LETTERS TO THE EDITOR

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Withdrawal reactions of a premature neonate after maternal use of paroxetine

EDITOR,—Paroxetine is an antidepressant of the selective serotonin reuptake inhibitor (SSRI) group. Its use during pregnancy can lead to premature birth and neonatal withdrawal symptoms.

A girl was born after 35+2 weeks gestation (birth weight 2690 g) and admitted because of prematurity. The pregnancy and delivery had been uneventful (Apgar score 9/10/10), with no apparent reason for prematurity. There were no problems in the first few days and she drank quickly (bottle feeding).

Thereafter she became irritable, lethargic, and needed tube feeding. She was hypertonic, apathetic, and jittery. The Finnegan score, a behaviour score for neonatal withdrawal reactions, was from day 1 to 10: 0, 0, 2, 2, 9, 9, 6, 6, 7, 7. There were no signs of infection; opiate and metabolic screening were negative. Cerebral ultrasound and an electroencephalogram were normal. The maternal use of paroxetine seemed to be the explanation. The baby improved spontaneously and was discharged at 37+6 weeks gestation. The Finnegan score had returned to zero at day 13. Follow up until four and a half months showed normal (neurological) maturation.

The mother had used paroxetine (40 mg once a day) before and during pregnancy. Her serum paroxetine concentration was 126 µg/l (normal levels 10–150 µg/l) after delivery, when still using the same dose.

We believe that paroxetine (trade name Seroxat) caused the deterioration. Similar neonatal withdrawal reactions have been reported, although not in a premature neonate (SmithKline Beecham Farma; *Summary of international databank*: 1. Seroxat: discontinuation in neonates; 2. Seroxat: use in pregnancy. 1998).[1]

The prematurity may also be ascribed to paroxetine as there are reports of premature births after Seroxat use in pregnancy, with the earliest delivery at 25 weeks gestation (Smith-Kline Beecham Farma; *Summary of international databank*: 1. Seroxat: discontinuation in neonates; 2. Seroxat: use in pregnancy. 1998). To our knowledge, none of these case reports have been published.

Irritability and jitteriness have been described in full term neonates after the use of other SSRIs.[1 2] The recommendation for SSRIs and tricyclic antidepressants is that they should not be used during pregnancy unless the potential benefit outweighs the possible risk.[1 2] As paroxetine is the seventh most commonly prescribed drug in The Netherlands,[3] and there may be similar use in other countries, we stress the importance of this message.

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1 Dahl ML, Olhager E, Ahlner J. Paroxetine withdrawal syndrome in a neonate. *Br J Psychiatry* 1997;**171**:391–2.
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Guidelines for Group B streptococcus

EDITOR,—As highlighted in a recent edition of *Fetal and Neonatal*, there is increasing concern about the previously unreported high levels of neonatal group B Streptococcal (GBS) infections in the UK.[1 2] It is important that we have statistics for regional variations in GBS infection so that we can to produce evidence based guidelines. It is also important that we are clear about the data on which we base our recommendations.

In the commentary which followed our recent paper,[2] Nicoll and Heath[1] refer to the incidence at which a risk factor based versus a screening approach to the prevention of Group B Streptococcus would be cost effective, quoting from a commentary by Isaacs.[3] The original article by Mohle-Boetani *et al* from which these data were derived,[4] actually gives figures of > 0.65 and > 1.45/1000 live births at which a risk factor and screening based approach, respectively would be cost effective. This contrasts with those quoted by Isaacs, and Nicoll and Heath, of 0.6 and > 1.2/1000 live births.

More importantly, it should be noted that these figures are obtained from a study which used significantly different criteria for both the definitions of a risk factor and on the decision to treat. In the paper by Mohle-Boetani *et al* the risk factor approach for treatment involved treatment of both "teenagers or blacks who developed labour complications".[4] The latter included either a temperature of > 37.5°C or prolonged rupture of membranes (PROM) for > 12 hours or preterm labour < 37 weeks of gestation. This is obviously a quite different population from those defined in the CDC guidelines[5] where all mothers who go into preterm labour (< 37 weeks gestation) or who have PROM (> 18 hours) or have a temperature (>38°C) would be offered treatment under a risk factor based strategy. The screening group in the paper by Mohle-Boetani *et al* were screened at 26–28 weeks gestation not 34–35 weeks as in the CDC guidelines, the latter interval being considered to be when colonisation status is most predictive of colonisation at delivery. Also, treatment was only given if the mothers also developed intrapartum risk factors, (temperature >37.5° C or PROM >12 hours or preterm labour).

Mohle-Boetani *et al* conclude "The strategy we developed is not generally applicable because different populations might have different risk factors for delivery of infants with GBS disease". In the study population, 40% of births occurred in women who were teenagers or black.

It is important that before these figures become established in the current literature, we review the original data and the premises on which they were based. It is important to pay attention to crucial differences in the composition of different populations and the risk factors employed in different studies. As new guidelines are being developed we should not make recommendations based on incorrect information.

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4 Mohle-Boetani JC, Schuchat A, Plikaytis BD, *et al*. Comparison of prevention strategies for neonatal group B streptococcal infection. A population-based economic analysis. *JAMA* 1993; **270**:1442–8.
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Reply

EDITOR,—We thank Dr Beardsall for her letter and would like to emphasise her own conclusion that it is important we establish the true incidence of GBS in the UK, and that when making recommendations we should be clear about the data on which they are based. Beardsall is also right in correcting us,[1] and Isaacs,[2] on the data quoted from the Molhe-Boetani study.[3] However, she is wrong in assuming that any recommendations for the UK would be based on such data. As she points out, there are crucial differences between UK and US populations that mean extrapolation of these thresholds to the UK is likely to be flawed. Among these are ethnic, socioeconomic, obstetric, and neonatal practices, and, perhaps most importantly, drug and hospital costs. For these reasons a health economic analysis based on the national BPSU study and a London based case control study is critical to the development of guidelines for the UK and is currently underway.

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2 Isaacs D. Prevention of early onset group B streptococcal infection: screen, treat or observe? *Arch Dis Child Fetal Neonatal Ed* 1998;**79**:F81–2.
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Neonatal intensive care and parental participation in decision making

EDITOR,—The letter from Dellagrammaticas and Iacovidou[1] provides interesting information and further support to the conclusion of our study[2]: namely, that neonatal intensive care units (NICUs) from Southern European countries (Italy, Spain, and, according to Dellagrammaticas, also Greece) adopt more restrictive parental visiting policies than in Northern countries. We agree that exploring the role of parents in decision making is much more complex, and that data collected through a structured questionnaire completed by the unit coordinator represent "only" that unit's policy, "that is the intention and stance of each unit" towards the issue at hand. In fact, this was precisely the aim of our study: to describe and compare NICUs' policies in the various countries.

In a separate part of the EURONIC project we also interviewed individual staff members (both doctors and nurses), asking for their views and practises regarding parental involvement in decision making. Overall, results match quite closely with findings from the NICUs policy study. It would certainly be very interesting to obtain the parents' views on the issue; however, results from interviews with parents carried out by an NICU's staff during a baby's hospital stay should be interpreted with caution, given the understandable tendency of interviewed parents to comply with perceived wishes and ideas of the staff caring for their baby.

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