offers similar or reduced HbA1c reduction, had comparable significant weight loss, improved blood pressure (SBP), incidence of hypoglycaemia and urinary tract infections (UTIs) at 24 weeks. RESULTS: From 6969 abstracts, 13 were included in the analysis. No RCTs involving TZDs were identified. Compared with placebo, mean changes in HbA1c were -0.65% (95% confidence interval [CI] -1.59 to -0.08), and -0.60% (95% CI -1.14 to -0.14%) for emagliflozin 10mg and 25mg. No significant differences were detected between interventions. Mean changes in weight with emagliflozin 10mg and 25mg were -1.77 (95% CI -2.19 to -1.35) and -2.00 (95% CI -2.44 to -1.57), respectively. Mean weight losses were fairly similar across SLGT-2s and GLP-1s ranging between -1.26% to -1.77% (95% CI -2.19 to -1.35) and -2.00% to -2.44% (95% CI -2.44 to -1.57), respectively. Mean changes in systolic blood pressure (SBP) were -4.09mmHg (95%CI -6.97 to -1.18) and -4.81mmHg (95% CI -7.69 to -2.00), respectively. No significant differences between Empagliflozin and other DPP-4s, TZDs, and SUs were detected. Incidence of hypoglycaemia for empagliflozin 10 and 25mg versus placebo were -4.09mmHg (95%CI -6.97 to -1.18) and -4.81mmHg (95% CI -7.69 to -2.00). No significant differences between Empagliflozin and other SLGT-2s, DPP-4s, and GLP-1s, empagliflozin offers similar HbA1c control at 24 weeks, a marked reduction in weight compared with DPP-4s, TZDs, and SUs, and a similar safety profile based on prior clinical studies that evaluated glucose meters’ errors in glucose measurements. Calculation of LYG was undertaken for oral anti-diabetic drugs (OAD) as monotherapy in this population - the 26 years period (the life-time period). Life years gained (LYG) was chosen as an outcome measure in assessment of health intervention. Calculation of LYG was based on prior clinical studies that evaluated glucose meters’ errors in glucose level measurements and risk of complications associated with blood glucose level. Data for patients with diabetes was obtained from prior epidemiological studies that had been published in Russian Federation. RESULTS: Use of manually coded blood glucose meters in the analyzed population with median age of 53 years during 26 years period was associated with 18.59 LYG. At the same time use of automated blood glucose meters was associated with 18.92 LYG. In case of using automated meters instead of using manually coding meters patients obtained 0.33 LYG more (120 days). CONCLUSIONS: Obtained results showed that difference in glucose measurement errors between manually coded and automated blood glucose meters can lead to the difference in long-term outcomes in diabetes treatment.

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ASSESSING THE RELATIONSHIP BETWEEN IMPROVED LIFE EXPECTANCY DUE TO BETTER CARDIOVASCULAR RISK FACTOR MANAGEMENT AND THE LIKELIHOOD OF MICROVASCULAR COMPLICATIONS IN TYPE 2 DIABETES MELLITUS

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OBJECTIVE: Type 2 diabetes mellitus (T2DM) is a chronic disease associated with increased risk of cardiovascular (CV) and microvascular complications. Improvements in blood pressure and cholesterol control have resulted in a reduction in CV event rates in clinical practice. The objective of this study was to assess changes in CV event rates, and the risk of microvascular disease for a range of glycemic control levels. METHODS: A lifetime analysis was conducted using the CORE diabetes model (CDM). Newly diagnosed T2DM simulated patients aged 52 years at baseline with HbA1c ≥ 7.1%. SBP 135 1 mmHg, total cholesterol: HDL 5.2 mmol/l were modelled. The impact of HbA1c on microvascular complications was assessed by running the CDM with baseline HbA1c ≥ 7.1 for scenario 1. 100% of patient receiving CV risk factor management (CVRFM) and no risk factor management (RFM) were modelled. The impact of CVRFM on microvascular complications was assessed by running the CDM with baseline HbA1c ≥ 7.1 for scenario 1. 100% of patient receiving CVRFM and no risk factor management (RFM) were modelled. Results: In scenario 1, the increase was 14.8% for microalbuminuria (MA), 24.8% for coronary artery disease (CAD), 14.6% for myocardial infarction (MI), and 34.7% for end stage renal disease (ESRD), respectively; for scenario 2, the increase was 15.5% for MA, 25.4% for CAD, 15.3% for MI, and 35.2% for ESRD. Conclusions: This is the first network assessing OAD monotherapy that can readily be extended to other T2DM inadequately controlled with metformin monotherapy were included. The mean differences (MD) in HbA1c were -0.56% (95% confidence interval CI -1.03 to -0.09). Similar MDs were obtained for emagliflozin 10mg and 25mg versus placebo were -4.09mmHg (95%CI -6.97 to -1.18) and -4.81mmHg (95% CI -7.69 to -2.00). No significant differences between Empagliflozin and other SLGT-2s, DPP-4s, and GLP-1s, empagliflozin offers similar HbA1c control at 24 weeks, a marked reduction in weight compared with DPP-4s, TZDs, and SUs, and a similar safety profile.