NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Single Technology Appraisal

Quetiapine for the treatment of generalised anxiety disorder

Final scope

Remit/appraisal objective

To appraise the clinical and cost effectiveness of quetiapine within its licensed indication for the treatment of generalised anxiety disorder.

Background

Generalised anxiety disorder (GAD) is a chronic illness characterised by excessive worry and tension about everyday events and problems that occur most days, for at least six months. The DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, Fourth Text Revision) defines generalised anxiety disorder as anxiety and worry accompanied by at least three additional symptoms including restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension and disturbed sleep. Additional symptoms of GAD include trembling, twitching, feeling shaky, muscle aches, soreness and somatic symptoms of sweating nausea and diarrhoea.

GAD is associated with increased use of mental health services, especially for patients with co-morbidities. It has been estimated that over 90% of people with GAD have co-morbidities, including depression, dysthymia (a chronic but less severe form of depression), somatisation (a chronic condition in which physical symptoms are caused by psychological problems), other anxiety disorders, bipolar disorder or substance abuse.

In 2009 the prevalence of GAD was estimated to be 44 cases per 1000 with higher prevalence in women compared to men. In Europe the illness has a lifetime prevalence of 4.3-5.9% and a probable 12 month prevalence of 1.2-1.9%.

Current NICE guidance (CG22) recommends a range of pharmacological, psychological and self-help therapies for the treatment of GAD. Immediate management of GAD may include the use of benzodiazepines, sedative antihistamines, problem solving and self-help. The guideline maintains that benzodiazepines should not be used beyond 2-4 weeks. The longer-term care of individuals with GAD includes psychological therapy, antidepressant medication and self-help (based on cognitive behavioural therapy (CBT) principles). If, following the course of a treatment, there has been no significant improvement, venlafaxine can be prescribed. If symptoms persist, then referral to specialist mental health services should be offered.

The technology

Quetiapine (Seroquel XL, AstraZeneca) is an atypical antipsychotic agent. It acts on the norepinephrine, serotonin and dopamine neurotransmitter systems which are all believed to be associated with affective disorders. Quetiapine and the active human plasma metabolite, N-desalkyl quetiapine exhibit affinity for brain serotonin (5HT2) and dopamine D1- and D2-receptors. It is administered orally.

Quetiapine does not currently have a marketing authorisation in the UK for the treatment of people with GAD. Quetiapine has been studied in clinical trials in comparison with placebo and in comparison with escitalopram and also paroxetine. Quetiapine has also been investigated as a monotherapy for maintenance therapy in comparison with placebo.

Intervention(s)	Quetiapine
Population(s)	Adults with generalised anxiety disorder
Comparators	• Selective Serotonin Reuptake Inhibitors (escitalopram, paroxetine, citalopram, fluoxetine, fluvoxamine, sertraline) • Dual reuptake inhibitors (duloxetine, venlafaxine) • Noradrenaline and Specific Serotoninergic Antidepressants (mirtazapine) • Pregabalin • Cognitive behavioural therapy (CBT)
Outcomes	The outcome measures to be considered include: • anxiety (including change from baseline) • response rate • remission rate • rate of relapse, time to relapse • depressive symptoms (including change from baseline) • quality of sleep • adverse effects of treatment • health-related quality of life

Economic analysis	The reference case stipulates that the cost effectiveness of treatments should be expressed in terms of incremental cost per quality-adjusted life year. The reference case stipulates that the time horizon for estimating clinical and cost effectiveness should be sufficiently long to reflect any differences in costs or outcomes between the technologies being compared. Costs will be considered from an NHS and Personal Social Services perspective.
Other considerations	Evidence permitting, subgroups will be considered. These may include subgroups by co-morbidities and prior therapies. Consideration will be given to the place of the technology in the pathway of care when the marketing authorisation is confirmed. Guidance will only be issued in accordance with the marketing authorisation.
Related NICE recommendations	Related Technology Appraisals: Technology Appraisal No.97, Feb 2006, Computerised cognitive behaviour therapy for depression and anxiety (Review of Technology Appraisal 51). To be updated as part of the update of clinical guideline No. CG22. Related Guidelines: Clinical Guideline No. 22, April 2007, 'Management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder), in adults in primary, secondary and community care'. Anticipated review date January 2011.