Pharmacology Grade Evidence Tables – Appendix 19c

Contents

Pharmacological interventions versus placebo and head-to head pharmacological interventions

Author(s):
Date: 2010-03-15
Question: Should **Escitalopram vs Placebo** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Escitalopram	Placebo	Relative (95% CI)	Absolute		
HAM-A (change from baseline) - Escitalopram (Better indicated by lower values)												
4	randomised	no serious	no serious	no serious	no serious	none	816	696	-	MD 2.36 lower (3.28 to	⊕⊕⊕⊕	

	trials	limitations	inconsistency	indirectness	imprecision					1.43 lower)	HIGH	
Non-response - Escitalopram												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	233/613 (38%)	279/494 (56.5%)	RR 0.68 (0.44 to 1.05)	181 fewer per 1000 (from 316 fewer to 28 more)	⊕⊕⊕O MODERATE	
Non-remission												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	240/344 (69.8%)	265/355 (74.6%)	RR 0.93 (0.85 to 1.02)	52 fewer per 1000 (from 112 fewer to 15 more)	⊕⊕⊕O MODERATE	
Discontinuation due to adverse events												
5	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	73/856 (8.5%)	38/745 (5.1%)	RR 1.72 (1.16 to 2.53)	37 more per 1000 (from 8 more to 78 more)	⊕⊕⊕⊕ HIGH	
Nausea												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	112/554 (20.2%)	42/432 (9.7%)	RR 2.02 (1.45 to 2.81)	99 more per 1000 (from 44 more to 176 more)	⊕⊕⊕⊕ HIGH	
Anorgasmia - Escitalopram												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[3]	none	17/427 (4%)	0/296 (0%)	RR 13.17 (1.83 to 94.89)	0 more per 1000 (from 0 more to 0 more)	⊕⊕⊕O MODERATE	
Insomnia												
2	randomised trials	no serious limitations	serious[4]	no serious indirectness	no serious imprecision	none	48/396 (12.1%)	21/275 (7.6%)	RR 1.81 (1.07 to 3.08)	62 more per 1000 (from 5 more to 159 more)	⊕⊕⊕O MODERATE	

[1] wide confidence interval compatible wih benefit and no benefit

[2] relatively wide confidence intervals

[3] very wide confidence interval
[4] I-squared > 50%

Author(s):
Date: 2010-03-15
Question: Should **Sertraline vs Placebo** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Sertraline	Placebo	Relative (95% CI)	Absolute		
HAM-A (change from baseline) - Sertraline (Better indicated by lower values)												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	347	351	-	MD 2.46 lower (4.53 to 0.39 lower)	⊕⊕⊕⊕ HIGH	
Non-response - Sertraline												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	150/347 (43.2%)	213/351 (60.7%)	RR 0.71 (0.6 to 0.85)	176 fewer per 1000 (from 91 fewer to 243 fewer)	⊕⊕⊕⊕ HIGH	
Non-remission												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	126/182 (69.2%)	154/188 (81.9%)	RR 0.85 (0.75 to 0.95)	123 fewer per 1000 (from 41 fewer to 205 fewer)	⊕⊕⊕O MODERATE	
Discontinuation due to adverse events												
2	randomised trials	no serious limitations	serious[2]	no serious indirectness	serious[3]	none	22/347 (6.3%)	21/351 (6%)	RR 1.07 (0.6 to 1.91)	4 more per 1000 (from 24 fewer to 54 more)	⊕⊕OO LOW	
Nausea												

2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	88/349 (25.2%)	48/352 (13.6%)	RR 1.85 (1.35 to 2.55)	116 more per 1000 (from 48 more to 211 more)	⊕⊕⊕⊕ HIGH	
Ejaculation disorder												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[4]	none	7/184 (3.8%)	0/189 (0%)	RR 15.41 (0.89 to 267.81)	0 more per 1000 (from 0 fewer to 0 more)	⊕⊕⊕O MODERATE	
Insomnia												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[3]	none	65/349 (18.6%)	52/352 (14.8%)	RR 1.26 (0.9 to 1.76)	38 more per 1000 (from 15 fewer to 112 more)	⊕⊕⊕O MODERATE	

[1] only data on 1 study
[2] I-squared >50%
[3] wide confidence intervals compatible with benefit and harm
[4] very small number of events

Author(s):
Date: 2010-03-15

Question: Should **Paroxetine vs Placebo** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Paroxetine	Placebo	Relative (95% CI)	Absolute		
HAM-A (change from baseline) - Paroxetine (Better indicated by lower values)												
6	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	1203	1007	-	MD 1.46 lower (2.23 to 0.69 lower)	⊕⊕⊕⊕ HIGH	
Non-response - Paroxetine												

4	randomised trials	no serious limitations	serious[1]	no serious indirectness	serious[2]	none	309/697 (44.3%)	386/701 (55.1%)	RR 0.79 (0.65 to 0.97)	116 fewer per 1000 (from 17 fewer to 193 fewer)	⊕⊕OO LOW	
Non-remission												
5	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	711/1119 (63.5%)	655/913 (71.7%)	RR 0.87 (0.82 to 0.92)	93 fewer per 1000 (from 57 fewer to 129 fewer)	⊕⊕⊕⊕ HIGH	
Discontinuation due to adverse events												
8	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	141/1493 (9.4%)	46/1291 (3.6%)	RR 2.5 (1.81 to 3.45)	53 more per 1000 (from 29 more to 87 more)	⊕⊕⊕⊕ HIGH	
Nausea												
7	randomised trials	no serious limitations	serious[1]	no serious indirectness	no serious imprecision	none	264/1272 (20.8%)	73/1032 (7.1%)	RR 2.98 (2.33 to 3.8)	140 more per 1000 (from 94 more to 198 more)	⊕⊕⊕O MODERATE	
Sexual problem												
7	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[3]	none	96/1272 (7.5%)	9/1068 (0.8%)	RR 7.22 (3.77 to 13.83)	52 more per 1000 (from 23 more to 108 more)	⊕⊕⊕O MODERATE	
Insomnia												
4	randomised trials	no serious limitations	serious[1]	no serious indirectness	no serious imprecision	none	42/547 (7.7%)	18/544 (3.3%)	RR 2.33 (1.35 to 4)	44 more per 1000 (from 12 more to 99 more)	⊕⊕⊕O MODERATE	

[1] I-squared >50%
[2] Confidence intervals compatible with benefit and no benefit
[3] small number of events

Author(s):
Date: 2010-05-18

Question: Should **Citalopram vs Placebo** be used for GAD?
Settings:
Bibliography:

Quality assessment							Summary of findings					
							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Citalopram	Placebo	Relative (95% CI)	Absolute		
Non-response												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	6/17 (35.3%)	0%	RR 0.46 (0.23 to 0.93)	0 fewer per 1000 (from 0 fewer to 0 fewer)	⊕⊕⊕O MODERATE	
Non-remission												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	9/17 (52.9%)	14/17 (82.4%)	RR 0.64 (0.39 to 1.06)	296 fewer per 1000 (from 502 fewer to 49 more)	⊕⊕⊕O MODERATE	
								0%		0 fewer per 1000 (from 0 fewer to 0 more)		
Discontinuation due to adverse events												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	1/17 (5.9%)	0%	RR 3.00 (0.13 to 68.8)	0 more per 1000 (from 0 fewer to 0 more)	⊕⊕⊕O MODERATE	

[1] Only one study

Author(s):
Date: 2010-03-15

Question: Should **Duloxetine vs Placebo** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					
							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Duloxetine	Placebo	Relative (95% CI)	Absolute		

HAM-A Mean change from baseline (Better indicated by lower values)												
4	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	799	654	-	MD 3.15 lower (4.1 to 2.21 lower)	⊕⊕⊕⊕ HIGH	
Non-Response												
4	randomised trials	no serious limitations	serious[1]	no serious indirectness	no serious imprecision	none	399/826 (48.3%)	433/665 (65.1%)	RR 0.75 (0.62 to 0.92)	163 fewer per 1000 (from 52 fewer to 247 fewer)	⊕⊕⊕O MODERATE	
Non-remission												
4	randomised trials	no serious limitations	serious[1]	no serious indirectness	serious[1]	none	561/826 (67.9%)	532/665 (80%)	RR 0.86 (0.75 to 0.98)	112 fewer per 1000 (from 16 fewer to 200 fewer)	⊕⊕OO LOW	
Discontinuation due to adverse events												
4	randomised trials	no serious limitations	serious[1]	no serious indirectness	no serious imprecision	none	122/826 (14.8%)	35/665 (5.3%)	RR 3.12 (1.55 to 6.31)	112 more per 1000 (from 29 more to 279 more)	⊕⊕⊕O MODERATE	
Nausea												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	206/506 (40.7%)	29/334 (8.7%)	RR 4.54 (2.91 to 7.1)	307 more per 1000 (from 166 more to 530 more)	⊕⊕⊕⊕ HIGH	
Sexual problems												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	28/506 (5.5%)	6/334 (1.8%)	RR 2.95 (1.2 to 7.29)	35 more per 1000 (from 4 more to 113 more)	⊕⊕⊕⊕ HIGH	
Insomnia												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	43/506 (8.5%)	11/334 (3.3%)	RR 2.46 (1.28 to 4.76)	48 more per 1000 (from 9 more to 124 more)	⊕⊕⊕⊕ HIGH	

[1] I-squared >50%

Author(s):
Date: 2010-03-15
Question: Should **Venlafaxine vs Placebo** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Venlafaxine	Placebo	Relative (95% CI)	Absolute		
HAM-A (Better indicated by lower values)												
5	randomised trials	no serious limitations	serious[1]	no serious indirectness	no serious imprecision	none	595	582	-	MD 3.16 lower (4.81 to 1.51 lower)	⊕⊕⊕O MODERATE	
Non-response												
8	randomised trials	no serious limitations	serious[1]	no serious indirectness	no serious imprecision	none	607/1301 (46.7%)	550/923 (59.6%)	RR 0.79 (0.69 to 0.91)	125 fewer per 1000 (from 54 fewer to 185 fewer)	⊕⊕⊕O MODERATE	
Non-remission												
6	randomised trials	no serious limitations	serious[1]	no serious indirectness	no serious imprecision	none	496/725 (68.4%)	586/716 (81.8%)	RR 0.83 (0.74 to 0.94)	139 fewer per 1000 (from 49 fewer to 213 fewer)	⊕⊕⊕O MODERATE	
Discontinuation due to adverse events												
10	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	302/1945 (15.5%)	95/1255 (7.6%)	RR 2.04 (1.58 to 2.65)	79 more per 1000 (from 44 more to 125 more)	⊕⊕⊕⊕ HIGH	
Nausea												
8	randomised	no serious	no serious	no serious	no serious	none	437/1253	117/976	RR 2.76 (2.28	211 more per 1000 (from 153 more to 281	⊕⊕⊕⊕	

	trials	limitations	inconsistency	indirectness	imprecision		(34.9%)	(12%)	to 3.34)	more)	HIGH	
Ejaculation disorder												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	68/526 (12.9%)	0/360 (0%)	RR 36.32 (7.76 to 170.02)	0 more per 1000 (from 0 more to 0 more)	⊕⊕⊕O MODERATE	
Insomnia												
6	randomised trials	no serious limitations	serious[1]	no serious indirectness	no serious imprecision	none	140/933 (15%)	60/738 (8.1%)	RR 1.56 (1.16 to 2.09)	46 more per 1000 (from 13 more to 89 more)	⊕⊕⊕O MODERATE	

[1] I-squared >50%
[2] small number of events

Author(s):
Date: 2010-03-15

Question: Should **Imipramine vs Placebo** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Imipramine	Placebo	Relative (95% CI)	Absolute		
HAM-A (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	very serious[1]	none	14	14	-	SMD 0.49 lower (1.24 lower to 0.27 higher)	⊕⊕OO LOW	

[1] 1 small study and very wide CIs

Author(s):
Date: 2010-03-15

Question: Should **Pregabalin vs Placebo** be used for GAD?

Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Pregabalin	Placebo	Relative (95% CI)	Absolute		
HAM-A (Better indicated by lower values)												
5	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	821	475	-	MD 2.97 lower (3.7 to 2.24 lower)	⊕⊕⊕⊕ HIGH	
Non-response												
8	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	674/1440 (46.8%)	425/705 (60.3%)	RR 0.77 (0.71 to 0.83)	139 fewer per 1000 (from 102 fewer to 175 fewer)	⊕⊕⊕⊕ HIGH	
Non-remission												
7	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	983/1319 (74.5%)	471/577 (81.6%)	RR 0.91 (0.87 to 0.96)	73 fewer per 1000 (from 33 fewer to 106 fewer)	⊕⊕⊕⊕ HIGH	
Discontinuation due to adverse events												
8	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	164/1440 (11.4%)	60/705 (8.5%)	RR 1.31 (0.99 to 1.74)	26 more per 1000 (from 1 fewer to 63 more)	⊕⊕⊕⊕ HIGH	
Nausea												
6	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	102/980 (10.4%)	47/552 (8.5%)	RR 1.19 (0.85 to 1.66)	16 more per 1000 (from 13 fewer to 56 more)	⊕⊕⊕O MODERATE	
Insomnia												
3	randomised	no serious	no serious	no serious	serious[2]	none	12/467	12/298	RR 0.7 (0.32	12 fewer per 1000 (from	⊕⊕⊕O	

	trials	limitations	inconsistency	indirectness			(2.6%)	(4%)	to 1.54)	27 fewer to 22 more)	MODERATE	
Dizziness												
6	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	270/980 (27.6%)	43/552 (7.8%)	RR 3.36 (2.46 to 4.58)	184 more per 1000 (from 114 more to 279 more)	⊕⊕⊕⊕ HIGH	
Fatigue												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[3]	none	12/121 (9.9%)	5/128 (3.9%)	RR 2.54 (0.92 to 6.99)	60 more per 1000 (from 3 fewer to 234 more)	⊕⊕⊕O MODERATE	

[1] Confidence intervals compatible with benefit or harm
[2] small number of events
[3] data only for 1 study

Author(s):
Date: 2010-03-15

Question: Should **Diazepam vs Placebo** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Diazepam	Placebo	Relative (95% CI)	Absolute		
HAM-A (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	12	12	-	SMD 0.21 lower (1.01 lower to 0.59 higher)	⊕⊕⊕O MODERATE	
Non-response												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	96/247 (38.9%)	149/258 (57.8%)	RR 0.67 (0.54 to 0.84)	191 fewer per 1000 (from 92 fewer to 266	⊕⊕⊕⊕ HIGH	

										fewer)		
Discontinuation due to adverse events												
4	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	20/259 (7.7%)	12/270 (4.4%)	RR 1.67 (0.82 to 3.39)	30 more per 1000 (from 8 fewer to 106 more)	⊕⊕⊕O MODERATE	
Libido												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	5/104 (4.8%)	0/104 (0%)	RR 11 (0.62 to 196.43)	0 more per 1000 (from 0 fewer to 0 more)	⊕⊕⊕O MODERATE	
Fatigue												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	17/104 (16.3%)	6/104 (5.8%)	RR 2.83 (1.16 to 6.9)	106 more per 1000 (from 9 more to 340 more)	⊕⊕⊕O MODERATE	
Dizziness												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	16/158 (10.1%)	5/161 (3.1%)	RR 3.26 (1.22 to 8.7)	70 more per 1000 (from 7 more to 239 more)	⊕⊕⊕⊕ HIGH	

[1] Confidence intervals compatible with benefit and no benefit

[2] data only on 1 study

Author(s):
Date: 2010-03-15

Question: Should **Alprazolam vs Placebo** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Alprazolam	Placebo	Relative (95% CI)	Absolute		

HAM-A (Better indicated by lower values)												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	209	210	-	MD 2.53 lower (3.9 to 1.17 lower)	⊕⊕⊕⊕ HIGH	
Non-response												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	55/93 (59.1%)	62/91 (68.1%)	RR 0.87 (0.7 to 1.08)	89 fewer per 1000 (from 204 fewer to 55 more)	⊕⊕⊕O MODERATE	
Non-remission												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	69/93 (74.2%)	76/91 (83.5%)	RR 0.89 (0.76 to 1.03)	92 fewer per 1000 (from 200 fewer to 25 more)	⊕⊕⊕O MODERATE	
Discontinuation due to adverse events												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	12/93 (12.9%)	9/91 (9.9%)	RR 1.3 (0.58 to 2.95)	30 more per 1000 (from 42 fewer to 193 more)	⊕⊕⊕O MODERATE	
Nausea												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	12/258 (4.7%)	16/258 (6.2%)	RR 0.74 (0.36 to 1.52)	16 fewer per 1000 (from 40 fewer to 32 more)	⊕⊕⊕O MODERATE	
Insomnia												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	3/63 (4.8%)	5/62 (8.1%)	RR 0.59 (0.15 to 2.37)	33 fewer per 1000 (from 69 fewer to 110 more)	⊕⊕⊕O MODERATE	
Fatigue												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	3/63 (4.8%)	4/62 (6.5%)	RR 0.74 (0.17 to 3.16)	17 fewer per 1000 (from 54 fewer to 139 more)	⊕⊕⊕O MODERATE	
Dizziness												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	30/258 (11.6%)	18/258 (7%)	RR 1.65 (0.95 to 2.85)	45 more per 1000 (from 3 fewer to 129 more)	⊕⊕⊕O MODERATE	

[1] Confidence intervals compatible with benefit and no benefit
[2] No explanation was provided

Author(s):
Date: 2010-03-15
Question: Should **Lorazepam vs Placebo** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Lorazepam	Placebo	Relative (95% CI)	Absolute		
HAM-A (Better indicated by lower values)												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	98	87	-	MD 2.49 lower (3.78 to 1.2 lower)	⊕⊕⊕⊕ HIGH	
Non-response												
4	randomised trials	no serious limitations	serious[1]	no serious indirectness	serious[2]	none	133/230 (57.8%)	152/223 (68.2%)	RR 0.84 (0.66 to 1.07)	109 fewer per 1000 (from 232 fewer to 48 more)	⊕⊕OO LOW	
Non-remission												
3	randomised trials	no serious limitations	serious[1]	no serious indirectness	serious[2]	none	151/200 (75.5%)	171/203 (84.2%)	RR 0.9 (0.77 to 1.05)	84 fewer per 1000 (from 194 fewer to 42 more)	⊕⊕OO LOW	
Discontinuation due to adverse events												
4	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	83/255 (32.5%)	20/260 (7.7%)	RR 4.04 (2.55 to 6.38)	234 more per 1000 (from 119 more to 414 more)	⊕⊕⊕⊕ HIGH	
Nausea												

4	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	29/222 (13.1%)	19/213 (8.9%)	RR 1.42 (0.82 to 2.46)	37 more per 1000 (from 16 fewer to 130 more)	⊕⊕⊕O MODERATE	
Insomnia												
3	randomised trials	no serious limitations	serious[1]	no serious indirectness	very serious[2]	none	15/154 (9.7%)	7/146 (4.8%)	RR 2.21 (0.3 to 16.32)	58 more per 1000 (from 34 fewer to 735 more)	⊕OOO VERY LOW	
Dizziness												
4	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	40/222 (18%)	14/213 (6.6%)	RR 2.76 (1.54 to 4.93)	116 more per 1000 (from 35 more to 258 more)	⊕⊕⊕⊕ HIGH	

[1] I-squared > 50%
[2] Confidence intervals compatible with benefit and no benefit

Author(s):
Date: 2010-03-15

Question: Should **Buspirone vs Placebo** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Buspirone	Placebo	Relative (95% CI)	Absolute		
HAM-A (Better indicated by lower values)												
4	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	260	259	-	MD 1.93 lower (3.04 to 0.82 lower)	⊕⊕⊕⊕ HIGH	
Non-response												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	107/180 (59.4%)	127/185 (68.6%)	RR 0.87 (0.74 to 1.01)	89 fewer per 1000 (from 178 fewer to 7 more)	⊕⊕⊕O MODERATE	

Discontinuation due to adverse events											
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	46/293 (15.7%)	22/298 (7.4%)	RR 2.02 (1.12 to 3.67)	75 more per 1000 (from 9 more to 197 more)	⊕⊕⊕⊕ HIGH	
Nausea											
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	56/178 (31.5%)	25/186 (13.4%)	RR 2.34 (1.53 to 3.58)	180 more per 1000 (from 71 more to 347 more)	⊕⊕⊕⊕ HIGH	
Insomnia											
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	10/80 (12.5%)	7/82 (8.5%)	RR 1.46 (0.59 to 3.66)	39 more per 1000 (from 35 fewer to 227 more)	⊕⊕⊕O MODERATE	
Dizziness											
4	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	137/375 (36.5%)	38/379 (10%)	RR 3.68 (2.66 to 5.08)	269 more per 1000 (from 166 more to 409 more)	⊕⊕⊕⊕ HIGH	

[1] Confidence intervals compatible with benefit or no benefit
[2] data only for 1 study

Author(s):
Date: 2010-03-15

Question: Should **Hydroxyzine vs Placebo** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Hydroxyzine	Placebo	Relative (95% CI)	Absolute		
HAM-A (Better indicated by lower values)												

3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	237	245	-	MD 3.51 lower (4.91 to 2.11 lower)	⊕⊕⊕⊕ HIGH	
Non-response												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	47/81 (58%)	58/81 (71.6%)	RR 0.81 (0.64 to 1.02)	136 fewer per 1000 (from 258 fewer to 14 more)	⊕⊕⊕O MODERATE	
Discontinuation due to adverse events												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	7/159 (4.4%)	5/169 (3%)	RR 1.48 (0.48 to 4.6)	14 more per 1000 (from 15 fewer to 107 more)	⊕⊕⊕O MODERATE	

[1] confidence intervals compatible with benefit or no benefit

Author(s):
Date: 2010-05-18

Question: Should **Quetiapine 50mg vs Placebo** be used for GAD?
Settings:
Bibliography:

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Quetiapine 50mg	Placebo	Relative (95% CI)	Absolute		
Non-response												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	186/455 (40.9%)	0%	RR 0.82 (0.71 to 0.95)	0 fewer per 1000 (from 0 fewer to 0 fewer)	⊕⊕⊕⊕ HIGH	
Non-remission												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	305/455 (67%)	0%	RR 0.92 (0.84 to 1)	0 fewer per 1000 (from 0 fewer to 0 more)	⊕⊕⊕O MODERATE	

Discontinuation due to adverse events												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	66/455 (14.5%)	0%	RR 2.62 (1.68 to 4.07)	0 more per 1000 (from 0 more to 0 more)	⊕⊕⊕⊕ HIGH	

[1] Wide confidence interval

Author(s):
Date: 2010-05-18

Question: Should **Quetiapine 150mg vs Placebo** be used for GAD?
Settings:
Bibliography:

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Quetiapine 150mg	Placebo	Relative (95% CI)	Absolute		
Non-response												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	253/678 (37.3%)	0%	RR 0.73 (0.62 to 0.85)	0 fewer per 1000 (from 0 fewer to 0 fewer)	⊕⊕⊕⊕ HIGH	
Non-remission												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	423/678 (62.4%)	0%	RR 0.86 (0.79 to 0.92)	0 fewer per 1000 (from 0 fewer to 0 fewer)	⊕⊕⊕⊕ HIGH	
Discontinuation due to adverse events												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	122/678 (18%)	0%	RR 2.97 (2.11 to 4.18)	0 more per 1000 (from 0 more to 0 more)	⊕⊕⊕⊕ HIGH	

Author(s):
Date: 2010-05-18

Question: Should **Quetiapine 300mg vs Placebo** be used for GAD?

Settings:
Bibliography:

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Quetiapine 300mg	Placebo	Relative (95% CI)	Absolute		
Non-response												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	219/448 (48.9%)	0%	RR 0.92 (0.81 to 1.05)	0 fewer per 1000 (from 0 fewer to 0 more)	⊕⊕⊕O MODERATE	
Non-remission												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	327/448 (73%)	0%	RR 1.00 (0.92 to 1.08)	0 fewer per 1000 (from 0 fewer to 0 more)	⊕⊕⊕O MODERATE	
Discontinuation due to adverse events												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	114/448 (25.4%)	31/450 (6.9%)	RR 3.69 (2.54 to 5.37)	185 more per 1000 (from 106 more to 301 more)	⊕⊕⊕O MODERATE	
								0%		0 more per 1000 (from 0 more to 0 more)		

[1] Wide confidence interval

Author(s):
Date: 2010-05-18

Question: Should **Quetiapine flexible dose vs Placebo** be used for GAD?
Settings:
Bibliography:

Quality assessment	Summary of findings			Importance
	No of patients	Effect	Quality	

No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Quetiapine flexible dose	Placebo	Relative (95% CI)	Absolute		
Non-response												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	219/448 (48.9%)	238/450 (52.9%)	RR 0.42 (0.34 to 0.51)	307 fewer per 1000 (from 259 fewer to 349 fewer)	⊕⊕⊕⊕ HIGH	
								0%		0 fewer per 1000 (from 0 fewer to 0 fewer)		
Non-remission												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	134/223 (60.1%)	198/227 (87.2%)	RR 0.69 (0.61 to 0.78)	270 fewer per 1000 (from 192 fewer to 340 fewer)	⊕⊕⊕⊕ HIGH	
								0%		0 fewer per 1000 (from 0 fewer to 0 fewer)		
Discontinuation due to adverse events												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	12/223 (5.4%)	3/227 (1.3%)	RR 4.07 (1.16 to 14.23)	41 more per 1000 (from 2 more to 175 more)	⊕⊕⊕O MODERATE	
								0%		0 more per 1000 (from 0 more to 0 more)		

[1] Wide confidence interval

Author(s):
Date: 2010-06-10

Question: Should **Escitalopram vs Paroxetine** be used for GAD?
Settings:
Bibliography:

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other	Escitalopram	Paroxetine	Relative	Absolute		

studies						considerations			(95% CI)			
HAM-A												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	0/326 (0%)	0/197 (0%) 0%	SMD -0.32 (0 to 0)	0 fewer per 1000 (from 0 fewer to 0 fewer) 0 fewer per 1000 (from 0 fewer to 0 fewer)	⊕⊕⊕⊕ HIGH	
Non-response												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	65/269 (24.2%)	56/140 (40%) 0%	RR 0.60 (0.45 to 0.81)	160 fewer per 1000 (from 76 fewer to 220 fewer) 0 fewer per 1000 (from 0 fewer to 0 fewer)	⊕⊕⊕⊕ HIGH	
Discontinuation due to adverse events												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	22/269 (8.2%)	13/140 (9.3%) 0%	RR 0.88 (0.46 to 1.69)	11 fewer per 1000 (from 50 fewer to 64 more) 0 fewer per 1000 (from 0 fewer to 0 more)	⊕⊕⊕O MODERATE	
Diarrhea												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	26/269 (9.7%)	12/140 (8.6%) 0%	RR 1.13 (0.59 to 2.17)	11 more per 1000 (from 35 fewer to 100 more) 0 more per 1000 (from 0 fewer to 0 more)	⊕⊕⊕O MODERATE	
Sexual problems												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	11/269 (4.1%)	10/140 (7.1%) 0%	RR 0.57 (0.25 to 1.32)	31 fewer per 1000 (from 54 fewer to 23 more) 0 fewer per 1000 (from 0 fewer to 0 more)	⊕⊕⊕O MODERATE	

Anxiety												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	7/269 (2.6%)	7/140 (5%) 0%	RR 0.52 (0.19 to 1.45)	24 fewer per 1000 (from 41 fewer to 23 more) 0 fewer per 1000 (from 0 fewer to 0 more)	⊕⊕⊕O MODERATE	

[1] Wide confidence interval

Author(s):
Date: 2010-03-15

Question: Should **Sertraline vs Paroxetine** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Sertraline	Paroxetine	Relative (95% CI)	Absolute		
Non-remission												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	15/25 (60%)	15/28 (53.6%)	RR 1.12 (0.7 to 1.79)	64 more per 1000 (from 161 fewer to 423 more)	⊕⊕⊕O MODERATE	
Non-response												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	8/25 (32%)	11/28 (39.3%)	RR 0.81 (0.39 to 1.7)	75 fewer per 1000 (from 240 fewer to 275 more)	⊕⊕⊕O MODERATE	

[1] Confidence intervals compatible with benefit for either intervention

Author(s):
Date: 2010-03-15

Question: Should **Escitalopram vs Venlafaxine** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					
							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Escitalopram	Venlafaxine	Relative (95% CI)	Absolute		
Non-response												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	64/131 (48.9%)	66/133 (49.6%)	RR 0.98 (0.77 to 1.26)	10 fewer per 1000 (from 114 fewer to 129 more)	⊕⊕⊕O MODERATE	
Non-remission												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	91/131 (69.5%)	93/133 (69.9%)	RR 0.99 (0.85 to 1.16)	7 fewer per 1000 (from 105 fewer to 112 more)	⊕⊕⊕O MODERATE	
Discontinuation due to adverse events												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	9/131 (6.9%)	17/133 (12.8%)	RR 0.54 (0.25 to 1.16)	59 fewer per 1000 (from 96 fewer to 20 more)	⊕⊕⊕O MODERATE	

[1] Confidence intervals compatible with benefit for either intervention
[2] Confidence interval compatible with benefit for escitalopram or no difference between interventions

Author(s):
Date: 2010-03-15

Question: Should **Duloxetine vs Venlafaxine** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					
							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Duloxetine	Venlafaxine	Relative (95% CI)	Absolute		
HAM-A (Better indicated by lower values)												

2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	320	333	-	MD 0.2 higher (0.92 lower to 1.32 higher)	⊕⊕⊕O MODERATE	
Non-response												
2	randomised trials	no serious limitations	serious[1,2]	no serious indirectness	serious[1]	none	152/320 (47.5%)	150/333 (45%)	RR 1.04 (0.78 to 1.39)	18 more per 1000 (from 99 fewer to 176 more)	⊕⊕OO LOW	
Non-remission												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[3]	none	219/320 (68.4%)	215/333 (64.6%)	RR 1.07 (0.94 to 1.21)	45 more per 1000 (from 39 fewer to 136 more)	⊕⊕⊕O MODERATE	
Sheehan Disability Scale (Better indicated by lower values)												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	320	333	-	MD 0.18 higher (0.83 lower to 1.2 higher)	⊕⊕⊕O MODERATE	
Discontinuation due to adverse events												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	43/320 (13.4%)	38/333 (11.4%)	RR 1.18 (0.78 to 1.77)	21 more per 1000 (from 25 fewer to 88 more)	⊕⊕⊕O MODERATE	
Diarrhea												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[3]	none	22/162 (13.6%)	12/164 (7.3%)	RR 1.86 (0.95 to 3.62)	63 more per 1000 (from 4 fewer to 192 more)	⊕⊕⊕O MODERATE	

[1] Confidence intervals compatible with benefit for either intervention
[2] I-squared >50%
[3] Confidence intervals compatible with benefit for venlafaxine or no difference

Author(s):
Date: 2010-03-15

Question: Should **Venlafaxine vs Pregabalin** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment	Summary of findings	Importance

							No of patients		Effect		Quality	
No of studies	**Design**	**Limitations**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Venlafaxine**	**Pregabalin**	**Relative (95% CI)**	**Absolute**		
HAM-A (Better indicated by lower values)												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	231	319	-	MD 1.35 higher (0.82 lower to 3.53 higher)	⊕⊕⊕O MODERATE	
Non-response												
2	randomised trials	no serious limitations	serious[2]	no serious indirectness	serious[3]	none	113/238 (47.5%)	134/328 (40.9%)	RR 1.13 (0.79 to 1.63)	53 more per 1000 (from 86 fewer to 257 more)	⊕⊕OO LOW	
Non-remission												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[4]	none	73/113 (64.6%)	135/207 (65.2%)	RR 0.99 (0.84 to 1.17)	7 fewer per 1000 (from 104 fewer to 111 more)	⊕⊕⊕O MODERATE	
Q-LES-Q (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[3]	none	125	121	-	SMD 0.09 lower (0.34 lower to 0.16 higher)	⊕⊕⊕O MODERATE	
Discontinuation due to adverse events												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	45/238 (18.9%)	36/328 (11%)	RR 1.72 (1.15 to 2.58)	79 more per 1000 (from 16 more to 173 more)	⊕⊕⊕⊕ HIGH	
Dizziness												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	26/238 (10.9%)	76/328 (23.2%)	RR 0.49 (0.32 to 0.74)	118 fewer per 1000 (from 60 fewer to 158 fewer)	⊕⊕⊕⊕ HIGH	
Insomnia												
2	randomised	no serious	no serious	no serious	no serious	none	20/238	9/328 (2.7%)	RR 2.8 (1.31	49 more per 1000 (from	⊕⊕⊕⊕	

	trials	limitations	inconsistency	indirectness	imprecision		(8.4%)		to 6.01)	9 more to 137 more)	HIGH	
Somnolence												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	10/238 (4.2%)	39/328 (11.9%)	RR 0.36 (0.18 to 0.72)	76 fewer per 1000 (from 33 fewer to 97 fewer)	⊕⊕⊕⊕ HIGH	
Nausea												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	63/238 (26.5%)	38/328 (11.6%)	RR 2.27 (1.57 to 3.29)	147 more per 1000 (from 66 more to 265 more)	⊕⊕⊕⊕ HIGH	

[1] Confidence intervals compatible with benefit for pregabalin or no difference
[2] I-squared > 50%
[3] Confidence intervals compatible with benefit for either intervention
[4] data from only one study

Author(s):
Date: 2010-03-15

Question: Should **Venlafaxine vs Buspirone** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Venlafaxine	Buspirone	Relative (95% CI)	Absolute		
Non-response												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	116/203 (57.1%)	55/98 (56.1%)	RR 1.02 (0.82 to 1.26)	11 more per 1000 (from 101 fewer to 146 more)	⊕⊕⊕O MODERATE	
Discontinuation due to adverse events												

1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	50/203 (24.6%)	15/98 (15.3%)	RR 1.61 (0.95 to 2.72)	93 more per 1000 (from 8 fewer to 263 more)	⊕⊕⊕O MODERATE	
Dizziness												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	38/203 (18.7%)	46/98 (46.9%)	RR 0.4 (0.28 to 0.57)	282 fewer per 1000 (from 202 fewer to 338 fewer)	⊕⊕⊕⊕ HIGH	
Nausea												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	78/203 (38.4%)	29/98 (29.6%)	RR 1.3 (0.91 to 1.85)	89 more per 1000 (from 27 fewer to 252 more)	⊕⊕⊕O MODERATE	

[1] Confidence intervals compatible with benefit for either intervention
[2] Confidence intervals compatible with benefit for buspirone or no difference

Author(s):
Date: 2010-03-15

Question: Should **Venlafaxine vs Diazepam** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Venlafaxine	Diazepam	Relative (95% CI)	Absolute		
Non-response												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	160/370 (43.2%)	39/89 (43.8%)	RR 0.99 (0.76 to 1.28)	4 fewer per 1000 (from 105 fewer to 123 more)	⊕⊕⊕O MODERATE	
Discontinuation due to adverse events												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	40/370 (10.8%)	2/89 (2.2%)	RR 4.81 (1.18 to 19.53)	86 more per 1000 (from 4 more to 416 more)	⊕⊕⊕O MODERATE	

[1] Confidence intervals compatible with benefit for either intervention
[2] Confidence intervals compatible with benefit for diazepam or no difference

Author(s):
Date: 2010-05-18
Question: Should **Quetiapine 50mg vs Paroxetine** be used for GAD?
Settings:
Bibliography:

Quality assessment							Summary of findings					
							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Quetiapine 50mg	Paroxetine	Relative (95% CI)	Absolute		
Non-response												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	76/217 (35%)	84/221 (38%)	RR 0.92 (0.72 to 1.18)	30 fewer per 1000 (from 106 fewer to 68 more)	⊕⊕⊕O MODERATE	
								0%		0 fewer per 1000 (from 0 fewer to 0 more)		
Non-remission												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	134/218 (61.5%)	150/221 (67.9%)	RR 0.91 (0.79 to 1.04)	61 fewer per 1000 (from 143 fewer to 27 more)	⊕⊕⊕O MODERATE	
								0%		0 fewer per 1000 (from 0 fewer to 0 more)		
Discontinuation due to adverse events												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	17/217 (7.8%)	26/221 (11.8%)	RR 0.67 (0.37 to 1.19)	39 fewer per 1000 (from 74 fewer to 22 more)	⊕⊕⊕O MODERATE	
								0%		0 fewer per 1000 (from 0 fewer to 0 more)		

[1] CIs compatible with benefit and no benefit

Author(s):
Date: 2010-05-18

Question: Should **Quetiapine 150mg vs Paroxetine** be used for GAD?
Settings:
Bibliography:

Quality assessment							Summary of findings					
							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Quetiapine 150mg	Paroxetine	Relative (95% CI)	Absolute		
Non-response												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	76/217 (35%)	65/218 (29.8%)	RR 1.17 (0.89 to 1.54)	51 more per 1000 (from 33 fewer to 161 more)	⊕⊕⊕O MODERATE	
								0%		0 more per 1000 (from 0 fewer to 0 more)		
Non-remission												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	134/218 (61.5%)	150/221 (67.9%)	RR 0.91 (0.79 to 1.04)	41 more per 1000 (from 61 fewer to 163 more)	⊕⊕⊕O MODERATE	
								0%		0 more per 1000 (from 0 fewer to 0 more)		
Discontinuation due to adverse events												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	17/217 (7.8%)	35/218 (16.1%)	RR 0.49 (0.28 to 0.84)	82 fewer per 1000 (from 26 fewer to 116 fewer)	⊕⊕⊕⊕ HIGH	
								0%		0 fewer per 1000 (from 0 fewer to 0 fewer)		

[1] CIs compatible with benefit and no benefit

Author(s):
Date: 2010-05-18

Question: Should **Quetiapine 150mg vs Escitalopram** be used for GAD?

Settings:
Bibliography:

Quality assessment							Summary of findings					
							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Quetiapine 150mg	Escitalopram	Relative (95% CI)	Absolute		
Non-response												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	94/203 (46.3%)	86/219 (39.3%)	RR 1.18 (0.94 to 1.47)	71 more per 1000 (from 24 fewer to 185 more)	⊕⊕⊕O MODERATE	
								0%		0 more per 1000 (from 0 fewer to 0 more)		
Non-remission												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	149/213 (70%)	140/219 (63.9%)	RR 1.09 (0.96 to 1.25)	58 more per 1000 (from 26 fewer to 160 more)	⊕⊕⊕O MODERATE	
								0%		0 more per 1000 (from 0 fewer to 0 more)		
Discontinuation due to adverse events												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	21/213 (9.9%)	39/219 (17.8%)	RR 0.55 (0.34 to 0.91)	80 fewer per 1000 (from 16 fewer to 118 fewer)	⊕⊕⊕O MODERATE	
								0%		0 fewer per 1000 (from 0 fewer to 0 fewer)		

[1] CIs compatible with benefit and no benefit

Author(s):
Date: 2010-05-18

Question: Should **Quetiapine 300mg vs Escitalopram** be used for GAD?
Settings:
Bibliography:

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Quetiapine 300mg	Escitalopram	Relative (95% CI)	Absolute		
Non-response												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	94/203 (46.3%)	101/207 (48.8%)	RR 0.95 (0.77 to 1.16)	24 fewer per 1000 (from 112 fewer to 78 more)	⊕⊕⊕O MODERATE	
								0%		0 fewer per 1000 (from 0 fewer to 0 more)		
Non-remission												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	149/213 (70%)	150/207 (72.5%)	RR 0.97 (0.85 to 1.09)	22 fewer per 1000 (from 109 fewer to 65 more)	⊕⊕⊕O MODERATE	
								0%		0 fewer per 1000 (from 0 fewer to 0 more)		
Discontinuation due to adverse events												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	21/213 (9.9%)	52/206 (25.2%)	RR 0.39 (0.24 to 0.62)	154 fewer per 1000 (from 96 fewer to 192 fewer)	⊕⊕⊕⊕ HIGH	
								0%		0 fewer per 1000 (from 0 fewer to 0 fewer)		

[1] CIs compatible with benefit and no benefit

Author(s):
Date: 2010-03-15

Question: Should **Hydroxyzine vs Buspirone** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment	Summary of findings	Importance

							No of patients		Effect		Quality	
No of studies	**Design**	**Limitations**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Hydroxyzine**	**Buspirone**	**Relative (95% CI)**	**Absolute**		
HAM-A (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	81	82	-	SMD 0.26 lower (0.57 lower to 0.05 higher)	⊕⊕⊕O MODERATE	
At least one side effect												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	32/81 (39.5%)	31/82 (37.8%)	RR 1.05 (0.71 to 1.54)	19 more per 1000 (from 110 fewer to 204 more)	⊕⊕⊕O MODERATE	

[1] Confidence intervals compatible with benefit for hydroxyzine or no difference
[2] Confidence intervals compatible with benefit for either intervention

Author(s):
Date: 2010-03-15

Question: Should **Buspirone vs Lorazepam** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	**Design**	**Limitations**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Buspirone**	**Lorazepam**	**Relative (95% CI)**	**Absolute**		
HAM-A (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	23	20	-	SMD 0.29 lower (0.89 lower to 0.32 higher)	⊕⊕⊕O MODERATE	

[1] Confidence intervals compatible with benefit for either intervention

Author(s):
Date: 2010-03-15
Question: Should **Pregabalin vs Lorazepam** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Pregabalin	Lorazepam	Relative (95% CI)	Absolute		
HAM-A (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	66	68	-	MD 1.55 lower (3.22 lower to 0.12 higher)	⊕⊕⊕O MODERATE	
Non-response												
3	randomised trials	no serious limitations	serious[2]	no serious indirectness	serious[3]	none	232/410 (56.6%)	108/200 (54%)	RR 1.04 (0.76 to 1.44)	22 more per 1000 (from 130 fewer to 238 more)	⊕⊕OO LOW	
Non-remission												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	325/410 (79.3%)	151/200 (75.5%)	RR 1.05 (0.95 to 1.15)	38 more per 1000 (from 38 fewer to 113 more)	⊕⊕⊕⊕ HIGH	
Discontinuation due to adverse events												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	59/410 (14.4%)	69/200 (34.5%)	RR 0.42 (0.31 to 0.56)	200 fewer per 1000 (from 152 fewer to 238 fewer)	⊕⊕⊕⊕ HIGH	
Dizziness												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[4]	none	62/205 (30.2%)	22/136 (16.2%)	RR 1.85 (1.18 to 2.91)	138 more per 1000 (from 29 more to 309 more)	⊕⊕⊕O MODERATE	

Somnolence											
2	randomised trials	no serious limitations	serious[2]	no serious indirectness	serious[1]	none	68/205 (33.2%)	78/136 (57.4%)	RR 0.62 (0.35 to 1.11)	218 fewer per 1000 (from 373 fewer to 63 more)	⊕⊕OO LOW	

[1] Confidence intervals compatible with benefit for pregabalin or no difference
[2] I-squared > 50%
[3] Confidence intervals compatible with benefit or no benefit
[4] Confidence intervals compatible with benefit for lorazepam or no difference

Author(s):
Date: 2010-03-15

Question: Should **Pregabalin vs Alprazolam** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Pregabalin	Alprazolam	Relative (95% CI)	Absolute		
HAM-A (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	261	88	-	SMD 0.09 lower (0.33 lower to 0.15 higher)	⊕⊕⊕O MODERATE	
Non-response												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	130/270 (48.1%)	55/93 (59.1%)	RR 0.81 (0.66 to 1)	112 fewer per 1000 (from 201 fewer to 0 more)	⊕⊕⊕O MODERATE	
Non-remission												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	203/270 (75.2%)	69/93 (74.2%)	RR 1.01 (0.88 to 1.16)	7 more per 1000 (from 89 fewer to 119 more)	⊕⊕⊕⊕ HIGH	

Discontinuation due to adverse events											
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	22/270 (8.1%)	12/93 (12.9%)	RR 0.63 (0.33 to 1.23)	48 fewer per 1000 (from 86 fewer to 30 more)	⊕⊕⊕O MODERATE	
Dizziness											
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	96/270 (35.6%)	14/93 (15.1%)	RR 2.36 (1.42 to 3.93)	205 more per 1000 (from 63 more to 441 more)	⊕⊕⊕⊕ HIGH	
Somnolence											
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	97/270 (35.9%)	39/93 (41.9%)	RR 0.86 (0.64 to 1.14)	59 fewer per 1000 (from 151 fewer to 59 more)	⊕⊕⊕O MODERATE	

[1] Confidence intervals compatible with benefit for either intervention
[2] Confidence intervals compatible with benefit for pregabalin or no difference

Comparing the effectiveness of different dosages

Author(s):
Date: 2010-05-13

Question: Should **Venlafaxine** be used for GAD?
Settings:
Bibliography: . [Intervention] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Venlafaxine	control	Relative (95% CI)	Absolute		
HAM-A - Venlafaxine 75mg vs 150mg (Better indicated by lower values)												
1	randomised	no serious	no serious	no serious	serious[1]	none	87	87	-	MD 1.5 lower (3.15 lower	⊕⊕⊕O	

	trials	limitations	inconsistency	indirectness						to 0.15 higher)	MODERATE	
Non Response - Venlafaxine 75mg vs 150mg												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	122/278 (43.9%)	48.2%	RR 0.93 (0.78 to 1.12)	34 fewer per 1000 (from 106 fewer to 58 more)	⊕⊕⊕O MODERATE	
Discontinuation due to Adverse Events - Venlafaxine 37.5mg vs 75mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	11/141 (7.8%)	12.7%	RR 0.61 (0.3 to 1.26)	50 fewer per 1000 (from 89 fewer to 33 more)	⊕⊕⊕O MODERATE	
Discontinuation due to Adverse Events - Venlafaxine 75mg vs 150mg												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	34/325 (10.5%)	12.3%	RR 0.85 (0.55 to 1.32)	18 fewer per 1000 (from 55 fewer to 39 more)	⊕⊕⊕O MODERATE	
Nausea - Venlafaxine 37.5mg vs 75mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	31/140 (22.1%)	34.3%	RR 0.65 (0.44 to 0.95)	120 fewer per 1000 (from 17 fewer to 192 fewer)	⊕⊕⊕⊕ HIGH	
Nausea - Venlafaxine 75mg vs 150mg												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	120/328 (36.6%)	43.6%	RR 0.82 (0.68 to 0.98)	78 fewer per 1000 (from 9 fewer to 140 fewer)	⊕⊕⊕⊕ HIGH	
Nausea - Venlafaxine 150mg vs 225mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	46/91 (50.5%)	46.7%	RR 1.08 (0.8 to 1.46)	37 more per 1000 (from 93 fewer to 215 more)	⊕⊕⊕O MODERATE	
Insomnia - Venlafaxine 75mg vs 150mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	16/92 (17.4%)	29.7%	RR 0.59 (0.34 to 1.01)	122 fewer per 1000 (from 196 fewer to 3 more)	⊕⊕⊕⊕ HIGH	
Insomnia - Venlafaxine 150mg vs 225mg												

1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	27/91 (29.7%)	31.1%	RR 0.95 (0.61 to 1.48)	16 fewer per 1000 (from 121 fewer to 149 more)	⊕⊕⊕O MODERATE	
Nervousness - Venlafaxine 75mg vs 150mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	10/92 (10.9%)	17.6%	RR 0.62 (0.3 to 1.29)	67 fewer per 1000 (from 123 fewer to 51 more)	⊕⊕⊕O MODERATE	
Nervousness - Venlafaxine 150mg vs 225mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	16/91 (17.6%)	10%	RR 1.76 (0.82 to 3.77)	76 more per 1000 (from 18 fewer to 277 more)	⊕⊕⊕O MODERATE	
Dizziness - Venlafaxine 37.5mg vs 75mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	21/140 (15%)	21.6%	RR 0.69 (0.42 to 1.15)	67 fewer per 1000 (from 125 fewer to 32 more)	⊕⊕⊕O MODERATE	
Dizziness - Venlafaxine 75mg vs 150mg												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	70/328 (21.3%)	22%	RR 0.82 (0.56 to 1.2)	40 fewer per 1000 (from 97 fewer to 44 more)	⊕⊕⊕O MODERATE	
Dizziness - Venlafaxine 150mg vs 225mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	20/91 (22%)	7.6%	RR 2.91 (1.6 to 5.29)	145 more per 1000 (from 46 more to 326 more)	⊕⊕⊕⊕ HIGH	
Asthenia - Venlafaxine 75mg vs 150mg												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	24/194 (12.4%)	17.5%	RR 0.7 (0.43 to 1.13)	53 fewer per 1000 (from 100 fewer to 23 more)	⊕⊕⊕O MODERATE	
Asthenia - Venlafaxine 150mg vs 225mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	12/91 (13.2%)	21.1%	RR 0.62 (0.32 to 1.21)	80 fewer per 1000 (from 143 fewer to 44 more)	⊕⊕⊕O MODERATE	

[1] Wide confidence interval

[2] No explanation was provided

Author(s):
Date: 2010-05-13

Question: Should **Escitalopram** be used for GAD?
Settings:
Bibliography: . [Intervention] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Escitalopram	control	Relative (95% CI)	Absolute		
HAM-A - Escitalopram 5mg vs 10mg (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	134	134	-	SMD 0.23 higher (0.01 lower to 0.47 higher)	⊕⊕⊕O MODERATE	
HAM-A - Escitalopram 10mg vs 20mg (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	134	132	-	SMD 0.07 lower (0.31 lower to 0.17 higher)	⊕⊕⊕O MODERATE	
Discontinuation due to Adverse events - Escitalopram 5mg vs 10mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	7/134 (5.2%)	5.9%	RR 0.89 (0.33 to 2.38)	6 fewer per 1000 (from 40 fewer to 81 more)	⊕⊕⊕O MODERATE	
Discontinuation due to Adverse events - Escitalopram 10mg vs 20mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	8/136 (5.9%)	10.5%	RR 0.56 (0.24 to 1.29)	46 fewer per 1000 (from 80 fewer to 30 more)	⊕⊕⊕O MODERATE	
Nausea - Escitalopram 5mg vs 10mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	20/134 (14.9%)	20.6%	RR 0.72 (0.43 to 1.22)	58 fewer per 1000 (from 117 fewer to 45 more)	⊕⊕⊕O MODERATE	

Nausea - Escitalopram 10mg vs 20mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	28/136 (20.6%)	21.1%	RR 0.98 (0.61 to 1.56)	4 fewer per 1000 (from 82 fewer to 118 more)	⊕⊕⊕O MODERATE	
Fatigue - Escitalopram 5mg vs 10mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	11/134 (8.2%)	10.3%	RR 0.8 (0.38 to 1.69)	21 fewer per 1000 (from 64 fewer to 71 more)	⊕⊕⊕O MODERATE	
Fatigue - Escitalopram 10mg vs 20mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	14/136 (10.3%)	16.5%	RR 0.62 (0.33 to 1.16)	63 fewer per 1000 (from 111 fewer to 26 more)	⊕⊕⊕O MODERATE	
Headache - Escitalopram 5mg vs 10mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	21/134 (15.7%)	25%	RR 0.63 (0.38 to 1.02)	93 fewer per 1000 (from 155 fewer to 5 more)	⊕⊕⊕O MODERATE	
Headache - Escitalopram 10mg vs 20mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	34/136 (25%)	15.8%	RR 1.58 (0.97 to 2.58)	92 more per 1000 (from 5 fewer to 250 more)	⊕⊕⊕O MODERATE	
Insomnia - Escitalopram 5mg vs 10mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	12/134 (9%)	12.5%	RR 0.72 (0.36 to 1.44)	35 fewer per 1000 (from 80 fewer to 55 more)	⊕⊕⊕O MODERATE	
Insomnia - Escitalopram 10mg vs 20mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	17/136 (12.5%)	10.5%	RR 1.19 (0.61 to 2.31)	20 more per 1000 (from 41 fewer to 138 more)	⊕⊕⊕O MODERATE	
Somnolence - Escitalopram 5mg vs 10mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	10/134 (7.5%)	3.7%	RR 2.03 (0.71 to 5.78)	38 more per 1000 (from 11 fewer to 177 more)	⊕⊕⊕O MODERATE	

Somnolence - Escitalopram 10mg vs 20mg											
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	5/136 (3.7%)	7.5%	RR 0.49 (0.17 to 1.39)	38 fewer per 1000 (from 62 fewer to 29 more)	⊕⊕⊕O MODERATE	
Anxiety - Escitalopram 5mg vs 10mg											
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	9/134 (6.7%)	2.2%	RR 3.04 (0.84 to 11)	45 more per 1000 (from 4 fewer to 220 more)	⊕⊕⊕O MODERATE	
Anxiety - Escitalopram 10mg vs 20mg											
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	3/136 (2.2%)	3%	RR 0.73 (0.17 to 3.21)	8 fewer per 1000 (from 25 fewer to 66 more)	⊕⊕⊕O MODERATE	
Dizziness - Escitalopram 5mg vs 10mg											
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	6/134 (4.5%)	10.3%	RR 0.43 (0.17 to 1.1)	59 fewer per 1000 (from 85 fewer to 10 more)	⊕⊕⊕O MODERATE	
Dizziness - Escitalopram 10mg vs 20mg											
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	14/136 (10.3%)	9%	RR 1.14 (0.55 to 2.37)	13 more per 1000 (from 41 fewer to 123 more)	⊕⊕⊕O MODERATE	

[1] Wide confidence interval
[2] No explanation was provided

Author(s):
Date: 2010-05-13

Question: Should **Paroxetine** be used for GAD?
Settings:
Bibliography: . [Intervention] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other	Paroxetine	control	Relative	Absolute		

studies						considerations			(95% CI)			
HAM-A - Paroxetine 20mg vs 40mg (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	188	197	-	MD 0.3 lower (2.02 lower to 1.42 higher)	⊕⊕⊕O MODERATE	
HADS-A - Paroxetine 20mg vs 40mg (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	188	197	-	MD 0.3 lower (2.02 lower to 1.42 higher)	⊕⊕⊕O MODERATE	
Non-response - Paroxetine 20mg vs 40mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	72/189 (38.1%)	32%	RR 1.19 (0.91 to 1.57)	61 more per 1000 (from 29 fewer to 182 more)	⊕⊕⊕O MODERATE	
Non-remission - Paroxetine 20mg vs 40mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	132/189 (69.8%)	64%	RR 1.09 (0.95 to 1.26)	58 more per 1000 (from 32 fewer to 166 more)	⊕⊕⊕O MODERATE	
Discontinuation due to Adverse Events - Paroxetine 20mg vs 40mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	19/189 (10.1%)	12.2%	RR 0.83 (0.47 to 1.46)	21 fewer per 1000 (from 65 fewer to 56 more)	⊕⊕⊕O MODERATE	
Nausea - Paroxetine 20mg vs 40mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	36/189 (19%)	16.8%	RR 1.14 (0.74 to 1.74)	24 more per 1000 (from 44 fewer to 124 more)	⊕⊕⊕O MODERATE	
Somnolence - Paroxetine 20mg vs 40mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	38/189 (20.1%)	17.8%	RR 1.13 (0.75 to 1.71)	23 more per 1000 (from 44 fewer to 126 more)	⊕⊕⊕O MODERATE	
Decreased libido - Paroxetine 20mg vs 40mg												

1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	24/189 (12.7%)	10.7%	RR 1.19 (0.69 to 2.07)	20 more per 1000 (from 33 fewer to 114 more)	⊕⊕⊕O MODERATE	
Decreased appetite - Paroxetine 20mg vs 40mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	13/189 (6.9%)	6.1%	RR 1.13 (0.53 to 2.41)	8 more per 1000 (from 29 fewer to 86 more)	⊕⊕⊕O MODERATE	

[1] Wide confidence interval

Author(s):
Date: 2010-05-13

Question: Should **Duloxetine** be used for GAD?
Settings:
Bibliography: . [Intervention] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Duloxetine	control	Relative (95% CI)	Absolute		
HAM-A - Duloxetine 20mg vs 60-120mg (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	83	151	-	MD 0.6 higher (1.09 lower to 2.29 higher)	⊕⊕⊕O MODERATE	
HAM-A - Duloxetine 60mg vs 120mg (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	165	169	-	MD 0.34 lower (2.47 lower to 1.79 higher)	⊕⊕⊕O MODERATE	
HADS-A - Duloxetine 20mg vs 60-120mg (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	83	151	-	MD 0.7 higher (0.19 lower to 1.59 higher)	⊕⊕⊕O MODERATE	
HADS-A - Duloxetine 60mg vs 120mg (Better indicated by lower values)												

1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	160	163	-	MD 0.18 lower (1.2 lower to 0.84 higher)	⊕⊕⊕O MODERATE	
Non-response - Duloxetine 20mg vs 60-120mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	34/84 (40.5%)	38%	RR 1.07 (0.77 to 1.48)	27 more per 1000 (from 87 fewer to 182 more)	⊕⊕⊕O MODERATE	
Non-response - Duloxetine 60mg vs 120mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	71/168 (42.3%)	44.1%	RR 0.96 (0.75 to 1.22)	18 fewer per 1000 (from 110 fewer to 97 more)	⊕⊕⊕O MODERATE	
Non-remission - Duloxetine 60mg vs 120mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	116/168 (69%)	61.8%	RR 1.12 (0.96 to 1.31)	74 more per 1000 (from 25 fewer to 192 more)	⊕⊕⊕O MODERATE	
Sheehan Disability Scale - Duloxetine 60mg vs 120mg (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	156	160	-	MD 0.99 lower (2.9 lower to 0.92 higher)	⊕⊕⊕O MODERATE	
Q-LES-Q-SF - Duloxetine 60mg vs 120mg (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	136	129	-	MD 0.18 higher (2.21 lower to 2.57 higher)	⊕⊕⊕O MODERATE	
Discontinuation due to Adverse Events - Duloxetine 20mg vs 60-120mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	4/84 (4.8%)	12.7%	RR 0.38 (0.13 to 1.06)	79 fewer per 1000 (from 110 fewer to 8 more)	⊕⊕⊕O MODERATE	
Discontinuation due to Adverse Events - Duloxetine 60mg vs 120mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	19/168 (11.3%)	15.3%	RR 0.74 (0.43 to 1.28)	40 fewer per 1000 (from 87 fewer to 43 more)	⊕⊕⊕O MODERATE	
Discontinuation due to Any Reason - Duloxetine 60mg vs 120mg												

1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	33/168 (19.6%)	27.1%	RR 0.73 (0.49 to 1.08)	73 fewer per 1000 (from 138 fewer to 22 more)	⊕⊕⊕O MODERATE	

[1] Wide confidence interval

Author(s):
Date: 2010-05-13
Question: **Pregablin** for [health problem]
Settings:
Bibliography: . [Intervention] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Pregablin	control	Relative (95% CI)	Absolute		
HAM-A - Pregablin 150mg vs 600mg (Better indicated by lower values)												
1	no methodology chosen	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	69	61	-	MD 2.28 higher (0.58 to 3.98 higher)	⊕⊕⊕O MODERATE	
HAM-A - Pregablin 200mg vs 400mg (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	78	89	-	MD 0.5 higher (1.07 lower to 2.07 higher)	⊕⊕⊕O MODERATE	
HAM-A - Pregablin 300mg vs 450mg (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	89	87	-	MD 1.2 lower (2.77 lower to 0.37 higher)	⊕⊕⊕O MODERATE	
HAM-A - Pregablin 400mg vs 450mg (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	89	88	-	MD 0.5 lower (2.07 lower to 1.07 higher)	⊕⊕⊕O MODERATE	
HAM-A - Pregablin 400mg vs 600mg (Better indicated by lower values)												

1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	94	104	-	MD 3.1 lower (4.69 to 1.51 lower)	⊕⊕⊕⊕ HIGH	
HAM-A - Pregablin 450mg vs 600mg (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	87	85	-	MD 0.8 higher (0.77 lower to 2.37 higher)	⊕⊕⊕O MODERATE	
HADS-A - Pregablin 400mg vs 600mg (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	94	104	-	MD 0.4 lower (1.41 lower to 0.61 higher)	⊕⊕⊕O MODERATE	
Non Response - Pregablin 300mg vs 450mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	35/91 (38.5%)	53.3%	RR 0.72 (0.52 to 1)	149 fewer per 1000 (from 256 fewer to 0 more)	⊕⊕⊕⊕ HIGH	
Non Response - Pregablin 450mg vs 600mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	48/90 (53.3%)	47.2%	RR 1.13 (0.84 to 1.51)	61 more per 1000 (from 76 fewer to 241 more)	⊕⊕⊕O MODERATE	
Discontinuation due to Adverse Events - Pregablin 150mg vs 600mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	7/69 (10.1%)	28.6%	RR 0.36 (0.16 to 0.79)	183 fewer per 1000 (from 60 fewer to 240 fewer)	⊕⊕⊕⊕ HIGH	
Discontinuation due to Adverse Events - Pregablin 300mg vs 450mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	3/91 (3.3%)	7.8%	RR 0.42 (0.11 to 1.59)	45 fewer per 1000 (from 69 fewer to 46 more)	⊕⊕⊕O MODERATE	
Discontinuation due to Adverse Events - Pregablin 400mg vs 600mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	6/97 (6.2%)	13.6%	RR 0.45 (0.18 to 1.12)	75 fewer per 1000 (from 112 fewer to 16 more)	⊕⊕⊕O MODERATE	

Discontinuation due to Adverse Events - Pregablin 450mg vs 600mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	7/90 (7.8%)	14.6%	RR 0.53 (0.22 to 1.27)	69 fewer per 1000 (from 114 fewer to 39 more)	⊕⊕⊕O MODERATE	
Discontinuation for any reason - Pregablin 400mg vs 600mg												
1	no methodology chosen					none	16/97 (16.5%)	26.4%	RR 0.63 (0.36 to 1.08)	98 fewer per 1000 (from 169 fewer to 21 more)		
Somnolence - Pregablin 150mg vs 600mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	10/69 (14.5%)	35.7%	RR 0.41 (0.21 to 0.78)	211 fewer per 1000 (from 79 fewer to 282 fewer)	⊕⊕⊕⊕ HIGH	
Somnolence - Pregablin 200mg vs 400mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	24/78 (30.8%)	37.1%	RR 0.83 (0.54 to 1.27)	63 fewer per 1000 (from 171 fewer to 100 more)	⊕⊕⊕O MODERATE	
Somnolence - Pregablin 300mg vs 450mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	35/91 (38.5%)	40%	RR 0.96 (0.67 to 1.38)	16 fewer per 1000 (from 132 fewer to 152 more)	⊕⊕⊕O MODERATE	
Somnolence - Pregablin 400mg vs 450mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	33/89 (37.1%)	23.9%	RR 1.55 (0.98 to 2.46)	131 more per 1000 (from 5 fewer to 349 more)	⊕⊕⊕⊕ HIGH	
Somnolence - Pregablin 400mg vs 600mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	13/97 (13.4%)	13.6%	RR 0.98 (0.49 to 1.96)	3 fewer per 1000 (from 69 fewer to 131 more)	⊕⊕⊕O MODERATE	
Somnolence - Pregablin 450mg vs 600mg												
1	randomised trials	no serious	no serious	no serious	serious[1]	none	36/90	41.6%	RR 0.96 (0.68	17 fewer per 1000 (from	⊕⊕⊕O	

		limitations	inconsistency	indirectness			(40%)		to 1.37)	133 fewer to 154 more)	MODERATE	
Dizziness - Pregablin 150mg vs 600mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	16/69 (23.2%)	38.6%	RR 0.6 (0.36 to 1.01)	154 fewer per 1000 (from 247 fewer to 4 more)	⊕⊕⊕O MODERATE	
Dizziness - Pregablin 200mg vs 400mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	27/78 (34.6%)	49.4%	RR 0.7 (0.48 to 1.01)	148 fewer per 1000 (from 257 fewer to 5 more)	⊕⊕⊕O MODERATE	
Dizziness - Pregablin 300mg vs 450mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	37/91 (40.7%)	37.8%	RR 1.08 (0.75 to 1.55)	30 more per 1000 (from 94 fewer to 208 more)	⊕⊕⊕O MODERATE	
Dizziness - Pregablin 400mg vs 450mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	44/89 (49.4%)	42.1%	RR 1.18 (0.85 to 1.62)	76 more per 1000 (from 63 fewer to 261 more)	⊕⊕⊕O MODERATE	
Dizziness - Pregablin 400mg vs 600mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	22/97 (22.7%)	26.4%	RR 0.86 (0.53 to 1.39)	37 fewer per 1000 (from 124 fewer to 103 more)	⊕⊕⊕O MODERATE	
Dizziness - Pregablin 450mg vs 600mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	34/90 (37.8%)	39.3%	RR 0.96 (0.66 to 1.39)	16 fewer per 1000 (from 134 fewer to 153 more)	⊕⊕⊕O MODERATE	
Nausea - Pregablin 150mg vs 600mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	5/69 (7.2%)	8.6%	RR 0.85 (0.27 to 2.64)	13 fewer per 1000 (from 63 fewer to 141 more)	⊕⊕⊕O MODERATE	

Nausea - Pregablin 300mg vs 450mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	10/91 (11%)	14.4%	RR 0.76 (0.35 to 1.65)	35 fewer per 1000 (from 94 fewer to 94 more)	⊕⊕⊕O MODERATE	
Nausea - Pregablin 400mg vs 600mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	9/97 (9.3%)	12.7%	RR 0.73 (0.33 to 1.61)	34 fewer per 1000 (from 85 fewer to 77 more)	⊕⊕⊕O MODERATE	
Nausea - Pregablin 450mg vs 600mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	13/90 (14.4%)	11.2%	RR 1.29 (0.59 to 2.78)	32 more per 1000 (from 46 fewer to 199 more)	⊕⊕⊕O MODERATE	
Headache - Pregablin 150mg vs 600mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	13/69 (18.8%)	21.4%	RR 0.88 (0.45 to 1.71)	26 fewer per 1000 (from 118 fewer to 152 more)	⊕⊕⊕O MODERATE	
Headache - Pregablin 400mg vs 600mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	7/97 (7.2%)	8.2%	RR 0.88 (0.34 to 2.28)	10 fewer per 1000 (from 54 fewer to 105 more)	⊕⊕⊕O MODERATE	
Insomnia - Pregablin 400mg vs 600mg												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	1/97 (1%)	2.7%	RR 0.38 (0.04 to 3.57)	17 fewer per 1000 (from 26 fewer to 69 more)	⊕⊕⊕O MODERATE	

[1] Wide confidence interval

Maintenance treatment

Author(s):
Date: 2010-05-18

Question: Should **Pregabalin versus Placebo** be used for GAD?

Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Pregabalin versus Placebo	control	Relative (95% CI)	Absolute		
Relapse												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	71/168 (42.3%)	65.3%	RR 0.65 (0.53 to 0.8)	229 fewer per 1000 (from 131 fewer to 307 fewer)	⊕⊕⊕O MODERATE	
HAM-A (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	168	170	-	SMD 0.52 lower (0.73 to 0.3 lower)	⊕⊕⊕O MODERATE	
Discontinuation for any reason												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	61/168 (36.3%)	22.4%	RR 1.62 (1.15 to 2.29)	139 more per 1000 (from 34 more to 289 more)	⊕⊕⊕O MODERATE	
Discontinuation due to adverse events												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	10/168 (6%)	2.4%	RR 2.53 (0.81 to 7.91)	37 more per 1000 (from 5 fewer to 166 more)	⊕⊕⊕O MODERATE	

[1] Only one study
[2] Wide confidence interval

Author(s):
Date: 2010-05-18
Question: Should **Duloxetine versus Placebo** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Duloxetine versus Placebo	control	Relative (95% CI)	Absolute		
Relapse												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	28/204 (13.7%)	41.8%	RR 0.33 (0.22 to 0.48)	280 fewer per 1000 (from 217 fewer to 326 fewer)	⊕⊕⊕O MODERATE	
Non-remission												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	68/213 (31.9%)	60.7%	RR 0.53 (0.42 to 0.66)	285 fewer per 1000 (from 206 fewer to 352 fewer)	⊕⊕⊕O MODERATE	
HAM-A (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1,2,3]	none	213	211	-	SMD 0.7 lower (0.9 to 0.51 lower)	⊕⊕⊕O MODERATE	
Q-LES-Q-SF (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	209	198	-	SMD 0.74 lower (0.94 to 0.53 lower)	⊕⊕⊕O MODERATE	
Discontinuation for any reason												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	49/216 (22.7%)	45.5%	RR 0.5 (0.37 to 0.66)	228 fewer per 1000 (from 155 fewer to 287 fewer)	⊕⊕⊕O MODERATE	
Discontinuation due to adverse events												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[3]	none	4/216 (1.9%)	0.9%	RR 1.97 (0.37 to 10.65)	9 more per 1000 (from 6 fewer to 87 more)	⊕⊕⊕O MODERATE	

[1] High drop out
[2] Only one study
[3] Wide confidence interval

Author(s):
Date: 2010-05-18
Question: Should **Paroxetine versus Placebo** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Paroxetine versus Placebo	control	Relative (95% CI)	Absolute		
Relapse												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1,2]	none	30/274 (10.9%)	40.1%	RR 0.27 (0.19 to 0.39)	293 fewer per 1000 (from 245 fewer to 325 fewer)	⊕⊕⊕O MODERATE	
Non-remission												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1,2]	none	74/274 (27%)	65.5%	RR 0.41 (0.33 to 0.51)	386 fewer per 1000 (from 321 fewer to 439 fewer)	⊕⊕⊕O MODERATE	
HAM-A (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1,2]	none	274	287	-	SMD 1.03 lower (1.2 to 0.85 lower)	⊕⊕⊕O MODERATE	
Discontinuation for any reason												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1,2]	none	62/278 (22.3%)	49%	RR 0.46 (0.36 to 0.58)	265 fewer per 1000 (from 206 fewer to 314 fewer)	⊕⊕⊕O MODERATE	
Discontinuation due to adverse events												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	11/278 (4%)	3.1%	RR 1.27 (0.53 to 3.01)	8 more per 1000 (from 15 fewer to 62 more)	⊕⊕⊕O MODERATE	

[1] Large drop out
[2] Only one study

Author(s):
Date: 2010-05-18

Question: Should **Escitalopram versus Placebo** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Escitalopram versus Placebo	control	Relative (95% CI)	Absolute		
Relapse												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	38/187 (20.3%)	56.4%	RR 0.36 (0.26 to 0.49)	361 fewer per 1000 (from 288 fewer to 417 fewer)	⊕⊕⊕O MODERATE	
Discontinuation for any reason												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	71/187 (38%)	72.3%	RR 0.52 (0.43 to 0.64)	347 fewer per 1000 (from 260 fewer to 412 fewer)	⊕⊕⊕O MODERATE	
Discontinuation due to adverse events												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	13/187 (7%)	8.5%	RR 0.82 (0.4 to 1.65)	15 fewer per 1000 (from 51 fewer to 55 more)	⊕⊕⊕O MODERATE	

[1] Only one study

Author(s):
Date: 2010-05-18

Question: Should **Quetiapine vs Placebo** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment	Summary of findings			Importance
	No of patients	Effect	Quality	

No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Quetiapine	Placebo	Relative (95% CI)	Absolute		
Time to anxiety event												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	0/0 (0%)	0%	HR 0.19 (0.12 to 0.32)	0 fewer per 1000 (from 0 fewer to 0 fewer)	⊕⊕⊕O MODERATE	
HAMA (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	216	216	-	SMD 0.61 lower (0.81 to 0.42 lower)	⊕⊕⊕O MODERATE	
QLESQ (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	216	216	-	SMD 0.23 lower (0.42 to 0.04 lower)	⊕⊕⊕O MODERATE	
Discontinuation due to adverse events												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	5/216 (2.3%)	2.8%	RR 0.83 (0.26 to 2.69)	5 fewer per 1000 (from 21 fewer to 47 more)	⊕⊕⊕O MODERATE	

[1] Only one study

Augmentation

Author(s):
Date: 2010-05-26

Question: Should Augmentation: **Olanzapine vs Placebo** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					
							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Augmentation: Olanzapine	Placebo	Relative (95% CI)	Absolute		

HAM-A (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	very serious[1]	none	9	12	-	SMD 0.3 lower (1.17 lower to 0.57 higher)	⊕⊕OO LOW	
Non-remission												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	very serious[1]	none	8/12 (66.7%)	11/12 (91.7%)	RR 0.73 (0.47 to 1.12)	247 fewer per 1000 (from 486 fewer to 110 more)	⊕⊕OO LOW	
								91.7%		248 fewer per 1000 (from 486 fewer to 110 more)		
Non-response												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	very serious[1]	none	7/12 (58.3%)	11/12 (91.7%)	RR 0.64 (0.38 to 1.06)	330 fewer per 1000 (from 568 fewer to 55 more)	⊕⊕OO LOW	
								91.7%		330 fewer per 1000 (from 569 fewer to 55 more)		
Discontinuation due to adverse events												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	very serious[1]	none	4/12 (33.3%)	8.3%	RR 4 (0.52 to 30.76)	249 more per 1000 (from 40 fewer to 2470 more)	⊕⊕OO LOW	

[1] 1 small study

Author(s):
Date: 2010-05-26

Question: Should Augmentation: **Risperidone vs Placebo** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other	Augmentation:	Placebo	Relative	Absolute		

studies						considerations	Risperidone		(95% CI)			
HAM-A (Better indicated by lower values)												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	215	214	-	SMD 0.27 lower (0.9 lower to 0.36 higher)	⊕⊕⊕O MODERATE	
Non-remission												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	158/196 (80.6%)	82%	RR 0.98 (0.89 to 1.08)	16 fewer per 1000 (from 90 fewer to 66 more)	⊕⊕⊕⊕ HIGH	
Non-response												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	117/196 (59.7%)	117/194 (60.3%) 60.3%	RR 0.99 (0.84 to 1.16)	6 fewer per 1000 (from 96 fewer to 96 more) 6 fewer per 1000 (from 96 fewer to 96 more)	⊕⊕⊕O MODERATE	
Discontinuation due to adverse events												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	24/215 (11.2%)	11/214 (5.1%) 5.1%	RR 2.17 (1.09 to 4.32)	60 more per 1000 (from 5 more to 171 more) 60 more per 1000 (from 5 more to 169 more)	⊕⊕⊕O MODERATE	

[1] CIs compatible with benefit and no benefit

Author(s):
Date: 2010-05-26

Question: Should Augmentation: **Quetiapine vs Placebo** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Augmentation: Quetiapine	Placebo	Relative (95% CI)	Absolute		
HAM-A (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	very serious[1]	none	11	11	-	SMD 0.24 lower (1.08 lower to 0.6 higher)	⊕⊕OO LOW	
Non-remission												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	very serious[1]	none	7/11 (63.6%)	9/11 (81.8%)	RR 0.78 (0.46 to 1.32)	180 fewer per 1000 (from 442 fewer to 262 more)	⊕⊕OO LOW	
								81.8%		180 fewer per 1000 (from 442 fewer to 262 more)		
Discontinuation due to adverse events												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	very serious[1]	none	4/11 (36.4%)	1/11 (9.1%)	RR 4 (0.53 to 30.33)	273 more per 1000 (from 43 fewer to 2666 more)	⊕⊕OO LOW	
								9.1%		273 more per 1000 (from 43 fewer to 2669 more)		

[1] 1 small study

Author(s):
Date: 2010-05-26

Question: Should Augmentation: **Antipsychotics vs Placebo** be used for GAD?
Settings:
Bibliography: . [Intervention A] versus [intervention B] for [health problem]. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Quality assessment							Summary of findings					Importance
							No of patients		Effect		Quality	
No of	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other	Augmentation:	Placebo	Relative	Absolute		

studies						considerations	Antipsychotics		(95% CI)			
HAM-A (Better indicated by lower values)												
5	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	245	244	-	MD 1.04 lower (2.49 lower to 0.41 higher)	⊕⊕⊕O MODERATE	
Non-response												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	124/208 (59.6%)	128/206 (62.1%) 76%	RR 0.85 (0.56 to 1.28)	93 fewer per 1000 (from 273 fewer to 174 more) 114 fewer per 1000 (from 334 fewer to 213 more)	⊕⊕⊕O MODERATE	
Non-remission												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	173/219 (79%)	179/217 (82.5%) 82%	RR 0.93 (0.78 to 1.09)	58 fewer per 1000 (from 181 fewer to 74 more) 57 fewer per 1000 (from 180 fewer to 74 more)	⊕⊕⊕O MODERATE	
Discontinuation due to adverse events												
5	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	37/279 (13.3%)	13/258 (5%) 5.2%	RR 2.53 (1.38 to 4.64)	77 more per 1000 (from 19 more to 183 more) 80 more per 1000 (from 20 more to 189 more)	⊕⊕⊕⊕ HIGH	

[1] CIs compatible with benefit for treatment or placebo

[2] 1 small study and 1 large study