conducted. Randomised controlled trials (RCTs) were of 24 weeks (+/- 6 weeks) treatment duration. Bayesian fixed-effect (FE) and random-effects (RE) models were used to estimate the relative efficacy and tolerability, and 95% credible intervals (CIs).

RESULTS: Fourteen RCTs were included. The FE model was selected to provide a better fit to the data than the unadjusted model. Canagliflozin 300mg had a greater reduction in HbA1c than placebo (mean, 95% Crl: -1.09%, -1.62% to -0.53%) in reducing HbA1c. EQW obtained a statistically significant reduction in HbA1c relative to lixisenatide 20mg QD. Favourable point estimates that did not reach statistical significance were observed for EQW vs. albigrutide 30mg QW, exenatide 5ug and 10ug twice daily (BID), and liraglutide 1.2mg and 1.8mg once daily (QD). A model adjusting for baseline HbA1c did not provide a better fit to the data than the unadjusted model. EQW was associated with a lower risk of nausea compared to all GLP-1 RAs, except exenatide 5ug BID (none of these differences were statistically significant). Risk of discontinuation due to adverse events was lower for EQW than for dulaglutide 1.5mg QW, and liraglutide 1.2mg and 1.8mg once daily (QD). A model adjusting for baseline HbA1c revealed a greater reduction in HbA1c for exenatide 5ug and 10ug (BID) none of these differences were statistically significant.

CONCLUSIONS: Evidence suggests that EQW is an effective, well-tolerated therapeutic option for the treatment of T2DM in adults inadequately controlled on MET alone.

PD65

NETWORK META-ANALYSIS (NMA) TO ASSESS RELATIVE EFFICACY MEASURED AS PERCENTAGE OF PATIENTS TREATED TO HBA1C TARGET WITH CANAGLIFLOZIN IN PATIENTS WITH TYPE 2 DIABETES MELLITUS (T2DM) INADEQUATELY CONTROLLED ON METFORMIN AND/ OR SULPHONYLUREA (MET/SU)

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OBJECTIVES: The growing prevalence of T2DM in Europe poses a significant economic and healthcare burden, mainly due to diabetes-related complications. Maintaining HbA1c well below 7% is crucial to reduce microvascular and macrovascular complications. Many other options, but also weight loss.

METHODS: A systematic literature review identified 14 randomised controlled trials, which were used to perform a Bayesian NMA to estimate the relative efficacy of canagliflozin added to MET/SU at 26 weeks. Relative efficacy was evaluated based on odds ratios (ORs) of the proportions of patients reaching the HbA1c target and Bayesian pairwise probabilities (P). Interpretation of results was based on ORs and P, where P<50% indicated a smaller effect and P>70% a larger effect than the comparison. ORs and 95%HPD of reaching HbA1c≤7% compared to dapagliflozin 10mg and empagliflozin 25mg (ORs of 1.12 [P=0.60] and 0.94 [P=0.44], respectively). Canagliflozin 300mg had significantly higher odds of reaching HbA1c≤7% versus dapagliflozin 10mg and empagliflozin 10mg and 25mg (ORs of 2.03 [P<0.01], 1.71 [P=0.03], and 2.29 [P<0.001], respectively). CONCLUSIONS: This NMA of add-on therapies to MET/SU suggests that the odds of achieving HbA1c≤7% at 26 weeks were higher for canagliflozin 100 mg and greater for canagliflozin 300 mg versus dapagliflozin and empagliflozin.

PD66

A NETWORK META-ANALYSIS (NMA) TO ASSESS THE LONG-TERM RELATIVE EFFICACY OF CANAGLIFLOZIN IN PATIENTS WITH TYPE 2 DIABETES MELLITUS (T2DM) INADEQUATELY CONTROLLED ON METFORMIN AND/or SULPHONYLUREA (MET/SU)

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OBJECTIVES: To assess the relative efficacy of canagliflozin, a sodium glucose co-transporter 2 (SGLT2) inhibitor, as add-on to metformin, versus newer anti-hyperglycemic agents (AHAs) that were not studied in phase 3 trials, namely liraglutide 1.8mg and exenatide 1.0mg and 0.5mg twice daily (BID), and liraglutide 1.2mg and 1.8mg once daily (QD). A model adjusting for baseline HbA1c revealed a greater reduction in HbA1c for exenatide 5ug and 10ug (BID), none of these differences were statistically significant.

METHODS: The systematic review identified 14 randomised controlled trials, which were used to perform a Bayesian NMA to estimate the relative efficacy of canagliflozin added to MET/SU at 26 weeks. Relative efficacy was evaluated based on odds ratios (ORs) of the proportions of patients reaching the HbA1c target and Bayesian pairwise probabilities (P). Interpretation of results was based on ORs and P, where P<50% indicated a smaller effect and P>70% a larger effect than the comparison. Canagliflozin 300mg had significantly higher odds of reaching HbA1c≤7% compared to dapagliflozin 10mg and empagliflozin 25mg (ORs of 1.12 [P=0.60] and 0.94 [P=0.44], respectively). Canagliflozin 300mg had significantly higher odds of reaching HbA1c≤7% versus dapagliflozin 10mg and empagliflozin 10mg and 25mg (ORs of 2.03 [P<0.01], 1.71 [P=0.03], and 2.29 [P<0.001], respectively). CONCLUSIONS: This NMA of add-on therapies to MET/SU suggests that the odds of achieving HbA1c≤7% at 26 weeks were higher for canagliflozin 100 mg and greater for canagliflozin 300 mg versus dapagliflozin and empagliflozin.

PD67

PREDICTING NETWORK META-ANALYSIS (NMA) TO ASSESS THE RELATIVE EFFICACY OF CANAGLIFLOZIN IN PATIENTS WITH TYPE 2 DIABETES MELLITUS (T2DM) INADEQUATELY CONTROLLED WITH INSULIN

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OBJECTIVES: To assess the relative efficacy of canagliflozin, a sodium glucose co-transporter 2 inhibitor (SGLT2) as add-on to insulin +/- oral antihyperglycaemic drugs for the treatment of T2DM compared to dipeptidyl peptidase-4 inhibitors (DPP-4), glucagon-like peptide-1 receptor agonists (GLP-1), sulphonylureas, pioglitazone, and other SGLT2 inhibitors, using Bayesian NMA methods.

METHODS: A systematic literature review was conducted according to NICE guidelines and available data on HbA1c, weight and systolic blood pressure (SBP) were extracted. Network meta-analysis (NMA) was performed for direct and indirect estimates in pre-specified comparisons. Heterogeneity was assessed with I² statistics. Results were pooled using a non-parametric random-effects model. Post-hoc sensitivity analyses were conducted. Randomised controlled trials evaluating the following interventions in adults with T2DM were selected: liraglutide (1.2mg and 1.8mg), exenatide (5mcg and 10mcg BID), and glibenclamide. Canagliflozin 300mg had significantly higher SBP reductions than dapagliflozin and empagliflozin. Empagliflozin 25mg and empagliflozin 10mg had significantly higher SBP reductions than placebo (mean; 95% CrI) (-1.09%; -1.62% to -0.53%) in reducing HbA1c. EQW obtained a statistically significant reduction in HbA1c relative to lixisenatide 20mg QD. Favourable point estimates that did not reach statistical significance were observed for EQW vs. albigrutide 30mg QW, exenatide 5ug and 10ug twice daily (BID), and liraglutide 1.2mg and 1.8mg once daily (QD). A model adjusting for baseline HbA1c did not provide a better fit to the data than the unadjusted model. EQW was associated with a lower risk of nausea compared to all GLP-1 RAs, except exenatide 5ug BID (none of these differences were statistically significant). Risk of discontinuation due to adverse events was lower for EQW than for dulaglutide 1.5mg QW, and liraglutide 1.2mg and 1.8mg once daily (QD). A model adjusting for baseline HbA1c revealed a greater reduction in HbA1c for exenatide 5ug and 10ug (BID), none of these differences were statistically significant.

CONCLUSIONS: Evidence suggests that EQW is an effective, well-tolerated therapeutic option for the treatment of T2DM in adults inadequately controlled on MET alone.