OBJECTIVES: To evaluate changes in anti-glycemic treatment patterns in patients newly initiating statin therapy with niacin extended-release (NER-S), relative to patients initiating alternative lipid regimens.

METHODS: An observational cohort study was conducted using integrated administrative claims and laboratory result data within the HealthCore Integrated Research Database. T2DM patients aged 18 to 64 initiating statin-augmenting therapy (NER+S, ezetimibe (EZE)-S, or fenofibrate (FENO)-S) between 1/1/2005-11/30/2008 (index date) were included. Patients with >12 months of pre-index eligibility and ≥1 laboratory result for hemoglobin A1c (HbA1c) within the 12-month period were included. The utilization and average daily dose (ADD) of anti-glycemic medications during the 12-month pre-index and follow-up period were compared between cohorts. RESULTS: A total of 42,250 patients were identified: 2,041 NER+S, 6,915 EZE-S, 3,095 FNO-S, and 30,199 SM. Compared to each cohort, NER+S patients had the smallest increase in ADD of DPP-4’s (sitagliptin: 0.3 ± 0.2), relative to alternative treatment regimens.

OBJECTIVES: To assess the relative efficacy and tolerability of amiodarone, sotalol, and dronedarone for the treatment of atrial fibrillation (AF) in Australia using mixed treatment comparisons (MTC) methods. This study highlights the potential of using rigorous modeling approaches to bridge evidence gaps.

METHODS: We constructed 5 FRS subgroups showing greater absolute benefit. The 5-year number needed to treat (NNT) to prevent a MACE event for R40 vs A80 for EURO-SCORE <5, and >5 were 142 vs 154 for 5 years and 154 and 72 for 10 years, respectively. The 5-year relative risk (RR) of MACE for R20 vs A40 was approximately 0.9, irrespective of baseline risk. The 5-year RR of MACE for R20 vs A80 ranged from 0.92 to 0.94, and for R40 vs A80 it was 0.88 to 0.90. RR estimates were similar at 10 and 20 years; however, NNT decreased over time. CONCLUSIONS: The Model estimated that R20 lowers the risk of MACE more than A40 and R40 further lowers risk compared to A80. The estimated absolute risk reduction with rosvastatin was greater with higher baseline risk and over time. While simulation models cannot replace controlled clinical trials, this study highlights the potential of using rigorous modeling approaches to bridge evidence gaps.

OBJECTIVES: The purpose of this analysis was to compare the effectiveness and safety of the alternative AADs. This approach was previously used by Freemantle et al (2011) to compare dronedarone not only with amiodarone and sotalol but also with flecainide and propafenone. As flecainide and propafenone are not widely used in Australia, we chose to exclude them from the current analysis. Literature in AF involving amiodarone, dronedarone, sotalol or placebo was searched systematically. The 10 selected trials were combined using MTC models to provide direct and indirect comparisons in a single analysis. Random-effects models with at least 1 month of follow-up were included. RESULTS: Results are presented versus placebo. Trends towards increased mortality for sotalol (OR 4.67, 95% CI 1.89 – 11.57) and amiodarone (OR 2.92, 95% CI 1.17 – 7.31) were found. Conversely, a trend towards decreased morbidity for dronedarone (OR 0.89, 95% CI 0.75 – 1.09) was observed.

OBJECTIVES: To compare the relative efficacy and tolerability of amiodarone, sotalol and dronedarone for the treatment of atrial fibrillation (AF) in Australia using mixed treatment comparisons (MTC) methods. There are limited data directly comparing the safety and effectiveness of dronedarone with the alternatively used antiarrhythmic drugs (AADs) in Australia. In the absence of direct comparisons, we have performed an MTC of networks of trials in order to provide best estimates of the relative effectiveness and safety of the alternative AADs. This approach was previously used by Freemantle et al (2011) to compare dronedarone not only with amiodarone and sotalol, but also with flecainide and propafenone. As flecainide and propafenone are not widely used in Australia, we chose to exclude them from the current analysis. Literature in AF involving amiodarone, dronedarone, sotalol or placebo was searched systematically. The 10 selected trials were combined using MTC models to provide direct and indirect comparisons in a single analysis. Random-effects models with at least 1 month of follow-up were included. RESULTS: Results are presented versus placebo. Trends towards increased mortality for sotalol (OR 4.67, 95% CI 1.89 – 11.57) and amiodarone (OR 2.92, 95% CI 1.17 – 7.31) were found. Conversely, a trend towards decreased morbidity for dronedarone (OR 0.89, 95% CI 0.75 – 1.09) was observed.

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