study were obtained from the PHARMO Record Linkage System, including among others linked drug-dispensing and hospital records of approximately three million individuals in defined areas of The Netherlands. Users of TC during 1992–2004, without diabetes, with ≥4 years of follow-up were selected. Diabetes onset was defined as first occurrence (index date) of an antidiabetic drug dispensing or hospitalization for diabetes or diabetes-related diagnoses. Each case was matched by age and sex to 4 controls without diabetes, with similar follow-up duration. Use of TC and systemic corticosteroids (SC) and/or inhaled corticosteroids (IC) as co medication were classified as current (≥2 years before index date), recent (4–2 years ago) and past/never (>4 years ago). Multivariate regression adjusted for co-medication and co-morbidity. RESULTS: Among 192,893 incident TC users, 2,212 developed diabetes and could be matched to 8,582 controls. Current TC use was associated with a 1.24 times increased risk of diabetes (95% CI 1.11–1.40). The Odds Ratio increased to 1.32 with >180 days of TC use and to 1.44 with a cumulative TC load (combined potency and units) 731–1,460 mg. Cases more often used SC and IC than controls (23% versus 17% and 18% versus 13% respectively). Among “Past/never” users of SC and/or IC, risk of diabetes with current TC use was 1.25 (95% CI 1.09–1.43); among “Current” users of SC and/or IC, this OR was 1.13 (95% CI 0.88–1.44). CONCLUSION: A statistically significant effect of TC use on diabetes was found. Use of TC as skin treatment among patients at increased risk of diabetes should be considered with some caution. 

DIABETES—Cost Studies

ROSIGLITAZONE IN THE TREATMENT OF PATIENTS WITH TYPE 2 DIABETES: IMPLEMENTATION OF BUDGET IMPACT ANALYSIS SOFTWARE

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OBJECTIVES: To implement a flexible PC program to support decision makers in evaluating the impact of the use of rosiglitazone in eligible diabetic patients on the Italian National Health System budget. METHODS: Rosiglitazone, an insulin-sensitising drug, is indicated for subjects with inadequate glycaemic control both as monotherapy, in those contraindicated to metformin (especially if overweight) and as combination therapy with metformin, sulphonylureas or both. The software developed has a user-friendly interface and is based on an analytic model, which pathway may be summarized as follows: a) estimate of the number of Italian type 2 diabetes patients, grouped according to current therapeutic classes; b) estimate of the number of patients with inadequate glycaemic control for each subgroup; c) identification of patients eligible to rosiglitazone treatment; d) identification of the comparator strategy for each patient sub-group; e) comparison of costs for each couple of alternative options; and f) calculation of budget impact. The user can modify most default data to adapt the analysis to the specific setting. RESULTS: Default data based scenario shows that adoption of rosiglitazone monotherapy induces a mild cost increase. Combination treatments induce significant cost savings, related to lower resource consumption for glycemic auto-monitoring and hypoglycaemia management, as compared to standard combination therapies. The hypothetical scenario in which all eligible Italian patients are treated with rosiglitazone is estimated to induce net savings for about 260 millions Euro per year. CONCLUSION: In type 2 diabetes, the maintenance of non-diabetic glycaemic levels has been shown to decrease the onset of long term complications.

Rosiglitazone represents a further option to postpone insulin therapy start with a potential cost-saving for the Italian National Health System.

THE COST OF THE INEFFICIENCY IN DIABETES IN HEALTH PRIMARY CARE

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OBJECTIVES: To estimate the economic inefficiency of bad control of Diabetes in terms of direct cost in diabetic patients in a rural area in Spain (Axarquia) during one-year of follow up. METHODS: Cohort study of 228 patients (2 rural health centres sampled in 2005–2006). The perspective analysis was National Health System. Total cost is composed of four items: insulin and oral hypoglycaemic agents, glycosylated haemoglobin, disposable and consumable goods (glucose test strips, needles, and syringes) and primary care visits. The statistical analysis was made by the SPSS package. For quantitative: mean, DS, IC95%; for qualitative: proportions. For inferential statistics: Student’s T-test for quantitative variables and test of Chi-square for the qualitative ones. Multivariate analysis considered: age, gender, control grade (ADA, 2006) and interaction gender-control of DM. The ratio cost-effectiveness and incremental cost of control compared with non-control of DM was analized with WinBugs controlled for age and gender. RESULTS: Sixty-seven percent of females; average age: 69 years. The average of prescribed drugs for DM control was 1.4 drugs/per patient (1.03% acarbos; 32.92% sulphonylurea; 64.43% biguanide, 13.40% metiglinide and the 27.32% insulin). The mean of primary care visits was 14.8/per patient/year. The Diabetes control was 68% (HbA1c< 7) with 1.34 drugs per year in controlled patients versus 1.61 drugs in non-controlled (p < 0.01). The direct health care cost of diabetic patient was €628/year (IC95%: €576–680). In patients non haemoglobin glycosylated controlled the cost was incremented in €193 per patient and the effectiveness decl in 32%. CONCLUSION: This economic study demonstrates the real possibility to improve the efficiency of our interventions. If we transferred the data found to our area of reference (Malaga) the saving in costs would be superior to €3 million. Health providers and policymakers should use this information in making clinical and policy decisions in order to use resources efficiently.

2-YEAR GLYCEMIC CONTROL FOLLOWING INITIATION OF INSULIN GLARGINE VERSUS NPH INSULIN IN INDIVIDUALS WITH TYPE 2 DIABETES (T2DM)

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OBJECTIVES: To evaluate 2-year real world outcomes of glycemic control in patients with T2DM initiating insulin glargine vs. NPH insulin. METHODS: Patients with T2DM (March 2001–March 2003) who failed oral antidiabetic agents, initiated glargine (n = 2105) or NPH (n = 734), with continuous plan enrollment for >18 months (6 months baseline) prior to and 12 months after insulin initiation and with available laboratory HbA1C values, were evaluated using a US managed care claims