Drug utilization was ascertained from prescription claims data. HIV, cancer) were identified using appropriate ICD-9 codes. Neuropathy, nephropathy), and other conditions (liver disease, brovascular, complications of uncontrolled diabetes (retinopathy, other lipid-lowering drugs. CONCLUSIONS: As expected from results of studies in other Medicaid populations, hypertension was the most prevalent co-morbid condition with Type-2 diabetes. Other cardiovascular conditions also prevailed, warranting treatment of these conditions as part of the metabolic syndrome.

**OBJECTIVE:**
Risk factors for Type-2 diabetes have been associated with other conditions, including cardiovascular conditions categorized under the metabolic syndrome. The objective of this study was to describe the prevalence of co-morbid conditions, as well as concomitant medication use, for Type-2 diabetes patients in a state Medicaid population. METHODS: Data for Type-2 diabetes patients were extracted from medical claims for the year 2001 using ICD-9 codes 250.00–250.90, where x equals zero or two. Patients under managed care coverage, or over age 65, were excluded. The patients were followed for one-year from the index date to determine the presence of co-morbid conditions and prescription drug utilization. The presence of co-morbid conditions such as cardiovascular, peripheral vascular, cerebrovascular, complications of uncontrolled diabetes (retinopathy, nephropathy, nephropathy), and other conditions (liver disease, HIV, cancer) were identified using appropriate ICD-9 codes. Drug utilization was ascertained from prescription claims data using National Drug Classification (NDC) codes. Prevalence of co-morbid conditions and concomitant medication use was described for the overall population and on the basis of age and gender. RESULTS: The most prevalent (70%) co-morbid condition among Type-2 diabetes patients was hypertension. In addition, approximately 55% of patients had medical services claims for co-morbid hyperlipidemia, and 41% had co-morbid cardiovascular conditions. Prevalence of hypertension and cardiovascular conditions among genders was similar; patients in the over 55 age category had the highest prevalence of cardiovascular conditions (52.2%) and hypertension (76.7%). For prescription use, nearly three-fourths of patients filled prescriptions for antihypertensives; 47.1% filled prescriptions for statins, fibrates, and other lipid-lowering drugs. CONCLUSIONS: As expected from results of studies in other Medicaid populations, hypertension was the most prevalent co-morbid condition with Type-2 diabetes. Other cardiovascular conditions also prevailed, warranting treatment of these conditions as part of the metabolic syndrome.

**OBJECTIVE:** To examine the relationship between pre-existing depression and incidence of type-2 diabetes. METHODS: Administrative claims data of a state Medicaid were used to meet the study objective. Medicaid enrollees with depression were identified in the year 1997 using ICD-9 codes for depression. A comparison group without depression was also identified in 1997. Enrollees with a medical/pharmacy claim for type-2 diabetes in 1997 were excluded from the analysis. Both these groups were then followed till December 31, 2002 to identify incident cases of type-2 diabetes. The analysis was restricted to patients who were continuously Medicaid eligible through the period 1997–2002. In addition to univariate chi-square analysis, logistic regression analysis was conducted to examine the association between depression and incidence of type-2 diabetes controlling for the effect of demographics and presence of co-morbidities. RESULTS: A total of 4472 eligible enrollees with depression were identified in the year 1997. The comparison group consisted of 5195 eligible non-depressed enrollees. A significantly higher fraction of depressed enrollees (15.7%) developed type-2 diabetes as compared to non-depressed enrollees (11.7%) (p < 0.01). Results of the logistic regression demonstrated a significant interaction effect between gender and presence of pre-existing depression, suggesting that the odds of developing incident type-2 diabetes in enrollees with depression were significant only in females. Females with pre-existing depression were nearly one and a half times more likely to develop incident type-2 diabetes as compared to non-depressed females, after controlling for age, race, and cardiovascular co-morbidity at baseline (Odds Ratio = 1.479, p < 0.01). CONCLUSION: The observed higher risk of type-2 diabetes among females with depression may suggest that physicians need to monitor diabetic metabolic changes in females with depression for early detection and treatment of type-2 diabetes.