# Contraceptive Sponge to Make Summer Comeback

More than a decade after it was taken off the market because of manufacturing issues, the contraceptive sponge has been cleared by the Food and Drug Administration and is expected to be available this summer.

The Today Sponge, which is made of polyurethane foam and contains a 1-g reservoir of nonoxynol-9, will be available over the counter this summer, according to Allendale Pharmaceuticals Inc., the N.J.-based company that bought the rights to the product in 1998. It is the same device taken off the market in 1994, when safety issues were raised with the facilities where the sponge was manufactured.

One sponge, which provides a physical barrier between the cervix and sperm, continually releases 125-150 mg of nonoxynol-9 into the vagina and can be used for 24 hours, the company said in a statement. The polyurethane foam "traps and absorbs semen" before the sperm are able to enter the cervix. It must be left in place for at least 6 hours after the last act of intercourse, and it does not protect against sexually transmitted diseases, the company said.

In multicenter clinical trials of more than 1,800 women conducted in the United States and eight other countries before the device was pulled from the market, the sponge was 89% effective in preventing pregnancies during 1 year among 939 parous women studied and 91% effective among 915 nulliparous women studied, when used properly for every act of intercourse, according to the company. When used improperly and inconsistently, the effectiveness rate ranged from 84% to 87%, the company said.

Use of the Today Sponge is contraindicated in individuals who are allergic or sensitive to nonoxynol-9. Typical symptoms can include vaginal burning, itching, redness, rash, and irritation, the company said. In the U.S. portion of the clinical study, 4% of women discontinued use of the sponge due to allergic symptoms. Worldwide, this figure was 2.1%. If either the user or her partner is allergic to sulfa drugs, he or she should consult a physician before using the sponge.

The sponge is contraindicated for use during menstruation. Some cases of nonmenstrual toxic shock syndrome have been reported in women using barrier contraceptives, including Today Sponge, the diaphragm, and the cervical cap.

**—Elizabeth Mechcatie**

# *NuvaRing Contraceptive Had Low Expulsion Rates in Four Clinical Trials*

SAN FRANCISCO — In a year's experience with the NuvaRing contraceptive, only 2.3% of women experience an expulsion of the device, according to the pooled results of four large, phase III clinical trials, Marc Kaptein, M.D., and Edio Zampaglione, M.D., reported in a poster presentation at the annual meeting of the American College of Obstetricians and Gynecologists.

In a retrospective analysis of 3,333 women and 33,462 cycles, expulsion occurred in only 0.5% of cycles, according to the investigators, both of whom are from Organon International Inc., Roseland, N.J. Organon is the manufacturer of NuvaRing.

The proportion of cycles with expulsions decreased over time, an effect the investigators attributed to users' increasing experience with the NuvaRing.

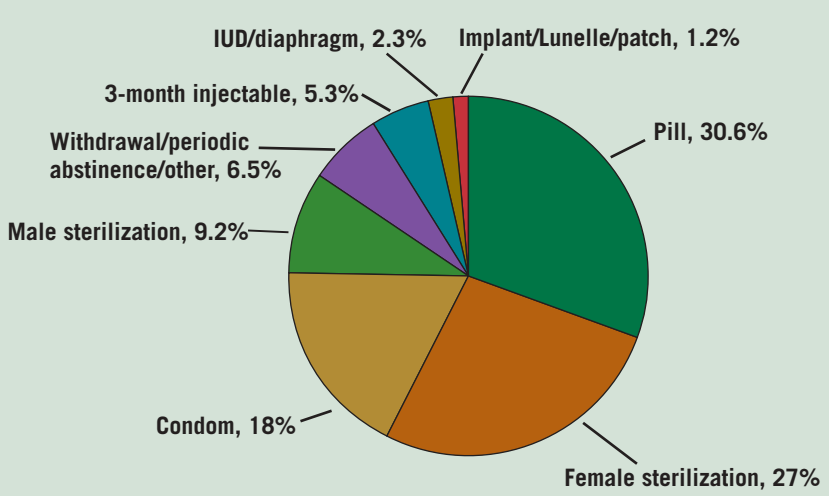
During the first three cycles, 1.7% of women experienced an expulsion.

The studies followed the women for 13 cycles. During the 11th, 12th, and 13th cycles only 0.2% of the women experienced expulsions.

**—Robert Finn**

## DATA WATCH

### Contraceptive Methods Used by Women Aged 15-44 Years




Note: Numbers may not equal 100% because of rounding.
Source: 2002 data, Centers for Disease Control and Prevention

KEVIN FOLEY, RESEARCH/ANGIE RIES, DESIGN

## DRUGS, PREGNANCY, AND LACTATION

# Neonatal Symptoms and SSRIs

Multiple articles over the past several years have cited perinatal symptoms in newborns whose mothers were taking an antidepressant late in pregnancy, including transient restlessness, jitteriness, tremulousness, and difficulty feeding.

There have now been enough reports to suggest that certain vulnerable children or subgroups of newborns exposed in utero may be at a slightly increased risk for this syndrome. Indeed, last year the Food and Drug Administration required the addition of related information to the labels of selective serotonin reuptake inhibitors (SSRIs) and serotonin norepinephrine reuptake inhibitors.

BY. LEE COHEN, MD

The results of a recent study of 93 cases worldwide (including 64 associated with paroxetine) from a World Health Organization adverse event reporting database do not represent new findings. The reports include descriptions of nervousness, agitation, abnormal crying, and tremors, which the authors consider a "signal" for perinatal or neonatal toxicity. The study also refers to 11 reports of neonatal convulsions and two grand mal seizures, with no further description of the cases (Lancet 2005;365:482-7).

Although the report of neonatal convulsions is relatively new, the study itself has several limitations. It is difficult to interpret these results because they are from a spontaneous adverse event reporting system, where typically adverse outcomes are overreported and do not provide adequate information on when the drug was used, the duration of illness, or whether the woman was depressed during pregnancy. And the absence of a controlled sample makes it difficult to estimate the incidence of this type of problem, which likely is very low, considering the wide use of these medications. Moreover, depression in the mother has been associated with many of the newborn symptoms reported.

The use of the term "withdrawal" syndrome is a dicey clinical call at best. Based on what we know about the kinetics and placental passage of these medications, what we're seeing is not acute withdrawal, like we see with heroin or methadone during pregnancy. The main metabolites of the drugs remain in the baby's circulation for at least days to weeks, so to see something so early and so transient, even for paroxetine (which has a shorter half-life than the other SSRIs), is not consistent with the pharmacokinetics of the compounds being described.

I don't disagree with these findings. Acknowledging the probable biases involved with collecting and reporting these cases, the report provides another data set that calls attention to the possibility of some type of perinatal syndrome associated with SSRI exposure later in pregnancy, which may not necessarily be a causal relationship. The authors suggest their findings are more of a "signal" that a problem may exist, rather than a definitive causal link. When considered with other case series in the literature, this study may indicate the potential risk for a perinatal syndrome.

What is of concern, however, is the impact this report may have on appropriate prescribing of these drugs to pregnant women, and the possibility that patients, as well as physicians, will uniformly and arbitrarily avoid these drugs during pregnancy.

The article falls profoundly short in terms of helping the clinician. While the results indicate that more vigilance is necessary during the peripartum period in cases of SSRI use, the data do not imply that any particular SSRI should be avoided in women of reproductive age. The authors conclude that the signal is stronger for paroxetine, which they say should either not be used during pregnancy or used at the lowest effective dose. I certainly would not rule out using paroxetine in women of reproductive age on the basis of this report, with the possible exception of a woman with immediate plans to become pregnant or a woman with recurrent disease.

A reduction in the appropriate use of these drugs in depressed pregnant women would be a serious problem because relapse of recurrent depression during pregnancy is exceedingly common, and depression during pregnancy is the strongest predictor of risk for postpartum depression. Reducing the dose or discontinuing the antidepressant around the time of labor and delivery increases the risk of relapse, although some women may tolerate this approach, particularly if the drug is reinstituted immediately post partum.

Physicians should remain vigilant and carefully plan their treatment approach in pregnant patients with depression. The data in this study may be a signal that a problem exists. But a signal should be some kind of beacon that guides the clinician. In this case, we have more fog obscuring any guidance for the clinician than we have clarification of an already complicated situation.

DR. COHEN *directs the perinatal psychiatry program at Massachusetts General Hospital, Boston, which offers information about pregnancy and mental health at www.womensmentalhealth.org. He is a consultant to manufacturers of several antidepressant drugs.*