OBJECTIVES: American Diabetes Association and European Association for the Study of Diabetes guidelines recommend that HbA1c level should be ≤6.5% and emphasize the importance of lifestyle interventions and metformin, addition of medications and transition to new regimens within 3–6 months when glycemic goals are not achieved, and addition of insulin in patients who remain uncontrolled. This study examines real-world adherence to, and changes in treatment among T2DM patients treated by commercially insured payers and relates to guideline recommendations. METHODS: A retrospective analysis using Truven Health MarketScan® Research Database identified adult T2DM patients from 2006–2012 with a minimum follow-up of one year. Patients were categorized based on initial therapy: cohort 1 (n=59,664) – newly diagnosed without treatment in the year prior to or following diagnosis; cohort 2 (n=342,511) – oral anti-diabetic drug (OAD) initiators; cohort 3 (n=95,578) – basal insulin initiators, and cohort 4 (n=8,476) – a combination of oral and injectable initiators. Patients were followed up for 4 years and transitioned out of a cohort once they met the criteria for the next cohort. All data were summarized using descriptive statistics. RESULTS: Mean age in cohort 1 was 59.1, 56.2, 58.1, and 58.4 years with approximately equal gender distribution. In cohort 1, average HbA1c remained stable, 6.3%, during follow-up. 9% of patients initiated treatment with OADs by year 2, and 19% by year 4. Those in cohort 2 not achieving HbA1c ≤5.7% insulin was infrequently initiated, approximately 1.5% transitioned from OADs to insulin. In cohorts 3 and 4, despite elevated HbA1c values ≥8%, the majority of patients were extensively treated with OADs prior to insulin initiation. In cohort 4, 65% of patients were using basal insulin at year 1, decreasing to 54% by year 4. CONCLUSIONS: Findings indicate discrepancies in regimens prescribed to T2DM patients in a real-world setting despite guideline recommendations to intensify treatment if patients fail to achieve glycemic targets.

PB140 QUALITY OF CARE FOR PATIENTS WITH DIABETES MELLITUS (DM) IN CANADA: FINDINGS FROM THE NATIONAL POPULATION-BASED SURVEY
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OBJECTIVES: An assessment of DM quality improvements, quality of care initiatives are being undertaken in many jurisdictions. In the 2012 Canadian Community Health Survey (CCHS), data were collected on healthcare received by those with DM. The objective was to characterize the demographics of, and healthcare received by, a contemporary population of adult Canadians with DM, and assess whether care quality varied according to age or sex. METHODS: Data from the subset of 2012 CCHS adult respondents (n=61,707) asked about diabetes care were analyzed. Demographic and clinical characteristics were tabulated, and respondents classified as receiving quality diabetic care if they had HbA1c or fasting glucose during the year, and retinal exams within two years. Predictors of receiving quality care were explored using logistic regression, and the frequency of pharmaceutical (PPIs) and nutritional therapy prescribing compared between those with and without receiving care. RESULTS: Of the diabetes care cohort (n=2,458), 48% were male, and 75.1% were ≥60 years. Eighty percent had a recent HbA1c test, and 69.2% and 55.2% had a recent eye or foot exam, respectively. Thirty-eight percent reported receiving quality diabetes care. While results were similar by sex, variability was observed by age. The percentage receiving quality care ranged from 30.4% (≥80 years), to 40.1% (60–69 years). Age was the only significant predictor; the odds of receiving quality care were lower by 38 years. The frequency of pharmacist visits and hospitalizations compared between those with and without receiving care. CONCLUSIONS: While some guideline monitoring was conducted for most respondents, less than half reported receiving all aspects of recommended diabetes care. Because these data were self-reported, respondents may have received evaluated evaluations but been unaware. Opportunities may therefore exist for improving the diabetic care of patients, and their awareness of that care.

GASTROINTESTINAL DISORDERS – Clinical Outcomes Studies
PG1 SYSTEMATIC REVIEW OF ESOXPMERAZOLE FOR THE TREATMENT OF GASTROESOPHAGEAL REFLUX DISEASE
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OBJECTIVES: An 8-week course of proton pump inhibitors (PPIs) is the therapy of choice for the treatment of gastroesophageal reflux disease (GERD). Esoxperazole, the S-isomer of omeprazole, seems to have more potent acid suppression compared to other PPIs due to improved pharmacokinetic profile. The aim of the current systematic review was to identify consistent evidence of differences in efficacy between esoxperazole and the other available PPIs. METHODS: A literature search of Medline, Embase and Cochrane Library was conducted (last search 8/2014) to identify randomized clinical trials comparing rates of endoscopic healing and heartburn resolution with esoxperazole versus other PPIs (i.e. lanzoprazole, omeprazole and pantoprazole) in the treatment of GERD. Search and selection criteria were applied independently by two reviewers. Only intention-to-treat population reported data were analyzed. RESULTS: Twelve RCT studies (3 vs omeprazole, 3 vs lanzoprazole and 6 vs pantoprazole) met the inclusion criteria and were included in the systematic review. All included studies had low or moderate risk of bias ( Jadad scale range 3-5). One study had high risk of bias. The analysis comparing esoxperazole 40 mg with lanzoprazole 30 mg showed a significant difference in endoscopic healing rate in favor of esoxperazole at 4 weeks (OR=1.25, 95%CI: 1.12-1.40) and 8 weeks (OR=1.29, 95%CI: 1.13-1.48). Similarly, esoxperazole 40 mg demonstrated significantly higher healing rate when compared with pantoprazole 40 mg at 8 weeks (OR=1.33, 95%CI: 1.15-1.52) and with omeprazole 20 mg at 8 weeks (OR=1.56, 95%CI: 1.08-2.25). Data from meta-analysis indicated that esoxperazole 40 mg provided also a greater proportion of patients with sustained resolution of heartburn for up 4 weeks than omeprazole 20 mg (OR=1.34, 95%CI: 1.19-1.65). The tolerability and safety of esoxperazole were comparable to that of other PPIs. CONCLUSIONS: Esoxperazole proved to be more effective in healing of erosive GERD than the other available PPIs.
PG2 EFFECTS OF NUTRITIONAL SUPPLEMENT USE ON MORTALITY IN PATIENT UNDERTAKING ABDOMINAL RESECTION SURGERY FOR NON-ONCOLOGICAL CONDITIONS
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OBJECTIVES: The abstract aims to report nutritional supplement use (NS) and its effect on mortality (M) in T2DM patients undergoing abdominal resection surgery (ARS) or are often disregarded. This abstract aims to report nutritional supplement use (NS) in patients undergoing abdominal resection surgery (ARS) for non-oncological conditions and the possible effect of NS on mortality in this population. METHODS: A retrospective, observational, inpatient cohort database of Social Security Institute. METHODS: Turkish GHI system has covered 98% of total population of Turkey. Therefore statistics obtained via the GHI database are highly representative of the population of Turkey. From GHI database, 289,145 patients who underwent ARS from 1 January 2009 and 31 December 2013 were analyzed. RESULTS: In GHI database, 5,787 patients (mean age: 55.0 years, 45.6% female) met selection criteria of this abstract. NS was used for 6.6% of the patients during hospitalization (median 12.0 days) and NS was used median 2.0 days during hospitalization. Mortality rate was 24.2% during hospitalization. Of the 4,384 discharged patients, 1.2% used NS during outpatient follow-up duration and 0.6% used NS on follow-up visit based on prescription data. Overall 97.9% of patients who received NS during hospitalization did not continue NS usage during outpatient follow-up duration. Median survival durations were 60.0 and 25.1 months in patients not used NS, and 12-month survival rates were 65.0% and 51.0%, respectively. CONCLUSIONS: The abstract showed NS usage patterns in patients who underwent ARS for non-oncological conditions in Turkey. Mortality risk increased with ARS due to type of intervention, but ratio of NS usage in daily practice is low and usage duration is relatively short. More survival analyses revealed that NS seems to be preferred for complicated patients. In conclusion all patients underwent ARS should be evaluated for malnourished and treated accordingly to avoid medical and economic burden.
PG3 HEALTHCARE PATHWAYS AND BURDEN OF DISEASE OF PATIENTS WITH INFLAMMATORY BOWEL DISEASES (IBD)
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OBJECTIVES: Inflammatory Bowel Diseases (IBD), which include Crohn’s disease and Ulcerative Colitis, are chronic and life-long conditions. Only symptomatic relief is available, because the exact cause is not entirely understood. The aim of this study was to analyze the healthcare profile and the overall cost of patients with IBD in the real clinical practice. METHODS: From ARNO Observatory database we carried out a record linkage analysis of disease diagnoses, drug prescriptions and hospitalization costs, with data from all hospitals in Italy with low cost data. Hospitalizations and specialist services of every single patient with IBD were followed up to 3 years after the accrual (from 01/01/2009 to 31/12/2009), while pharmaceutical and medical data were collected up to 4 years. All pharmaceutical prescriptions, hospital care (re-hospitalizations, gastro-intestinal surgery, in-hospital mortality), diagnostic procedures and their costs (mean patient/year) were analyzed. RESULTS: 25,427 patients with IBD (50.5%, female, mean 56.7±18.7 y.o.) received specific drugs: Inflammatory bowel agents (92.3%), intestinal antifibiotics/antibiotics for systemic use (49.7%), the most prescribed and immunosuppressants the most expensive. As non-specific therapy, patients with IBD received Protonic Pump Inhibitors (62.3%), antibiotics in the treatment of systemic use infections – 58%, Macrolides – 39% and Quinolones – 35.8% prescriptions. Focus on hospitalizations revealed: cancer chemotherapy was the first cause of day-hospital admissions and the most expensive one; 8.4% of patients had cardiovascular complications; the most frequent re-hospitalizations of men aged 15–44 years; the most prevalent in-hospital mortality of women aged 80 years. The 1-year follow-up costs analysis provided that hospitalizations were the most expensive (54.4% total expenditure, mean cost 1.166€/patient) and that specific drugs accounted only for the 9.4%. CONCLUSIONS: In-hospital cares are the main cost driver for patients with IBD. This must be considered by LHUs and Physicians when evaluating patient healthcare pathways with chronic disease and estimating costs of the disease (as obtained from National official databases), before and up to three years after the introduction of vedolizumab versus standard of care.