposed infants).
- Infants exposed to SSRIs in late pregnancy may have an increased risk for persistent pulmonary hypertension of the newborn (PPHN). PPHN occurs in 1 – 2 per 1,000 live births in the general population and is associated with substantial neonatal morbidity and mortality. Epidemiological studies have shown that the use of SSRIs (including paroxetine) in pregnancy, particularly use in late pregnancy, was associated with an increased risk of PPHN. The increased risk among infants born to women who used SSRIs late in pregnancy was reported to be 4 to 5 times higher than observed in the general population.
- One study including two, nested, case-control analyses demonstrated a dose-response relationship for both major congenital malformations and major cardiac malformations. Infants born to women exposed to > 25 mg/day of paroxetine during the first trimester had a significantly increased risk of both major congenital malformations and major cardiac malformations.
- The results of a prospective longitudinal study of 201 women with a history of major depression who were euthymic at the beginning of pregnancy showed that women who discontinued antidepressant medication during pregnancy were more likely to experience a relapse of major depression than women who continued antidepressant medication.
- When treating a pregnant woman with paroxetine during the third trimester, health care professionals should carefully consider the potential risks and benefits of treatment.
- *Paxil CR Tablets* and *Paxil Tablets* are Pregnancy Category D.
- Important safety information is found in the attached Prescribing Information.

- The prescribing information for this product contains a boxed warning. Please consult the WARNING section of the attached prescribing information for further details and for important safety information.

OVERVIEW

Epidemiological studies of pregnancy outcomes following maternal exposure to antidepressants in the first trimester have reported an increase in the risk of congenital malformations, particularly cardiovascular (ventricular and atrial septal defects), associated with the use of paroxetine.⁽¹⁾ The data suggest that the risk of having an infant with a cardiovascular defect following maternal paroxetine exposure is approximately 1/50, compared with an expected rate for such defects of approximately 1/100 infants in the general population. There have been reports of premature birth in pregnant women exposed to paroxetine or other SSRIs, although a causal relationship with drug therapy has not been established.

Neonates should be observed if maternal use of paroxetine continues into the later stages of pregnancy, because there have been reports of complications in neonates exposed to paroxetine or other SSRIs late in the third trimester of pregnancy.⁽¹⁾ However, a causal association with drug therapy has not been confirmed. Reported clinical findings have included: respiratory distress, cyanosis, apnoea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycemia, hypertonia, hypotonia, hyperreflexia, tremor, jitteriness, irritability, lethargy, constant crying and somnolence. In some instances, the reported symptoms were described as neonatal withdrawal symptoms. In a majority of instances the complications were reported to have arisen either immediately or soon (<24 hours) after delivery.

The prevalence of congenital malformations in the U.S. general population is approximately 3% for any malformation and approximately 1% for cardiovascular malformations alone.⁽²⁾

Cohen, et al. reported in a prospective longitudinal study of 201 women with a history of major depression who were euthymic at the beginning of pregnancy, that women who discontinued antidepressant medication during pregnancy were more likely to experience a relapse of major depression than women who continued antidepressant medication.⁽³⁾

PREGNANCY OUTCOMES, INCLUDING CONGENITAL MALFORMATION

Meta-Analyses

A meta-analysis based on original research published from 1992 to 2008 (n = 21) was conducted to provide a systematic review of epidemiological data regarding first trimester paroxetine use and the prevalence of congenital, including cardiac, malformations.⁽⁴⁾ Data from case reports, case series, non-human data, neonatal consequences from breast-milk exposure, third trimester-only exposure, and neonatal complications unrelated to congenital defects were excluded. The analysis suggested that first-trimester paroxetine exposure was associated with an increased risk of both cardiac malformations (1.46; 95% CI 1.17 – 1.82) and total malformations (1.24; 95% CI 1.08 – 1.43).

A meta-analysis of 9 studies published between 1985 and 2007 was conducted to examine the risk of cardiac defects in infants following first trimester exposure to paroxetine.⁽⁵⁾ Three case-control studies demonstrated a non-significant increase in risk (OR 1.18; 95% CI 0.88 – 1.59). In the 6 remaining cohort studies, the rates of cardiac malformations were 1.14% in the paroxetine-exposed infants and 1.09% in the controls, both of which fell within the 95% confidence interval for the population at large (0.7% – 1.2%). Additionally, a non-significant weighted average difference of 0.3% was noted between the paroxetine-exposed and non-exposed groups.

A meta-analysis of 7 studies conducted from 1985 to 2006 was conducted to quantify first-trimester exposure to paroxetine and birth defects.⁽⁶⁾ Results indicated that first-trimester exposure to paroxetine was associated with a significant increase in the risk of cardiac malformations (OR 1.72; 95% 1.22 – 2.42). The authors discuss the potential for a detection bias to influence this finding.

Epidemiological Data

A retrospective cohort study using U.S. United Healthcare data evaluated 5,956 infants of mothers dispensed paroxetine or other antidepressants during the first trimester (n=815 for paroxetine).^(7,8) This study showed a trend towards an increased risk for cardiovascular malformations for paroxetine as monotherapy compared to other antidepressants (OR 1.46; 95% confidence interval (CI) 0.74-2.88). The prevalence of cardiovascular malformations following first trimester dispensing was 1.5% for paroxetine vs. 1% for other antidepressants. Nine out of 12 infants with cardiovascular malformations whose mothers were dispensed paroxetine in the first trimester had ventricular septal defects (VSDs). This study also suggested an increased risk of overall major congenital malformations (inclusive of the cardiovascular defects) for paroxetine compared to other antidepressants (OR 1.89; 95% CI 1.20-2.98). The prevalence of all congenital malformations following first trimester exposure was 4% for paroxetine vs. 2% for other antidepressants.

Outcomes of infants exposed to paroxetine during pregnancy were collected from teratology information services and database studies to determine the rate of cardiovascular effects compared to that of an unexposed population (women from teratology services with exposures to medications considered safe).⁽⁹⁾ Of 1,174 cases of first-trimester, paroxetine exposures obtained through teratogen information services, there were 9 cardiovascular birth defects [incidence = 0.7%, 95% CI, 0.4-1.4]. In the unexposed group, the rate of cardiovascular defects was 0.7% (odds ratio=1.1, 95% CI, 0.36–2.78). Additionally, there were 34 cases of cardiovascular malformations based on information from 2,205 published cases on paroxetine exposures during pregnancy (incidence = 1.5%, 95% CI, 1.1-2.1). When the two data sets were combined, the mean rate of cardiovascular defects was 1.2 % (95% CI, 1.1-2.1).

A retrospective cohort study using administrative data from five large managed care organizations, evaluated 1,047 infants of mothers who used a selective serotonin reuptake inhibitor (SSRI) during early pregnancy (n=182 for paroxetine).⁽¹⁰⁾ Paroxetine exposure was not associated with an increased risk of septal defects (relative risk [RR] 0.50; 95% CI 0.07-3.54) or other congenital anomalies of the heart (RR 1.98; 95% CI 0.64-6.15). In subanalyses, an increased risk for congenital anomalies of the eye was found with paroxetine exposure (RR 2.36; 95% CI 1.2-4.66). A chart review of these cases revealed most of the eye conditions were either not confirmed or self resolving conditions common in infancy (dacryostenosis). Overall, the risk of preterm delivery was significantly increased among infants exposed to SSRIs compared to infants unexposed to SSRIs (RR 1.45; 95% CI 1.25-1.68). Fullterm infants with first-trimester exposure to any SSRI were not at increased risk of congenital anomalies.

An analysis of the case-control surveillance data from the Slone Epidemiology Center Birth Defects Study was conducted to evaluate whether exposure to SSRIs (fluoxetine, sertraline, paroxetine) and non-SSRIs during the first trimester increases the overall risk of major structural birth defects, the overall risk of cardiac defects or risk of specific cardiac defects.⁽¹¹⁾ Cases were defined as mothers of infants with any birth defect (n=9,849) and controls were defined as mothers of infants with no birth defects (n=5,860). Overall, use of SSRIs was not associated with significantly increased risks of craniosynostosis, omphalocele, or heart defects overall. When specific defects were analyzed, there was a statistically significant increase in the risk for right ventricular outflow tract obstruction (RVOTO) defects with paroxetine (OR 3.3; 95% CI 1.3-8.8). A significantly increased risk of neural-tube defects (OR 3.3; 95% CI 1.1-10.4) and clubfoot (OR 5.8; 95% CI 2.6-12.8) with paroxetine. The association between paroxetine and undescended testis had a lower confidence bound of 1 (OR 2.8; 95% CI 1.0-7.8). For "any SSRI", there was a significantly increased risk of clubfoot (OR 2.2; 95% CI 1.4-3.6).

Berard, et al. conducted two nested case-control analyses to evaluate the association between exposure to paroxetine in the first trimester of pregnancy and cardiac malformations as well as a potential dose-response relationship.⁽¹²⁾ Controls in both studies were defined as no major or minor malformations. Data from all pregnancies occurring in Quebec from January 1, 1997 to June 30, 2003 were retrieved from the population-based Medication and Pregnancy Registry. Of these, 1,403 women met the study inclusion criteria and had exposure to the following antidepressants in the first trimester of pregnancy: paroxetine (n=542; 39%), other SSRIs (n=443; 31%), and non-SSRI antidepressants (n=418; 30%). Major

congenital malformations were identified in 101 infants, 24 of whom had major cardiac malformations. The rate of major congenital malformations was 8%, 6% and 6% in the paroxetine, other SSRI and non-SSRI groups, respectively. The rate of major cardiac malformations was 2% in the paroxetine group and 1% in both the other SSRI and non-SSRI groups. Paroxetine (adjusted OR 1.32; 95% CI 0.79-2.2) and other SSRIs (adjusted OR 0.93; 95% CI 0.53-1.62) did not increase the risk of major congenital malformations compared to non-SSRI antidepressants. Neither paroxetine (adjusted OR 1.38; 95% CI 0.49-3.92) nor other SSRIs (adjusted OR 0.89; 95% CI 0.28-2.84) increased the risk of major cardiac malformations compared to non-SSRI antidepressants. However, classification of women by the dose of paroxetine received during the first trimester of pregnancy suggested a dose-response relationship for both major congenital malformations and major cardiac malformations. Infants born to women exposed to >25 mg/day of paroxetine on average during the first trimester had a significantly increased risk of both major congenital malformations (adjusted OR 2.23; 95% CI 1.19-4.17) and major cardiac malformations (adjusted OR 3.07; 95% CI 1.00-9.42).

Studies of delivery outcomes following maternal use of SSRI antidepressants in early pregnancy were conducted utilizing the Swedish national registry data.^{(13,14) (15) (16)} The latest study included analysis of infants (n=6,555) born to 6,481 women exposed to SSRIs in early pregnancy from July 1, 1995 to December 31, 2004.⁽¹⁴⁾ Among them, 943 women (959 infants) reported the use of paroxetine, 35 of whom used paroxetine in combination with another antidepressant. No increase in the overall rate of congenital malformations was observed in infants exposed to SSRIs (4.1%), compared with the general population (4.7%) (adjusted OR 0.89; 95% CI 0.79-1.07). Congenital malformations were observed in 46 infants exposed to paroxetine during early pregnancy (adjusted OR 1.03; 95% CI 0.76-1.38). There was an increased risk for cardiac defects in infants exposed to paroxetine (OR 1.63; 95% CI 1.05-2.53), including an increased risk of ventral septal defect (VSD) and atrial septal defect (ASD) (OR 1.81; 95% CI 0.96-3.09); 13 of 20 paroxetine-exposed infants with cardiac defects had a VSD or ASD. An increased risk of cardiac defects was not observed in infants whose mothers received an SSRI other than paroxetine. Two separate analyses were conducted to evaluate the relative risk (RR) of cardiac defects occurring with paroxetine therapy compared to other SSRIs. The first analysis excluded non-Swedish women, subfertile women and women with high body mass index (BMI >26). In infants born to paroxetine-treated women (n=405), the relative risk for any cardiac defect was 2.63 (95% CI 1.4-4.5) and for VSD/ASD was 3.07 (95% CI 1.32-6.04). Infants exposed to other SSRIs had an odds ratio of 0.64 (95% CI 0.41-1.01) for any cardiac defect and 0.56 (95% CI 0.29-1.08) for VSD/ASD. The second analysis additionally excluded women who had taken certain identified medications in combination with their SSRI (neuroleptics, sedatives, hypnotics, folic acid, nonsteroidal anti-inflammatory drugs [NSAIDs] and anticonvulsants). For infants born to paroxetine-treated women (n=340), the relative risk for any cardiac defect was 2.93 (95% CI 1.52-5.13) and for VSD/ASD was 3.23 (95% CI 1.30-6.65). Infants exposed to other SSRIs had an odds ratio of 0.61 (95% CI 0.37-1.01) for any cardiac defect and 0.38 (95% CI 0.16-0.87) for VSD/ASD.

Malm, et al. conducted a population based study of 1,782 women exposed to SSRIs during pregnancy from three governmental organization databases in Finland and reported major malformations were not more common in infants or fetuses of women with first trimester SSRI purchases (n=1,398) when compared with matched controls with no drug purchases (n=1,398) ($P=0.4$).⁽¹⁷⁾ For first trimester purchases of paroxetine (n=152), the crude odds ratio compared to women with no drug purchases (n=1,782) was 1.0 (95% CI 0.4-2.8). After adjustment for maternal age, smoking, low social status, nulliparity, and purchases of other reimbursed drugs than SSRIs during the corresponding period, the adjusted odds ratio was 0.4 (95% CI 0.1-3.3). In addition, a higher rate of neonatal treatment in special or intensive care unit was observed after third trimester exposure to SSRIs; however, these results were not reported by individual SSRI exposure.

Wu Wen, et al. conducted a retrospective cohort study in 972 pregnant women from the Saskatchewan Health databases who had been given at least one SSRI prescription in the year before delivery and compared fetal outcomes to the infants of matched, nonexposed women from the same database.⁽¹⁸⁾ The risks of low birth weight (OR 1.58; 95% CI 1.19-2.11), preterm birth (OR 1.57; 95% CI 1.28-1.92), fetal death (OR 2.23; 95% CI 1.01-4.93), and seizures (OR 3.87; 95% CI 1.00-14.99) were increased in infants

born to mothers with SSRI therapy; however, there were no increased risks of birth defects or maternal complications observed.

Diav-Citrin, et al. reported pregnancy outcomes in pregnant women exposed to paroxetine (n=463; 410 in the first trimester) or fluoxetine (n=346; 314 in the first trimester) who contacted teratogen information services in Israel, Italy, or Germany. ⁽¹⁹⁾ After exclusion of genetic and cytogenetic anomalies, there was a higher overall rate of major congenital malformations in infants exposed to paroxetine in the first trimester [18/348 (5.2%)] compared to infants in a control group with drug exposures not known to be teratogenic [34/1359 (2.5%)] [$P < 0.05$]. A higher rate of cardiovascular anomalies was also observed in the paroxetine group [7/348 (2.0%)] compared to the control group [8/1359 (0.6%)] [$P < 0.05$; adjusted odds ratio (OR) 2.66, 95% CI 0.80–8.90]. Similar trends were reported in the fluoxetine group and were statistically significantly higher than the control group. Logistic regression was conducted to evaluate the relative contribution of variables to the risk of cardiovascular anomalies. Only cigarette smoking ≥ 10 cigarettes a day and fluoxetine exposure were significant variables.

Wichman, et al conducted a retrospective cohort study at the Mayo Clinic 1993 to 2005 to determine the incidence of congenital cardiac abnormalities associated with SSRI use during pregnancy.⁽²⁰⁾ Of 25,214 total deliveries, 808 mothers (3.2%) had been prescribed SSRIs, including paroxetine (n = 134), at some point during their pregnancy. Results were categorized according to timing of first SSRI exposure (conception, discontinuation because of a positive pregnancy test result, first trimester, second trimester, and third trimester). The majority of paroxetine exposure was at conception (76.5%) or discontinued due to positive pregnancy test (10.9%). The median dose of paroxetine during all trimesters was 20 mg/d (n = 15). Cardiac abnormalities assessed consisted of CHD (congenital heart disease), VSD (ventricular septal defect), and PPHN (persistent pulmonary hypertension of the newborn). Of all deliveries, 208 newborns (0.8%) were diagnosed with CHD; prevalence of CHD in neonates born to SSRI-exposed mothers was similar to the unexposed group (0.4% vs 0.8%, $P = 0.23$). The incidences of events by SSRI were not provided. No newborns with known exposure to SSRIs were diagnosed with PPHN or VSD.

Kulin, et al. reported retrospectively collected pregnancy outcomes in 267 mothers exposed to an SSRI during the first trimester of pregnancy (n=97 exposed to paroxetine) and compared these outcomes to those of a prospectively identified group of women who were not exposed to any known teratogens during pregnancy. ⁽²¹⁾ A statistical analysis of the outcomes showed no statistical differences between the study group outcomes and the control group outcomes. Though specific data were not provided, the investigators indicated that pregnancy outcome among women who took an SSRI throughout pregnancy (n=49; number specifically receiving Paxil Tablets not provided) did not differ from those who took the drug only during the first trimester.

Maschi, et al. prospectively followed pregnant women (n=200, mean age 31 years) who received SSRI antidepressants to determine the incidence of early adverse effects in newborns associated with antidepressant exposure during pregnancy.⁽²²⁾ A control group (n=1,200) not exposed to teratogenic medications known to cause neonatal side effects was also followed during the same time. *Paxil Tablets* was the most used antidepressant (n=58) with the median dose of 20 mg daily. No significant adverse event differences were found between neonates exposed to antidepressants in *utero* and the control group. Adverse effects associated with *Paxil Tablets* included respiratory distress (n=2), jaundice (n=1), and heart defect (n=1). Differences were found in prematurity rate in exposed newborns compared with nonexposed newborns (OR=2.31; 95% CI 1.14-4.63) and in the rate of caesarean deliveries (OR=1.92; 95% CI 1.40-2.63).

Simon, et al. compared the effects of prenatal exposure (identified by mothers having antidepressant prescription filled or refilled during the 270 days prior to delivery) to a tricyclic antidepressant (TCA; n=209) or SSRIs (*Paxil Tablets*, n=28) on gestational age, head circumference, birth weight, Apgar scores, major malformations, minor malformations, motor delay, and speech delay with an equal number of matched infants not exposed to antidepressants. ⁽²³⁾ Significantly more women in the exposed group (n=8) self-reported cocaine use compared to the unexposed group (n=0). No significant differences were observed between exposed and unexposed infants in the rates of major malformations, minor

malformations, developmental delay, head circumference or other neurological disorder in either the TCA or SSRI groups. There were statistically significant differences in gestational age, birth weight, and Apgar scores at 5 minutes between infants exposed to SSRIs and those not exposed. Since differences in birth weights or Apgar scores may be due to differences in rates of prematurity, secondary analyses were done to adjust for gestational age. After this adjustment, infants exposed to SSRIs did not differ significantly in mean birth weight. Analyses of perinatal outcomes according to specific SSRI agent yielded similar results for *Paxil Tablets*, fluoxetine, and sertraline. Exposure to SSRIs during the third trimester was associated with statistically significantly lower Apgar scores. The long-term clinical impact of this difference is not known.

Hendrick, et al. prospectively followed women who received SSRI antidepressants to determine the incidence of congenital anomalies and neonatal complications after prenatal exposure. (24) Birth outcomes were obtained from a review of obstetric and neonatal records of 138 women who were treated with fluoxetine (n=73), sertraline (n=36), paroxetine (n=19), citalopram (n=7) or fluvoxamine (n=3). Eighty-five of these women received antidepressants during the entire pregnancy and 131 women were receiving the medication at delivery. The incidence of congenital anomalies in this study was 1.4% which is comparable to general population. Four cases (2.9%) of low birth weight were reported; all involved infants who had been exposed to fluoxetine therapy (40 to 80 mg daily) throughout pregnancy. Nine cases (6.5%) of preterm births were reported; five fluoxetine exposures (6.8%), two paroxetine exposures (including one birth of twins, 10.5%), and two sertraline exposures (5.5%).

Hostetter, et al. assessed the medication dosage requirements of SSRIs in pregnant women with a primary diagnosis of major depressive disorder in a naturalistic study. (25) These women were followed prospectively through pregnancy at monthly intervals with symptom assessment. Thirty-four women treated with SSRI monotherapy were included in the final analysis. Of these, 19 women entered the study during their first trimester and 15 entered during their second trimester. These patients received *Paxil Tablets* (n=12), sertraline (n=13) or fluoxetine (n=9). Twenty-two of the 34 women (65%) required an increase in dose to maintain euthymia during pregnancy; there was no difference among the 3 SSRIs with respect to dosage adjustment. While the primary purpose of this study was to assess dosage change requirements in these patients, obstetrical outcomes were reported overall. Thirty-one women had normal deliveries of healthy infants. Two women experienced pre-term delivery and 1 woman suffered a placental abruption at week 37 with fetal demise. Overall, no significant differences in neonatal outcome were found between the medications.

Alwan, et al. evaluated data from the National Birth Defects Prevention Study, an ongoing case study of risk factors for birth defects, on infants delivered from 1997 to 2002 with or without selected major birth defects. (26) A total of 9,622 infants with selected major birth defects (either isolated or multiple) and 4,092 normal controls were identified. Adjusted analyses showed that women who took an SSRI in the period between 1 month before and 3 months after conception were more likely than those who were not exposed to have an infant with anencephaly (OR 2.4; 95% CI 1.1-5.1), craniosynostosis (OR 2.5; 95% CI 1.5-4), or omphalocele (OR 2.8, 95% CI; 1.3-5.7). When pooling the occurrence of these three defects together, the use of paroxetine (OR 4.2; 95% CI 2.1-8.5) was reported to be associated with the strongest effect. For isolated defects, paroxetine was significantly associated with anencephaly (OR 5.1; 95% CI 1.7-15.3), right ventricular outflow tract obstruction (OR 2.5; 95% CI 1.0-6.0, omphalocele (OR 8.1; 95% CI 3.1-20.8), and gastroschisis (OR 2.9; 95% CI 1.0-8.4).

An observational cohort study in the United Kingdom (UK), conducted by Prescription Event Monitoring (PEM), investigated the frequency of events that were noted by practitioners following the prescribing of paroxetine. (27) (28,29) PEM questionnaires, generated from prescriptions written by general practitioners during the first year that paroxetine was marketed, requested that the practitioner report all significant events recorded in the treated patients' records without regard of the event's relationship to the use of paroxetine. Between March 1991 and March 1992, data collected on 13,741 patients treated with paroxetine were analyzed. Of the sample, there were 9,279 women (67.5%) with a mean age of 48.8 years. There were 138 pregnancies reported during this time period. Exposure to paroxetine during the first trimester was likely for 63 of the pregnancies. The pregnancy outcomes are summarized in Table 1. There

were no congenital abnormalities in the live births. One baby of a set of twins was stillborn, 1 intrauterine death was reported at 18 weeks gestation in a mother diagnosed with idiopathic thrombocytopenic purpura and 1 baby was reported to have a ‘jittery episode’. Note that the pregnancies may have involved exposure to other agents and may have included women with various medical conditions.

Table 1. Pregnancy Outcomes in Women Exposed to Paroxetine during the First Trimester (27) (28,29)

Pregnancies	Live Birth	Ectopic	Spontaneous Abortion	Elective Termination	Still Birth	IUD	Not known
63*	42	0	8	11	1**	1	3
IUD = Intra-uterine death.							
*Drawn from 63 pregnancies which included three sets of twins.							
**One baby of a set of twins.							

GSK conducted a review of over 1,100 reports of patients who were treated with paroxetine during pregnancy, most of whom received paroxetine during the first trimester.⁽³⁰⁾ At the time of review, an outcome was available for over 650 of these pregnancies, and in most of these cases the mother had been exposed to paroxetine during the first trimester. These pregnancies with a known outcome included those that had been notified to GSK prospectively (for example, the initial notification of exposure to paroxetine in pregnancy was received before the final outcome of pregnancy was known to the reporter) and those received retrospectively (for example, the outcome was already known at the time of reporting). Many of the reports received stated a normal outcome, however, abnormal pregnancy outcomes, including congenital abnormalities, miscarriages, intra-uterine death, stillbirth, elective and medical terminations and ectopic pregnancy have been reported. Overall, the pattern of congenital abnormalities was similar to that reported in the general population and there was no unexpected clustering of abnormalities among the reports which might be suggestive of a teratogenic effect. Observations since the review have been consistent with the findings. Please note that these reports primarily consist of spontaneous reports and do not reflect a systematic collection of pregnancy outcomes. In addition, concomitant disease or drug therapy may confound outcome data collected.

NONTERATOGENIC EFFECTS

Perinatal outcomes associated with antidepressant exposure during pregnancy are described in the literature.^{(22) (31,32,33) (34,35,36) (37)}

Dubnov-Raz et al analyzed data collected on all neonates born to mothers receiving SSRIs or venlafaxine during pregnancy in Israel between 2000 and 2005 to determine the effect of antenatal SSRI exposure on the QT interval in newborns.⁽³⁸⁾ Prolonged QTc interval was defined as > 460 milliseconds. Fifty-two neonates born to mothers receiving a SSRI (paroxetine, n = 25) at onset of labor (with no other concomitant chronic medications) were compared with 52 newborns of healthy mothers taking no medications before delivery, matched according to gestational age. The mean QTc interval was significantly longer in neonates exposed to SSRIs compared with control (unexposed) neonates (409 vs 392 ms [milliseconds]; $P = 0.02$). The mean uncorrected QT interval was 7.5% longer (280 vs 261 ms, $P < 0.001$) and the mean JT interval was 10% longer (229 vs 209 ms; $P < 0.001$) in exposed newborns. Mean QTc intervals were similar among the most commonly used SSRIs, suggesting a class effect on QT interval. Five SSRI-exposed neonates (10%) had a markedly prolonged QTc interval (> 460 milliseconds) compared to no unexposed infants ($P = 0.057$); 3 of these infants had been exposed to paroxetine and the remaining 2 to fluoxetine. All 5 infants had normal QTc intervals upon follow-up ECG (within 48 hours for 3 infants and at 1 year for 2 infants).

Infants exposed to SSRIs in late pregnancy may have an increased risk for persistent pulmonary hypertension of the newborn (PPHN).⁽³⁹⁾ Chambers, et al. enrolled 377 infants born with PPHN and 836 healthy infants in a retrospective case-control evaluation to evaluate whether PPHN is associated with exposure to SSRIs during late pregnancy. Of these infants, 14 with PPHN and 6 healthy controls were exposed to an SSRI after the 20th week of pregnancy (adjusted OR 6.1; 95% CI 2.2- 16.8). The risk for developing PPHN was approximately six-fold higher for infants exposed to SSRIs after the 20th week

of gestation compared to infants who had not been exposed to antidepressants during pregnancy. The number of patients in each group was too small to examine the effects of dose size, specific SSRI used, or reduction of the length of exposure before delivery.

Kallen conducted an epidemiological study utilizing the Swedish Medical Birth Registry to examine neonatal outcome after maternal use of antidepressants in late pregnancy. ⁽³⁷⁾ Infants born between July 1995 and December 2001 were selected for study and those whose mothers had been prescribed an antidepressant after the first antenatal care visit were identified. A total of 997 infants whose mothers received antidepressant therapy after the first antenatal visit were included in the study. Among the 987 mothers, 395 had used tricyclic drugs, 558 had used SSRIs (paroxetine, n = 106, and 63 had used other antidepressants. There were 31 women who had used 2 antidepressants during late pregnancy, of whom 19 had used a tricyclic and an SSRI and 8 had used an SSRI and an antidepressant other than a tricyclic or another SSRI. The pregnancy weeks when the drug was used were not stated in 387 cases, in 70 cases the drug was stopped before week 24, and in 561 cases, the drug was started or continued past week 23. Gestational duration, birth weight and fetal growth were examined in singleton births. The OR for preterm delivery (<37 weeks) for infants exposed to any antidepressant was 1.96 (95% CI 1.60-2.41), and there was no significant difference between the ORs when the mother had used a tricyclic drug [2.50 (95% CI 1.87-3.34)] and when she had used an SSRI [2.06 (95% CI 1.58-2.69)]. For women using any antidepressant after pregnancy week 23, the OR for preterm delivery was 2.02 (95% CI 1.54-2.63). The OR for low birth weight (<2,500g) was also around 2, and similar between the tricyclic and SSRI groups. There was no increase in the risk of small for gestational age (SGA), but a higher rate of large for gestational age (LGA) in the antidepressant exposed infants that did not reach statistical significance [OR 1.20 (95% CI 0.93-1.56)]. With respect to infant diagnoses, there was a statistically significant increase in the OR for respiratory distress [2.21 (95% CI 1.71-2.86)] among those exposed to antidepressants. This was slightly higher after the use of tricyclics [2.20 (95% CI 1.44-3.35)] than after use of SSRIs [1.97 (1.38-2.83)], but the authors noted that the difference may be random. There was no significant effect on the rate of neonatal jaundice, which was non-significantly increased after the use of tricyclics but not after the use of SSRIs. For neonatal hypoglycemia, a significantly increased OR was seen, which was stronger after the use of tricyclic antidepressants than after the use of SSRIs. The OR for low Apgar score (in singletons) was increased after the use of antidepressants drugs, with a similar magnitude for tricyclic drugs [2.99 (95% CI 1.58-5.65)] and SSRIs [2.28 (95% CI 1.27-4.1)]. Neonatal convulsions were registered more often with than without antidepressants, and the risk ratio was higher after the use of tricyclic antidepressants [OR 6.8 (95% CI 2.2-16)] than after the use of SSRIs [OR 3.6 (95% CI 1-9.3)]. The frequency of a diagnosis of cerebral excitation was also higher with than without antidepressants, but the difference did not reach statistical significance [OR 1.22 (95% CI 0.91-1.65)].

In view of the previous findings on paroxetine the author specifically compared neonatal outcome following paroxetine exposure with that for other SSRIs (as a group). ⁽³⁷⁾ Only crude comparisons were made (without adjustment for year of birth, maternal age, etc.), because numbers were low and comparisons were made within SSRIs, where it was noted that confounding factors should be roughly equal. Paroxetine exposure gave higher ORs than exposure to other SSRIs for some conditions [preterm delivery (OR 1.28), low birth weight (OR 1.44), LGA (OR 1.77), respiratory distress (OR 1.23) and convulsions (OR 1.4)], but none reached statistical significance. Paroxetine was associated with lower ORs than other SSRIs for SGA, jaundice and hypoglycemia. On the basis of these data, the author concluded that outcomes after exposure to paroxetine were not worse than after exposure to other SSRIs.

Sanz, et al. conducted a review of spontaneously reported cases of suspected SSRI-induced neonatal withdrawal syndrome reported to the World Health Organization Collaborating Centre for International Drug Monitoring before the second quarter of 2003. ⁽⁴⁰⁾ Of the 93 suspected cases identified, 64 were associated with paroxetine. Based on a logarithmic analysis to measure for an association of particular drugs and adverse drug reports, paroxetine, sertraline (n=9), citalopram (n=7), and fluoxetine (n=14) were all demonstrated to have a statistically significant association between the drug and neonatal convulsions or neonatal withdrawal syndrome.

Levinson-Castiel, et al. found a 30% (18/60) rate of neonatal abstinence syndrome (NAS) [45% severe and 55% mild] in a large population-based study that included infants with a reported prolonged in-utero exposure to SSRIs.⁽⁴¹⁾ Of these neonates 62% (37/60) were exposed to paroxetine at a dose range of 10-40 mg.

PRESCRIBING INFORMATION

In December 2005, the pregnancy precaution for *Paxil CR* and *Paxil* was revised to a Pregnancy Category D.⁽¹⁾ These revisions are based on updated data from two epidemiological studies showing that infants born to women who had first trimester paroxetine exposure had an increased risk of cardiovascular malformations, primarily ventricular septal defects (VSDs) and atrial septal defects (ASDs) (see Epidemiological Data section of this letter for further details).

Some information contained in this response may be outside the approved Prescribing Information. This response is not intended to offer recommendations for administering in a manner inconsistent with its approved labeling. This product is designated Pregnancy Category D. If you become aware of patients who have received this product at any time during their pregnancy, we encourage healthcare professionals to report such information to the company.

In order for GlaxoSmithKline to monitor the safety of our products, we encourage healthcare professionals to report adverse events or suspected overdoses to the company at 888-825-5249. Please consult the attached Prescribing Information.

This response was developed according to the principles of evidence-based medicine and, therefore, references may not be all-inclusive.

REFERENCE(S)

1. GlaxoSmithKline Local Label. *
2. Honein MA, Paulozzi LJ, Cragan JD, et al. Evaluation of selected characteristics of pregnancy drug registries. *Teratology* 1999;60:356-364.*
3. Cohen LS, Altshuler LL, Harlow BL, et al. Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. *JAMA* 2006;295:499-507.*
4. Data on File. Study WEUSRTP2280. *
5. O'Brien L, Einarson TR, Sarkar M, Einarson A, Koren G. Does paroxetine cause cardiac malformations?. *JOGC* 2008;30(8):696-701.*
6. Bar-Oz B, Einarson T, Einarson A, et al. Paroxetine and congenital malformations: meta-analysis and consideration of potential confounding factors. *Clin Ther* 2007;29:918-926.*
7. Data on File. Study EPIP083, December 2005. *
8. Cole JA, Ephross SA, Cosmatos IS, et al. Paroxetine in the first trimester of pregnancy and the prevalence of congenital malformations. *Pharmacoepidemiol Drug Saf* 2007;16(10):1075-1085. EPI40404.*
9. Einarson A, Pistelli A, DeSantis M, et al. Evaluation of the risk of congenital cardiovascular defects associated with the use of paroxetine during pregnancy. *Am J Psychiatry* 2008;165:749-752.*
10. Davis RL, Rubanowice D, McPhillips H, et al. Risks of congenital malformations and perinatal events among infants exposed to antidepressant medications during pregnancy. *Pharmacoepidemiol Drug Saf* 2007;16(10):1086-1094.*
11. Louik C, Lin AE, Werler MM, et al. First-trimester use of selective serotonin-reuptake inhibitors and the risk of birth defects. *NEJM* 2007;356(26):2675-2683.*
12. Berard A, Ramos E, Rey E, et al. First trimester exposure to paroxetine and risk of cardiac malformations in infants: the importance of dosage. *Birth Defects Research (Part B)* 2007;80:18-27.*

13. Kallen B. Letter to the editor: Antidepressant drugs during pregnancy and infant congenital heart defects. *Reproductive Toxicology* 2006;21:221-222.*
14. Kallen BAJ, Olausson PO. Maternal use of selective serotonin re-uptake inhibitors in early pregnancy and infant congenital malformations. *Birth Defects Research (Part A)* 2007;79:301-308.*
15. Ericson A, Kallen B, Wilholm BE. Delivery outcome after the use of antidepressants in early pregnancy. *Eur J Clin Pharmacol* 1999;55:503-508.*
16. Hallberg P, Sjoblom V. The use of selective serotonin reuptake inhibitors during pregnancy and breast-feeding: a review and clinical aspects. *J Clin Psychopharmacol* 2005;25:59-73.*
17. Malm H, Klaukka, T, and Neuvonen PJ. Risks associated with selective serotonin reuptake inhibitors in pregnancy. *Obstet Gynecol* 2005;106:1289-1296.*
18. Wu Wen S, Yan Q, Garner P, et al. Selective serotonin reuptake inhibitors and adverse pregnancy outcomes. *Am J Obstet Gynecol* 2006;194:961-966.*
19. Diav-Citrin O, Shechtman S, Weinbaum D, et al. Paroxetine and fluoxetine in pregnancy: a prospective, multicentre, controlled, observational study. *Br J Clin Pharmacol* 2008;66(5):695–705.*
20. Wichman CL, Moore KM, Lang TR, et al. Congenital heart disease associated with selective serotonin reuptake inhibitor use during pregnancy. *Mayo Clin Proc* 2009;84(1):23–27.*
21. Kulin NA, Pastuszak A, Sage S, et al. Pregnancy outcome following maternal use of the new selective serotonin reuptake inhibitors - A prospective controlled multicenter study. *JAMA* 1998;279:609-610.*
22. Maschi S, Clavenna A, Campi R, et al. Neonatal outcome following pregnancy exposure to antidepressants: a prospective controlled cohort study. *BJOG* 2008;115:283-289.*
23. Simon GE, Cunningham ML, Davis RL. Outcomes of prenatal antidepressant exposure. *Am J Psychiatry* 2002;159:2055-2061.*
24. Hendrick V, Smith LM, Suri R, et al. Birth outcomes after prenatal exposure to antidepressant medication. *Am J Obstet Gynecol* 2003;188:812-815.*
25. Hostetter A, Stowe ZN, Strader JR, et al. Dose of selective serotonin uptake inhibitors across pregnancy: Clinical implications. *Depress Anxiety* 2000;11:51-57.*
26. Alwan S, Reefhuis J, Rasmussen SA, et al. Use of selective serotonin-reuptake inhibitors in pregnancy and the risk of birth defects. *NEJM* 2007;356(26):2684-2692.*
27. Inman W, Kubota K, Pearce G, et al. Prescription-event monitoring (PEM) report number 6. Paroxetine. *Pharmacoepidemiol Drug Saf* 1993;2:393-422.*
28. Mackay FJ, Dunn NR, Wilton LV, et al. A comparison of fluvoxamine, fluoxetine, sertraline and paroxetine examined by observational cohort studies. *Pharmacoepidemiol Drug Saf* 1997;6:235-246.*
29. Wilton LV, Pearce GL, Martin RM, et al. The outcomes of pregnancy in women exposed to newly marketed drugs in general practice in England. *Br J Obstet Gynaecol* 1998;105:882-889.*
30. Data on File. RM2006/00744/00, 2000. *
31. Costei AE, Kozer E, Ho T, et al. Perinatal outcome following third trimester exposure to paroxetine. *Arch Pediatr Adolesc Med* 2002;153:1129-1132.*
32. Costei AE, Ho T, Kozer E, et al. Perinatal outcome following third trimester exposure to paroxetine. In: American Pediatric Society for Pediatric Research Annual Meeting. Baltimore, MD, May 4-7, 2002. Abstract No. 387 *
33. Pearson KH, Nonacs RM, Viguera AC, et al. Birth outcomes following prenatal exposure to antidepressants. *J Clin Psychiatry* 2007;68(8):1284-1289.*
34. Zeskind PS, Stephens LE. Maternal selective serotonin reuptake inhibitor use during pregnancy and newborn neurobehavior. *Pediatrics* 2004;113:368-375.*
35. Oberlander TF, Grunau RE, Fitzgerald C. Pain reactivity in 2 month old infants after prenatal and postnatal selective serotonin reuptake inhibitor medication exposure. *Pediatrics* 2006;115:411-425.*
36. Oberlander TF, Warburton W, Misri S, et al. Neonatal outcomes after prenatal exposure to selective serotonin reuptake inhibitor antidepressants and maternal depression using population-based linked health data. *Arch Gen Psychiatry* 2006;63:898-906.*

37. Kallen B. Neonate characteristics after maternal use of antidepressants in late pregnancy. *Arch Pediatr Adolesc Med* 2004;158:312-316.*
38. Dubnov-Raz G, Juurlink DN, Fogelman R, et al. Antenatal use of selective serotonin-reuptake inhibitors and QT interval prolongation in newborns. *Pediatrics* 2008;122Le710–e715.*
39. Chambers CD, Hernandez-Diaz S, Van Marter LJ, et al. Selective serotonin-reuptake inhibitors and risk of persistent pulmonary hypertension of the newborn. *N Engl J Med* 2006;354:579-587.*
40. Sanz EJ, De-las-Cuevas C, Kiuri A, et al. Selective serotonin reuptake inhibitors in pregnant women and neonatal withdrawal syndrome: a database analysis. *Lancet* 2005;365:482-487.*
41. Levinson-Castiel R, Merlob P, Linder N, et al. Neonatal abstinence syndrome after in utero exposure to selective serotonin reuptake inhibitors in term infants. *Arch Pediatr Adolesc Med* 2006;160:173-176.*