47% (±21%) and 22% to 16% (%), respectively. CONCLUSIONS: For Product A, after the regulation update the prescription rate for w-biguanides decreased, while that for w-sulphonylureas and monotherapy options are increased. However, for Product B, prescription rate for w-sulphonylureas is decreased, while those for w-biguanides and monotherapy options are increased. For both products, prescription rate for monotherapy options (w-biguanides, w-sulphonylureas) increased. Limitation of the study is the lack of information about adjustment of antidiabetic treatment during hospitalization.

METHODS: To identify a change in medication in patients suffering from diabetes a retrospective and cross-sectional study was performed. Data was collected from 500 general practitioners (GPs). Patients' characteristics, treatment history, comorbidities and disease control were analyzed. Biochemical control was defined as an age/gender adjusted IGF-1 data (n:109). Standardized Mortality Ratio (SMR) was calculated and compared to general age/gender matched UK population. RESULTS: A total of 218 patients with Cushing’s disease were identified (227 alive and 23 dead). Among alive patients, mean age (SD) was 46(15) years respectively. Remaining patients were not controlled. SMR was 7.4, 5.1 and 3.1 at 5, 10 and 15 years respectively. CONCLUSIONS: This study demonstrated significant mortality and morbidity burden of Cushing’s disease in the UK primary practice.

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TREATMENT PATTERNS AND BURDEN OF ILLNESS OF ACROMEGALY IN THE UNITED KINGDOM: REAL WORLD (RW) DATA FROM CLINICAL PRACTICE RESEARCH DATALINK (CPRD)

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OBJECTIVES: To critically appraise current evidence on the cost-effectiveness (CE) of therapeutic education for people with type 2 diabetes (T2D) and prediabetes compared to usual care. METHODS: We conducted a systematic review of economic evaluations of educational programs for people with T2D or prediabetes which were based on randomized controlled trials and published between 2002 and 2012. The quality of the clinical and the health economic evidence was ranked high, moderate, or very low after critical appraisal by means of the Cochrane Collaboration’s tool for assessing risk of bias and the Consensus Health Economic Criteria List. Interventions were classified based on the reported incremental cost-effectiveness ratios (ICERs). RESULTS: The search yielded 1,868 publications. Fourteen met the inclusion criteria. In prediabetes, patient education was found to be cost-saving in two out of five studies. The reported ICERs were €850, €24,400; (€110,850 per quality adjusted life-year (QALY) gained from the payer’s perspective and €6,800; €40,000; €48,500 per QALY gained from the societal perspective. In T2D, the costs of patient education varied from cost-saving to moderate or low in 3 out of 5 studies, and the single intervention was not cost-effective and had a mean ICER of €44,500 (range: €6,380; €83,000) per QALY gained from the payer’s perspective. The quality of the health economic evidence was mainly moderate or low in all studies of T2D, and considerable in two studies of prediabetes. The uncertainty analysis were not exhaustive in most studies. In the modeling studies (n = 10), the models’ structural assumptions and validation methods were in general not properly reported. CONCLUSIONS: Current evidence on CE of therapeutic education in diabetes and T2D is scarce, limited, and of varying quality but consistently suggests that investing in patient education may offer good value for money. Studies of better quality are needed to reconfirm these findings. Commonly accepted methodologies for performance and assessment of health economic evaluations should guide further research.