PostScript

LETTERS

Neonatal effects of exposure to selective serotonin reuptake inhibitors during pregnancy

Selective serotonin reuptake inhibitors (SSRIs) are often prescribed during pregnancy.

It has long been debated whether adverse neonatal effects described after maternal SSRI use¹⁻⁴ are caused by serotonin toxicity or withdrawal.⁵ Recently, the information of a database analysis of 93 suspected cases of SSRI induced neonatal withdrawal has been regarded as enough information to confirm a possible causal relation.⁶

We describe six infants with neonatal symptoms after maternal SSRI use. Table 1 summarises data from these infants. Mothers in cases 1 and 4 used multiple drugs during pregnancy. Because neonatal withdrawal to clorazepate has been described as neurological depression, this agent may have played an additional role in the initial symptoms in case 1. Neither oxcarbazepine nor thyroxine are known to cause neonatal abstinence. Gastro-oesophageal reflux, observed in case 1, may contribute to feeding problems, but the infant's symptoms decreased before the start of anti-reflux medication, suggesting multi-causality.

Feeding problems in cases 3 and 4 may be related to prematurity, as may hypothermia in case 4, but not myoclonic activity observed

in both infants. Association with maternal SSRI use must therefore be considered.

Discrimination between serotonin withdrawal and toxicity is hampered by the clinical similarity of its symptoms. As shown in table 1, three neonates developed symptoms within the 1st day of life, whereas the others did so on days 3, 5, and 7 respectively. The late development of symptoms in half of the cases, together with the low serum SSRI concentrations measured, are consistent with withdrawal, not toxicity.

The neonates who presented later than day 3 of life were admitted from their domestic situation. Withdrawal symptoms may have been recognised earlier in a clinical setting. Most neonates presented in the first 3 days of life. The most common symptoms were restlessness, feeding problems, irritability, and hypothermia. We suggest a three day clinical observation period for neonates born to mothers who used SSRI during the last trimester of pregnancy.

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Congenital chylothorax: what is the best strategy?

Chemical pleurodesis with povidone-iodine has recently been proposed in persistent congenital chylothorax as an alternative method to surgery.¹ We report the case of a neonate treated by povidone-iodine pleurodesis who developed shock and chronic renal failure.

A bilateral chylothorax with fetal hydrops was diagnosed in a foetus at 34 weeks. Bilateral pleuroamniotic tubes were inserted and maintained until birth at 35 weeks

Table 1 Patient data, signs and symptoms, time course of symptoms in the six patients, and serum SSRI concentrations measured (patients 1, 4, and 6)

Case	Maternal medication	Sex	GA	Signs and symptoms	Comorbidity	Start of symptoms (day)	Maximal symptoms (day)	Duration of symptoms (days)	Serum SSRI level
1	Paroxetine (40 mg/day), oxcarbazepine (2100 mg/day), clorazepate (15 mg/day)	M	Term	Hypotonia (first hours of life), increased tone, irritability, jitteriness, feeding problems	Gastro-oesophageal reflux	1	3	17	Paroxetine 20 µg/l (day 2) (n = 20-200)
2	Paroxetine (20 mg/day)	F	33 ⁺⁶	Jitteriness, myoclonic activity, EEG abnormalities		1	3	13 (phen)	
3	Paroxetine (20 mg/day)	M	35 ⁺⁶	Jitteriness, myoclonic activity, feeding problems		1	11	22	
4	Paroxetine (20 mg/day)	F	36 ⁺³	Myoclonic activity, hypothermia, feeding problems, EEG abnormalities		7	7	4	Paroxetine 0 µg/l (day 7) (n = 20-200)
5	Fluoxetine (40 mg/day)	M	37 ⁺¹	Hypertonia, restlessness, jitteriness		5	5	3	
6	Sertraline (50 mg/day)	F	32 ⁺⁶	Myoclonic activity, smacking of lips, irritability, jitteriness, opisthotonus propensity, EEG abnormalities		3	3	14 (phen)	Sertraline 0 µg/l (day 3) (n = 50-250)

Patients 2 and 6 needed phenobarbitone for successful relief of symptoms.

EEG, electroencephalogram; GA, gestational age; SSRI, selective serotonin reuptake inhibitor; phen, phenobarbitone.