Characterization of Transplacental Transfer of Paroxetine in Perfused Human Placenta: Development of a Pharmacokinetic Model to Evaluate Tapered Dosing

Marie Nagai, Hisakazu Ohtani, Hiroki Satoh, Sayo Matsuoka, Satoko Hori, Tomoyuki Fujii, Yuji Taketani, and Yasufumi Sawada

Department of Drug Informatics, Graduate School of Pharmaceutical Sciences, the University of Tokyo (M.N., H.S., S.H., Y.S.); Department of Clinical Pharmacy, Faculty of Pharmacy, Keio University (H.O.); Faculty of Pharmaceutical Sciences, University of Tokyo (S.M.); Interfaculty Initiative in Information Studies, the University of Tokyo (S.H.); Department of Obstetrics and Gynecology, Graduate School of Medicine, the University of Tokyo (T.F., Y.T.), Tokyo, Japan

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ABSTRACT

The aim of this study was to determine whether a tapered dosage regimen of paroxetine in pregnant women might be useful to avoid withdrawal syndromes in neonates after delivery. We characterized the transplacental transfer of paroxetine in perfused human placenta, fitting a pharmacokinetic model to the results and applying the model and parameters to evaluate a tapered dosage regimen. Paroxetine was perfused from the maternal or fetal side of an isolated human placental preparation with various perfusion protocols, and paroxetine concentrations in the effluent and placental tissue were determined. The transplacental pharmacokinetic parameters of paroxetine were estimated by simultaneous fitting of a five-compartment transplacental pharmacokinetic model to the set of paroxetine concentration profiles. The developed model and parameters were used to simulate the maternal and fetal concentrations of paroxetine, and the results were compared with reported data. Paroxetine showed a larger distribution volume in placental tissue and a smaller transplacental transfer as compared with antipyrine, a passive diffusion marker. A five-compartment model could well describe the transplacental transfer of paroxetine and could well simulate the maternal and umbilical venous concentrations of paroxetine at delivery. Transplacental transfer kinetic parameters of paroxetine were estimated by fitting a pharmacokinetic model to perfusion study data. The model and parameters appeared to be suitable for simulation of paroxetine kinetics in fetus. The model was also applicable to design a dosage regimen to avoid an abrupt decrease of paroxetine concentration in fetal plasma.

Introduction

Almost one-fifth of pregnant women are thought to have depression or anxiety disorder (O’Keane and Marsh, 2007). To treat psychiatric symptoms during pregnancy, selective serotonin reuptake inhibitors (SSRIs) have been widely used. However, questions have been raised concerning a possible association between the use of paroxetine during pregnancy and an increase in teratogenesis (Källén and Otterblad Olausson, 2006; Louik et al., 2007). Moreover, there are several reports of neonates delivered from mothers taking paroxetine that exhibit withdrawal syndrome or paroxetine intoxication, such as respiratory distress, cyanosis, apnea, hyperreflexia, tremor, shivering, irritability, drowsiness, and sleeping disorder (Dahl et al., 1997; Nordeng et al., 2001; Stiskal et al., 2001). From this point of view, paroxetine use in pregnant women should be avoided. However, some authors state that cessation of antidepressants during pregnancy may be physically and mentally unfavorable for the mother and may even have a negative influence on the neonate (Bonari et al., 2004; Cohen et al., 2006). Substitution of paroxetine with a safer antidepressant is not always feasible because the clinical response to antidepressants is quite specific among patients; consequently, some pregnant women necessarily continue to use paroxetine. The risk of discontinuation symptoms after cessation of a SSRI is considered to depend on the elimination rate of the drug; that is, a longer half-life results in a lower risk (Judge et al., 2002). Therefore, prediction of the concentration profile of paroxetine in fetal plasma after maternal intake of paroxetine, based on a quantitative evaluation of the transplacental transfer properties of paroxetine, may enable us to design an optimal dosage regimen to avoid fetal withdrawal syndrome after delivery.

Abbreviations: C_{0,f}, fetal concentration; C_{0,m}, maternal concentration; C_{f}, drug concentration in fetal effluent or drug concentration in fetal venous compartment; C_{m,f}, drug concentration into compartment; C_{m,m}, drug concentration in maternal effluent or drug concentration in interstitial compartment; C_{p,f}, plasma concentration in the fetus; C_{p,m}, plasma concentration; CYP, cytochrome P450; f_{a,m}, unbound fraction in fetal plasma; f_{u,m}, unbound fraction in maternal plasma; f_{u,p}, unbound fraction in perfusate; HPLC, high-performance liquid chromatography; K_{a}, first-order rate constant; K_{p}, tissue-to-perfusate concentration ratio; K_{f,p}, tissue-to-unbound perfusate concentration ratio; K_{f,u,T}, placental tissue-to-fetal effluent partition ratio; K_{u}, influx clearances into placental tissue; Q_{a}, transfer rate constants; MBI, mechanism-based inactivation; Q_{m}, fetal perfusion flow rate; Q_{h}, hepatic blood flow rate; Q_{o,m}, maternal perfusion flow rate; SSRI, selective serotonin reuptake inhibitor; TPTD, transplacental transfer value at the steady state; TPTD_{op}, TPTD value in the opposite direction; V_{f,m}, fetal distribution volume; V_{f}, fetal vascular volume in placental tissue; V_{m,m}, maternal interstitial volume in placental tissue; V_{p,f}, distribution volume of the placental compartment; X_{f,m}, drug amount in placental compartment; X_{m,m}, drug amount in central placental compartment; X_{p,f}, drug amount in deep compartment.
It is not feasible to perform a clinical study to evaluate the placental permeability of drugs in pregnant women for ethical reasons. Although some researchers have attempted to estimate the transplacental permeability by analyzing drug concentrations in umbilical venous plasma and maternal plasma after delivery (Hirt et al., 2007), they could not determine the concentration of drug during pregnancy and could not control the time of sampling after drug intake.

Human placental perfusion (Schneider et al., 1972) can be used to determine the drug concentration-time profile and to observe influx into and efflux from the placental tissue. We have analyzed the transplacental transfer kinetics of salicylic acid, diclofenac, and antipyrine in detail by fitting a transplacental pharmacokinetic model to the results of human placental perfusion studies (Shintaku et al., 2007, 2009). This model provides estimates of the kinetic parameters of drug transfer between placental tissue and maternal or fetal perfusate and the results enable us to simulate the drug influx kinetics into fetus across the placenta based on the maternal plasma concentration profile as an input function (Shintaku et al., 2012).

We have developed a pharmacokinetic model that enables prediction of the pharmacokinetic profiles of paroxetine in neonates after delivery from mothers taking paroxetine. First, we characterize the transplacental transfer of paroxetine in perfused human placenta with various perfusion schedules and fit the results to a five-compartment pharmacokinetic model. The developed model and estimated parameters were used to design a suitable tapered dosage regimen to achieve a slowly decreasing concentration profile of paroxetine in the fetus.

Materials and Methods

Human full-term placentae were obtained from gravidae after normal vaginal or cesarean delivery. The study protocol was approved by the ethics committee of the University of Tokyo, and written informed consent was provided by the gravidae before delivery. Paroxetine hydrochloride was purchased from Toronto Research Chemicals (Ontario, Canada). Fluvoxamine malate and diethyl ether were purchased from Sigma Aldrich (St. Louis, MO). Human serum albumin was purchased from Kaketsukken (Chemo-Sero-Therapeutic Research Institute, Kumamoto, Japan). All other reagents used were of the highest grade commercially available.

Krebs-Ringer-bicarbonate buffer (118 mM NaCl, 4.7 mM KCl, 1.3 mM MgSO4, 2.4 mM NaHCO3, 2.5 mM CaCl2) containing Na-glucose (1.0 g/l), dextan (MW 35,000–50,000, 1.0 g/l), heparin (12,500 IU/l), and human serum albumin (2.0 g/l) was used as the perfusate. The maternal and fetal perfusates were aerated with 95% O2 and 5% CO2, respectively, and warmed to 37°C. Aeration was continued throughout the experiment.

Placental Perfusion

The human placental perfusion study was performed as previously reported elsewhere (Shintaku et al., 2007) using antipyrine as a passive diffusion marker. Briefly, after cannulation, the cotyledon sample was perfused with drug-free perfusate for 30 minutes to stabilize the preparation and then perfused with drug-free perfusate containing antipyrine as a passive diffusion marker. The maternal and fetal perfusates were adjusted to pH 7.3 with HCl, and warmed to 37°C. Aeration was continued throughout the experiment.

Protocol I

Maternal perfusate was changed to perfusate containing paroxetine (41.5 ng/ml, mean ± 7.0 ng/ml, mean ± S.D.), perfusion was conducted for 60 minutes. Maternal and fetal effluents were sampled periodically for 60 minutes.

Protocol Ia

Maternal perfusate was changed to perfusate containing both paroxetine (128 ng/ml) and antipyrine (48.3 μg/ml), and perfusion was conducted for 10 minutes to determine the concentration of drugs in the placental cotyledon at 10 minutes.

Protocol Ib

Maternal perfusate was changed to perfusate containing both paroxetine (128 ± 12 ng/ml, mean ± S.D.) and antipyrine (51.4 ± 7.0 μg/ml, mean ± S.D.), and perfusion was conducted for 60 minutes. Then, the perfusate was changed to a drug-free perfusate, and perfusion was continued up to 180 minutes. The effluents were sampled periodically for 180 minutes. The concentration profile data until 60 minutes were merged with data from protocol I, and the average profile was used for the model analysis.

Protocol II

Fetal perfusate was changed to perfusate containing both paroxetine (128 ± 4 ng/ml, mean ± S.D.) and antipyrine (55.3 ± 5.2 μg/ml, mean ± S.D.), and perfusion was conducted for 60 minutes. Maternal and fetal effluents were sampled periodically for 60 minutes.

Determination of Paroxetine

The total concentration of paroxetine in effluent or perfusate was determined by means of high-performance liquid chromatography (HPLC) with UV detection. An aliquot of 500 μl of sample was spiked with 50 μl of internal standard solution (10 μg/ml fluvoxamine), then 30 μl of 1 N NaOH and 5 ml of organic solvent (a mixture of n-hexane and isoamyl alcohol; 99:1, v/v) were added, and the mixture was shaken for 10 minutes. The sample was centrifuged at 2600g for 4°C for 10 minutes, and 4 ml of the organic layer was transferred to a glass tube. Further organic solvent was added to the remaining sample, and the mixture was shaken, then the organic layer was separated. The organic layers were combined and evaporated to dryness under a gentle nitrogen stream. The residue was dissolved with 200 μl of mobile phase and subjected to HPLC.

The HPLC system consisted of a pump (LC-20AD; Shimadzu, Kyoto, Japan), a UV-VIS detector (SPD-20AV, Shimadzu), an integrator (CR-8A Chromatopac; Shimadzu), and a column oven (CT-20A; Shimadzu), and an auto sampler (SIL-20A, Shimadzu). A reversed-phase column (Cosmosil 5C18, 4.6 mm × 150 mm, 5 μm; Nakalai Tesque, Tokyo, Japan) was used for separation. The mobile phase consisted of 0.01 M phosphate buffer (pH 2.8) and acetonitrile (60:39, v/v) and was pumped at a rate of 1.5 ml/min. The detection wavelength was set at 295 nm. The detection limit of paroxetine was 1 ng/ml.

To determine the concentration of paroxetine in placental tissue, the sample was weighed and cut into small pieces, added to 2 volumes of water and homogenized with a blender (Phycotron; Microtech Nichion, Chiba, Japan) and a Tellon-glass homogenizer (Mini D.C. Stirrer; Eyela, Tokyo, Japan). An aliquot of 3 ml of homogenate was spiked with 100 μl of internal standard solution (50 μg/ml fluvoxamine), then 5 ml of diethyl ether and 70 μl of 4 M NaOH were added. The mixture was shaken for 10 minutes and centrifuged to separate the organic layer. The organic layer (4 ml) was transferred into a glass tube, to which 2 ml of HCl solution (pH 2.0) was added. The mixture was shaken for 10 minutes and centrifuged again. The aqueous layer (1.8 ml) was transferred to a glass tube and again shaken for 10 minutes with 5 ml of organic solvent (mixture of n-hexane and isooamyl alcohol; 99:1, v/v), then centrifuged to separate the organic layer. The organic layer (4 ml) was evaporated to dryness under a gentle nitrogen stream. The residue was dissolved in 200 μl of mobile phase and subjected to HPLC.

Determination of Antipyrine

The total concentration of antipyrine in effluent, perfusate, or placental tissue was determined using our previously reported method (Shintaku et al., 2007). The detection limit of antipyrine was 0.1 μg/ml.
Evaluation of Permeability across the Placenta

The transplacental transfer value at the steady state (TPTSS), an index of permeability across the placenta (Heikkinen et al., 2000), was calculated as the ratio of the amount of drug transferred to fetal effluent across the placenta to that infused at the steady state (60 minutes after the start of perfusion for paroxetine, and 20–60 minutes for antipyrine) and used to evaluate the permeability in protocols I, Ia, and Ib. The TPTSS was defined as a TPTSS value in the opposite direction (Shintaku et al., 2009) and was used to evaluate the results of protocol II.

Pharmacokinetic Analysis of Transplacental Transfer

Antipyrine. The transplacental transfer of antipyrine was characterized by fitting a three-compartment model, consisting of a dead volume compartment, intervillous compartment, and placental compartment (Shintaku et al., 2007), without weighing to the set of concentration profiles of antipyrine in maternal and fetal effluents and placental tissue using a nonlinear least-squares program (MLAB; Civilized Software, Bethesda, MD) to estimate transplacental transfer parameters such as $K_1$ (influx clearance from intervillous compartment to placental compartment; ml/min/g cotyledon) and $k_2$ (efflux rate from placental compartment to intervillous compartment; min$^{-1}$). The initial parameters for fitting were arbitrarily determined. The placental compartment represents the union of placental tissue and fetal intravascular space, which is considered to be in rapid equilibrium. The first-order influx rate constant from the dead volume compartment to the intervillous compartment in protocol I, Ia, or Ib was also incorporated to the model to correct the dead volume of the line and set to 1.02 min$^{-1}$ as previously reported elsewhere (Shintaku et al., 2007).

Paroxetine

A five-compartment model, which consists of a dead volume compartment, intervillous compartment, placental compartment, fetal venous compartment, and deep compartment, was used to analyze the transplacental transfer of paroxetine (Fig. 1). The sets of mass-balance equations for protocols I, Ia, Ib, and II based on the five-compartment model are as follows:

[Protocol I and Ia]

\[
\frac{dx_a}{dt} = C_{wa} \cdot Q_{wa} - k_6 \cdot x_a
\]

\[
\frac{dx_m}{dt} = k_6 \cdot x_a - C_m \cdot (k_1 + Q_m) + k_2 \cdot x_{pa}\]

\[
\frac{dx_{pa}}{dt} = C_m \cdot K_1 - (k_2 + k_3 + k_5) \cdot x_{pa} + C_f \cdot K_4 + x_{pb} \cdot k_6
\]

\[
\frac{dx_{pb}}{dt} = k_5 \cdot x_{pa} - k_4 \cdot x_{pb}
\]

\[
\frac{dx_p}{dt} = x_{pa} + x_{pb}
\]

\[
\frac{dc}{dt} = k_3 \cdot x_m - C_f \cdot (K_4 + Q_f)
\]

[Protocol Ib] ($t > 62$)

\[
\frac{dx_a}{dt} = -k_6 \cdot x_a
\]

All other equations are same to those for protocol I.

[Protocol II]

\[
\frac{dx_{ma}}{dt} = -C_m \cdot (k_1 + Q_m) + k_2 \cdot x_{pa}
\]

\[
\frac{dx_{pa}}{dt} = C_m \cdot K_1 - (k_2 + k_3 + k_5) \cdot x_{pa} + C_f \cdot K_4 + x_{pb} \cdot k_6
\]

Maternal-to-fetal perfusion

\[
\frac{dx_{mpa}}{dt} = k_3 \cdot x_{pa} - k_6 \cdot x_{mpa}
\]

\[
x_p = x_{pa} + x_{pb}
\]

\[
\frac{dx_{fp}}{dt} = C_m \cdot Q_f + k_3 \cdot x_{mpa} - C_f \cdot (K_4 + Q_f)
\]

where $C_m$, $C_f$, and $X_p$ represent the concentration of paroxetine in maternal effluent, that in fetal effluent, and the amount of paroxetine in placental tissue, respectively. The time $t$ was defined to be 0 at the start of infusion. The sets of equations 1–6, 1’, 2–6, and 7–11 were simultaneously fitted to the set of concentration profiles of paroxetine in maternal effluent, fetal effluent, and placental tissue observed in protocols I/ia, Ib, and II, respectively, to estimate transplacental kinetic parameters such as $K_1$, $k_2$, $k_3$, $K_4$, and $k_6$ by using a nonlinear least-squares program as described earlier. The parameters $K_1$ and $K_4$ represent the apparent clearance as given by multiplying the respective unbound clearance by unbound fraction in the effluent.

Correction of Clearance Values by Unbound Fraction

The unbound fraction ($f_u$) of paroxetine and antipyrine in the perfusate was determined by ultrafiltration. The perfusate (2 ml) containing 148 ng/ml paroxetine and 50.2 µg/ml antipyrine was transferred to a Centricon Ultracel YM-30 (Millipore, Bedford, MA) and spun at 1000 g for 2 minutes. The $f_u$ value was determined from the concentration in the filtrate ($C_2$) and that in solution remaining in the upper cell ($C_1$) by means of eq. 12.

\[
f_u = \frac{C_2}{C_1}
\]

The unbound influx clearance, $K'_1$ and $K'_4$, was calculated by dividing $K_1$ and $K_4$ by $f_u$. The estimated influx clearance from the maternal plasma, $K''_1$, was calculated by multiplying $K'_1$ by the unbound fraction in maternal plasma.
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Estimation of Paroxetine Output from Placental Compartment to Fetal Umbilical Vein In Utero

To simulate the pharmacokinetics of paroxetine in the maternal circulation, we used a pharmacokinetic model incorporating the mechanism-based inactivation (MBI) previously developed by us (Mikami et al., 2013). The influx profile of paroxetine into fetal plasma and the plasma concentration profile in the fetal plasma after repetitive oral administration of paroxetine to the mother at a dose of 40 mg once a day were simulated with a hybrid model (Fig. 2) using the maternal concentration profile of paroxetine (C_m) as an input function based on the parameters previously reported by us (Mikami et al., 2013). The mass-balance equations that describe the hybrid model are as follows.

\[
\frac{dC_m}{dt} = \frac{C_{b,m} \cdot Q_m - C_m \cdot (K_1' + Q_m) + k_2 \cdot X_{pf}}{V_m}
\]

\[
\frac{dX_{pf}}{dt} = C_m \cdot K_1' - (k_3 + k_5 + k_6) \cdot X_{pf} + C_f \cdot K_1' + X_{pb} \cdot k_6
\]

where \( C_{b,m} \) and \( V_{b,f} \) represent the plasma concentration and distribution volume of paroxetine in the fetus, respectively. The \( V_{b,f} \) value was fixed to 20.3 l based on the assumption that \( V_{b,f} \) per body weight is the same as \( V_{b,m} \) per body weight (\( V_{b,m} = 405.1 \) l/body, Mikami et al., 2013; body weight of mother = 60 kg; body weight of fetus = 3 kg) and that paroxetine is not metabolized in the fetus.

Validation of the Model

To validate the model and estimated parameters, the observed concentrations of paroxetine in maternal plasma and umbilical venous plasma at delivery for five cases were collected from the literature and compared with the values estimated by the model, using the dosage regimen in each case as an input function. The simulation was performed under a steady-state condition because in all five cases the mother had been taking paroxetine for more than 60 days.

Simulation Study

The concentration profiles of paroxetine in fetal plasma and placental tissue at a dose of 40 mg once daily to a pregnant mother, as well as under a tapered dosage regimen from 40 mg/d, were simulated by using the developed model.

Results

Permeability of Antipyrine across the Placenta. In protocols I, Ia, and Ib, the concentration of antipyrine in the fetal and maternal effluents reached the steady state at about 10 minutes after the start of perfusion (Fig. 3) and the TPT_SS value at the steady state (21 to 60 minutes) was 9.16% ± 2.67% (mean ± S.D.). Protocol Ib revealed that the efflux of antipyrine from placental tissue to maternal and fetal effluents was rapid, with half-lives of 3 and 1 minutes, respectively (Fig. 3). The concentration of antipyrine in the placental tissue at 180 minutes was 0.44 ± 0.51 µg/g tissue. The tissue-to-perfusate concentration ratios (Kp) of antipyrine are summarized in Table 1, together with those of paroxetine.

In protocol II, the antipyrine concentration in the maternal and fetal effluents also reached the steady state at about 10 minutes after the start of perfusion.

Transplacental kinetic parameters obtained by fitting eqs. 1–11 to the data are shown in Table 2.

Permeability of Paroxetine across the Placenta. In protocols I and Ib, the concentration of paroxetine in the maternal and fetal effluents did not reach the steady state within 60 minutes (Fig. 4). In protocol I, with maternal perfusate containing 41.5 ng/ml paroxetine, the concentration of paroxetine in the fetal effluent remained below the quantification limit until 19 minutes after the start of infusion and reached 3.35 ng/ml at 60 minutes (Fig. 4E). The paroxetine concentrations in the maternal efflux and placental tissue at 60 minutes were 24.4 ng/ml and 1670 ng/g tissue, respectively (Fig. 4, A and B). When the concentration of paroxetine in the maternal perfusate was as high as 138 ± 21 ng/ml, the concentration of paroxetine in the fetal effluent reached the quantification limit at 7 minutes and was 20.2 ± 15.2 ng/ml at 60 minutes (Fig. 4A). The concentration in the maternal effluent was 80.6 ± 20.5 ng/ml at 60 minutes, while that in the placental tissue was as high as 742 ng/g tissue at 10 minutes and 2840 ± 2510 ng/g tissue at 60 minutes (Fig. 4, A and B; Table 1). The placental tissue-to-fetal effluent partition ratio (K_p,fetal) was 232 at 60 minutes. The unbound fraction (f_u) of paroxetine in the effluent was 0.263. Thus, the K_p,fetal Value was calculated to be 882 (Table 1). The TPT_60 value for paroxetine was 3.64% ± 2.26%, which is 40% of TPT_SS for antipyrine. The total recovery rates of paroxetine in protocol I and protocol Ib were 103% ± 9% and 121% ± 18%, respectively.

In protocol Ib, paroxetine was detected in maternal and fetal effluents at concentrations of 12.1 ± 7.3 and 2.22 ± 1.93 ng/ml, respectively, even after washout with drug-free perfusate for 118 minutes. The decay of the concentration in maternal effluent was biexponential.
with half-lives of 18.2 and 108 minutes. The placental concentration of paroxetine remained as high as 1750 ± 20 ng/g tissue even after washout for 118 minutes (Table 1).

In protocol II, the concentration in the fetal effluent was 10.3 ng/ml at 60 minutes, while that in the maternal effluent reached the quantification limit after 30 minutes and did not reach a steady state within 60 minutes (Fig. 4C).

Equations 1–11 were simultaneously fitted to all the results in protocols I, Ia, Ib, and II to estimate the transplacental pharmacokinetic parameters (Table 2). The influx clearances from maternal and

<table>
<thead>
<tr>
<th>Time (min)</th>
<th>Paroxetine</th>
<th>Antipyrine</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>2</td>
<td>742</td>
</tr>
<tr>
<td>60</td>
<td>3</td>
<td>2840 ± 2510</td>
</tr>
<tr>
<td>180</td>
<td>3</td>
<td>1750 ± 20</td>
</tr>
</tbody>
</table>

The unbound fractions of paroxetine and antipyrine in perfusate were 0.263 and 0.926, respectively. $K_{p,t}$, tissue-to-unbound perfusate concentration ratio. Mean (n=2), (mean ± S.D., n = 3).
fetal effluents were corrected by the $f_u$ value of 0.263 to yield the respective unbound influx clearances ($K_{1fu}$ and $K_{2fu}$) in Table 2 as well as $K_{1fu}$ and $K_{2fu}$, which are the influx clearances in human plasma calculated by multiplying the plasma unbound fraction of paroxetine in human plasma (0.05).

The model and parameters could explain well the observed profile of the concentration of paroxetine in the effluents and placental tissue (Fig. 4).

**Validation of the Model.** Table 3 shows the results of model validation by using the observed paroxetine concentrations in the maternal and umbilical venous plasma at delivery. There are considerable discrepancies between observed and model-predicted concentrations.

**Simulation Study.** Figure 5 shows the simulated profiles of the paroxetine concentration in fetal and maternal plasma and placenta after maternal administration of paroxetine (40 mg/d, PO), using the developed model and parameters. During repeated administration, the fetal concentration gradually increased with the maternal profile, reaching the steady state. The maternal and fetal plasma concentrations were simulated to reach steady states within 1 week. After the mother stops taking paroxetine, the maternal and fetal plasma concentrations are simulated to decrease with half-lives of 8 and 10 hours, respectively. The fetal plasma concentration was considered to decrease more slowly than the maternal plasma concentration because the placental tissue acts as a reservoir, supplying paroxetine to the fetal plasma. However, abrupt cessation of paroxetine may cause withdrawal syndromes in the mother, so we next simulated the case where the fetus continues to receive paroxetine from the maternal compartment.

**Discussion**

In the present study, we evaluated the transplacental transfer kinetics of paroxetine by analyzing the results of a human placental perfusion study with several perfusion protocols using a pharmacokinetic model, and we successfully used the developed model and estimated parameters to predict the concentration of paroxetine in fetal plasma.

We employed the transplacental pharmacokinetic model previously reported by us (Shintaku et al., 2007) with a minor modification, that is, introduction of a deep compartment in the placental tissue (Fig. 1), because biphasic decay of the paroxetine concentration in effluents was observed in the washout phase of protocol Ia. Most human placental perfusion studies employ a single protocol such as protocol I. However, we clearly detected the existence of a deep compartment in the placental tissue by using protocol Ia, suggesting that the use of a set of various perfusion protocols is preferable to characterize the transplacental transfer kinetics of drugs. The modified model could successfully explain the concentration profiles of paroxetine in the maternal and fetal effluents. Although the present study did not provide any information with regard to the physiologic entity of the deep compartment, it is noteworthy that paroxetine shows high affinity for a serotonin transporter expressed on the basilar membranes of human trophoblast cells (Cool et al., 1990).

As for the recovery rate of paroxetine, it was estimated to exceed 100%. To calculate the total amount of drug recovered, we integrated the drug concentrations in maternal and fetal effluents to estimate the amount of drug flowed out, and added the amount of drug remaining in the placental tissue at the end of perfusion. This amount recovered was then divided by the total amount of drug flowed into the preparation. Most of paroxetine was recovered from the placental tissue so that increase in the flow rate of perfusate leads to the overestimation of recovery rate. Another feasible cause is the heterogeneous distribution of drug in the placental preparation, although we did not detect any significant differences in the drug concentration among various parts of placental preparation in our preliminary experiments.

We have already performed a series of studies to analyze the transplacental transfer kinetics of various drugs such as diclofenac and salicylic acid using a similar experimental approach (Shintaku et al., 2007, 2009). When those results are compared with the present findings, the unbound influx clearance ($K_{1fu}$) for paroxetine (12.4 ml/min/g cotyledon) was found to be higher than those for antipyrine.
(0.28 ml/g cotyledon; Table 2), salicylic acid (0.0451 ml/min/g cotyledon; Shintaku et al., 2007), and diclofenac (6.27 ml/g cotyledon; Shintaku et al., 2009). The membrane permeability of a drug that is not transported by a specific transport system(s) is known to be correlated with the ratio of the octanol-water partition coefficient at pH 7.4 to the square root of molecular weight. The permeability values of the four drugs estimated according to this assumption show a good correlation with the $K_{1}$ values (data not shown), suggesting that the

**TABLE 3**

Comparison between observed and predicted concentrations of paroxetine in maternal and umbilical venous plasma at delivery

<table>
<thead>
<tr>
<th>No.</th>
<th>Daily Dose</th>
<th>Duration of Paroxetine Treatment</th>
<th>Time of Delivery after Last Dose of Paroxetine</th>
<th>Observed Values at Delivery*</th>
<th>Model-Predicted Values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>mg</td>
<td></td>
<td></td>
<td>Maternal Concentration</td>
<td>Umbilical Venous Concentration</td>
</tr>
<tr>
<td>1</td>
<td>10</td>
<td>wk 12–</td>
<td>6</td>
<td>59</td>
<td>24</td>
</tr>
<tr>
<td>2</td>
<td>20</td>
<td>wk 15–</td>
<td>21</td>
<td>34</td>
<td>31</td>
</tr>
<tr>
<td>3</td>
<td>25</td>
<td>wk 10–</td>
<td>13</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>40</td>
<td>Throughout pregnancy</td>
<td>13</td>
<td>38</td>
<td>24</td>
</tr>
<tr>
<td>5</td>
<td>15</td>
<td>wk 1–5, 16–</td>
<td>19</td>
<td>22</td>
<td>&lt;1</td>
</tr>
</tbody>
</table>

* Hendrick et al., 2003.
high permeability of paroxetine into placental tissue may be largely explained by its physicochemical properties. However, recent in vitro studies have demonstrated that paroxetine is a substrate as well as an inhibitor of P-glycoprotein (Maines et al., 2005; Yasui-Furukori et al., 2007). P-glycoprotein is reported to be expressed in placental tissue, and its substrates, such as saquinavir, methadone, paclitaxel, and quentapine, were shown to be unidirectionally transported in in vitro placental preparations (Nagashige et al., 2003; Ushigome et al., 2003; Mölsä et al., 2005; Nanovskaya et al., 2005; Rahi et al., 2007). Therefore, it is possible that P-glycoprotein affects the transplacental transfer of paroxetine. A perfusion study using both paroxetine and a P-glycoprotein inhibitor may clarify the influence of P-glycoprotein.

The paroxetine concentrations in umbilical and maternal plasma have been reported and can be used to estimate the permeation of paroxetine into the fetus. We compared the observed values reported by Hendrick et al. (2003) and found that the estimated fetal plasma concentrations were within a 5-fold range of the observed values (Table 3), except for no. 5. A 5-fold difference is considered not to be unreasonable because paroxetine is primarily metabolized by cytochrome P450 (CYP) 2D6, which is highly polymorphic. Moreover, the estimated maternal-umbilical concentration ratios were also comparable to the observed values, except for no. 5. We assumed that paroxetine is not metabolized in the fetus because the enzymatic activity of CYP2D6 in fetal liver is reported to be absent or to be only about 4% of that in adults in some (30%) fetal liver samples (Treluyer et al., 1991; Jacqz-Aigrain and Cresteil 1992; Hakkola et al., 1996). Taken together, the results suggest that the model has potential to predict the fetal plasma level of paroxetine from the concentration profile in the maternal plasma, although no definite criteria exists to validate the prediction.

After the validation of the model and parameters, we attempted to estimate the concentration profile of fetal plasma paroxetine by using the maternal plasma concentration as an input function. The developed model predicted that during the repetitive oral administration of paroxetine at a dose of 40 mg daily, the fetal plasma concentration would increase day by day along with the increase in the maternal plasma concentration and would reach a steady state within 1 week. After the cessation of paroxetine before delivery, the fetal plasma level is predicted to decrease rather abruptly, though with a half-life longer than that in maternal plasma. However, the model simulation has indicated that tapering of the paroxetine dosage before delivery might be effective to produce a slow and prolonged decrease of paroxetine in fetal plasma. Therefore, we suggest that a strategy of tapering the dosage of paroxetine before delivery might be effective to reduce the incidence of withdrawal syndrome of neonates as well as mothers.

In conclusion, we characterized the transplacental transfer kinetics of paroxetine by means of perfusion studies with human placenta, using various perfusion protocols. The developed model and estimated parameters enable us to predict the fetal plasma concentration profile from the maternal one. The model and parameters determined in this study are expected to be useful to design an optimal dosage regimen to reduce adverse reactions such as withdrawal syndrome and to investigate the relationship between the fetal concentration profile and the nature of adverse reactions in fetus.
Appendix

Model equations for antipyrine (Shintaku et al., 2007).

Protocol I, Ia, Ib (t ≤ 60):

\[
\begin{align*}
\frac{dX_u}{dt} &= C_m \cdot Q_m - k_a \cdot X_u \\
\frac{dC_m}{dt} &= k_a \cdot X_u - C_m \cdot \left[ (k_1 + Q_m) + k_2 \cdot C \cdot (V_p + V_f) \right] \\
X_p &= C_f \cdot (V_p + V_f) \\
\frac{dC_f}{dt} &= C_m \cdot k_1 - (k_2 + k_3) \cdot C_f \cdot (V_p + V_f) - Q_f \cdot C_f \\
&= \frac{V_f}{V_p + V_f} \\
&= \frac{V_f}{V_p + V_f} \\
&= \frac{V_f}{V_p + V_f} \\
&= \frac{V_f}{V_p + V_f}
\end{align*}
\]

Protocol Ib (t > 60):

\[
\frac{dX_u}{dt} = -k_a \cdot X_u
\]

Protocol II:

\[
\frac{dC_m}{dt} = \frac{-C_m \cdot (k_1 + Q_m) + k_2 \cdot C_f \cdot (V_p + V_f)}{V_m}
\]

\[
X_p = C_f \cdot (V_p + V_f)
\]

\[
\frac{dC_f}{dt} = \frac{C_m \cdot k_1 - (k_2 + k_3) \cdot C_f \cdot (V_p + V_f) - Q_f \cdot C_f}{V_f + V_f}
\]

Authorship Contributions


References


Address correspondence to: Dr. Yasufumi Sawada, Graduate School of Pharmaceutical Sciences, The University of Tokyo, 7-3-1, Hongo, Bunkyo-ku, Tokyo 113-0033, Japan. E-mail: sawada@mol.u.tokyo.ac.jp