



Quetiapine (Seroquel) PBS listed for acute mania



The Pharmaceutical Benefits Scheme (PBS) listing of quetiapine (Seroquel) was extended on 1 December 2007 to include acute mania associated with bipolar disorder. The streamlined authority-required listing allows an episode of acute mania to be treated for up to 6 months. The Pharmaceutical Benefits Advisory Committee (PBAC) found that quetiapine was as effective as olanzapine (Zyprexa) for no greater cost.^{*1} The existing streamlined authority listing of quetiapine for schizophrenia remains unchanged.

Quetiapine, olanzapine and risperidone (Risperdal) have distinct and non-interchangeable PBS authority listings for use in bipolar disorder (see [Table 1](#)). The differences in PBS listings mean that patients may need to switch drugs if switching from monotherapy to combination therapy, or if switching from acute to maintenance treatment. Quetiapine is the only atypical antipsychotic PBS listed for monotherapy in acute mania. On the other hand, if an atypical antipsychotic is required as an adjunct to a mood stabiliser (e.g. carbamazepine, lithium or valproate) in acute mania, risperidone is the only PBS-listed option. Note that, of the atypical antipsychotics, only olanzapine is available on the PBS for continuing maintenance therapy to prevent relapses of mania or bipolar depression.

* While olanzapine has a TGA-approved indication for monotherapy of acute mania associated with bipolar I disorder, it is not available on the PBS for this indication because the manufacturer has not sought a listing.

Table 1. Indications and PBS listings for atypical antipsychotic drugs in bipolar I disorder

Drug	TGA-approved indication(s)		PBS listing	
	Acute mania	Maintenance	Acute mania	Maintenance
Olanzapine (Zyprexa)	Yes	Yes	No	Yes
Quetiapine (Seroquel)	Yes (monotherapy)	No	Yes (monotherapy), streamlined	No
Risperidone (Risperdal)	Yes	No	Yes (adjunct), streamlined	No
Ziprasidone (Zeldox)	Yes (monotherapy)	No	No	No

Place in therapy

Recent UK NICE guidelines give olanzapine, quetiapine, risperidone, valproate and lithium as first-line treatment options for acute mania in people who are not currently taking an antipsychotic or mood stabiliser (carbamazepine is not licensed in the UK for acute mania and ziprasidone is not registered).² While PBS listings may constrain the choice, other points to consider in choosing a drug include:

- whether the same drug can be used in future prophylactic treatment
- differences in adverse-effect profiles
- that an antipsychotic is preferable if there are severe manic symptoms or marked behavioural disturbances
- previous response to therapy
- avoiding valproate in women of child-bearing age
- avoiding lithium monotherapy if symptoms are severe, because of the slower onset of action.²

The combination of an antipsychotic and a mood stabiliser appears to be more efficacious than a mood stabiliser alone³ and may be useful when monotherapy is inadequate.² Unlike risperidone and olanzapine, quetiapine does not have a TGA-approved indication for adjunctive use in combination with a mood stabiliser in mania (see [Table 1](#)).

There are two published trials demonstrating the efficacy of quetiapine in reducing the symptoms of acute mania.^{4,5} Pooling the results, after 3 weeks of treatment, 100/208 study participants (48%) responded[†] to quetiapine treatment, while 61/195 (31%) responded to placebo.⁶ Response rates continued to increase up until the end of 12 weeks (67% with quetiapine, 40% with placebo).⁶ Each trial also included an active comparator; this was haloperidol, a conventional antipsychotic, in one trial, and lithium in the other.^{4,5} The responses to all 3 active treatments were comparable at 12 weeks, although the studies were not powered to test if any active treatment was superior to the others.⁴ There are no other published, double-blind head-to-head comparisons of quetiapine with drugs for mania (e.g. valproate, risperidone or olanzapine).

[†] Response was defined as a 50% or greater decrease from the baseline score on the Young Mania Rating Scale (YMRS).

Safety issues

Adverse effects commonly associated with quetiapine are dry mouth, somnolence, dizziness, constipation, orthostatic hypotension and tachycardia.⁷ The one trial comparing quetiapine with lithium in acute mania found similar numbers of withdrawals and adverse events leading to withdrawal.⁴ In the trial with haloperidol as the comparator, 13% of people receiving quetiapine reported extrapyramidal symptoms, compared with 60% of people receiving haloperidol.⁵ All antipsychotics may cause irreversible tardive dyskinesia with long-term use, although the risk is considerably higher with conventional agents.⁸

Several epidemiological studies have found an association between the onset of type 2 diabetes and using olanzapine, quetiapine, or risperidone.^{9,10} Check fasting plasma glucose, lipids and body mass index (BMI) when starting any antipsychotic, and on a regular basis (e.g. annually).¹¹

See [NPS News 51: What's 'atypical' about the newer antipsychotics?](#) for further information about adverse effects of antipsychotics.

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