A controlled, prospective longitudinal, interventional, naturalistic study to evaluate the unique health care program “conversation map®” for Turkish patients with type 2 diabetes mellitus (T2DM) who failed metformin monotherapy

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OBJECTIVE: To examine the time to add-on medication use after metformin monotherapy failure in clinical practice.

METHODS: Selected from a large US EMR database between January 1, 1997 and December 31, 2008, included patients had to be ≥18 years with a diagnosis of T2DM who had Hba1c ≥7.0% or ≥2 fasting blood glucose levels of 126 mg/dL or greater. Treatment failure was defined as Hba1c ≥7% (index date) after metformin monotherapy for at least 6 months. Baseline data were collected one year prior to the index date. Time to add-on medication use was defined by index date to the first add-on medication use during follow-up and was evaluated for the overall cohort and for the three Hba1c subgroups: <8%, 8-9%, and ≥9%. A Cox proportional hazard model was employed to determine baseline clinical, demographic, and lifestyle characteristics associated with shorter time to add-on medication use.

RESULTS: There were 12,566 patients meeting the inclusion criteria: 8656, 2175 and 1735 had Hba1c < 8%, 8-9% and ≥9%, respectively. The overall mean age was 63 (12) years and 51% were female. The median time to add-on medication use was 15.7 months overall and 17.6, 13.9 and 11.3 months for patients with index Hba1c < 8%, 8-9% and ≥9%, respectively. Higher index Hba1c, greater body mass index, younger Charlson comorbidity index, younger age, males, lower LDL were significantly associated with shorter time to add-on medication use (all \(P < 0.05\)). CONCLUSIONS: This indicates, in US clinical practice, it takes over a year for a diabetic patient who has substantial glycomic level after initial metformin monotherapy to receive add-on medications. There is room through disease management so that patients who have failed metformin monotherapy, if eligible and appropriate, receive add on therapy sooner rather than later.

Prescribed daily doses of once-daily liraglutide in the German statutory health insurance (SHI)

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OBJECTIVE: To evaluate the prescribed daily dose of liraglutide for patients in German statutory health insurances. The novel once-daily injectable analogue, liraglutide, mimics the effect of endogenous glucagon-like peptide 1 (GLP-1). Liraglutide was launched in Germany in July 2009 in a device allowing 3 different dosages (0.6 mg for initial titration; and the two maintenance doses 1.2 and 1.8 mg). The defined daily dose (DDD) was set by WHO at 1.2 mg. The prescribed daily dose (PDD) has not been evaluated so far. METHODS: Sampled data from German statutory health insurances (SHI) were provided by Insign Health (patient tracking data) for the period from July 2009 to March 2010 (9 months) covering about 11% of all patients in German SHI. All patients with prescriptions of liraglutide were identified (n = 4,284). Patients with only one prescription and less than 4 weeks between first and last date of prescription were excluded to avoid overrepresented influence of low dose therapy starters (remaining patients: n = 2,118). Total number of prescribed pens was determined from first to second last prescription and total consumption in mg was calculated. Number of days between first and last prescription was determined and mean average consumption in mg per day was calculated. RESULTS: The mean PDD of liraglutide in 2,118 patients was 1.28 mg. Sensitivity analyses including only patients with longer periods in Gewod decreasing average consumption; patients with at least 10 weeks duration of treatment showed a mean daily dose of 1.25 mg. Stoking effects (prescription before package is empty) could have driven the increase in average use in the starting period and at the end of the calendar year. CONCLUSIONS: The longer patients use liraglutide the lower the observed PDDs. DDD of 1.2 mg is a valid estimate for real life usage of liraglutide.

Time to treatment modification among patients with type 2 diabetes who initiated exenatide or insulin glargine

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OBJECTIVES: To examine time to treatment modification for patients with type 2 diabetes (T2D) initiating treatment with exenatide BID or insulin glargine. METHODS: A retrospective analysis was conducted using the Thomson Reuters Research Database database of insured patients with T2D with initiated exenatide (N = 9197) or glargine (N = 3449) between October 1, 2006 and September 30, 2007 with 12 months pre- and 18 months post-index continuous enrollment were included. Treatment modification was defined as the first event of change in the treatment and was classified further into the following: intensification, switch or discontinuation of therapy. RESULTS: The 2 cohorts were 1:1 propensity score matched on baseline demographics, clinical characteristics, and prior health care utilization. Survival analysis was used to examine time to treatment modification. RESULTS: Propensity score matching resulted in the inclusion of 3774 exenatide and 4 glargine patients with a mean age of 57 years, mean Deyo Charlson Comorbidity Index score of 1.6, and with proportionately more males (54%) than females. All of the patients concomitantly used a non-index antidiabetes medication in post-index period. The 18-month discontinuation rates were 33%, 40.0% (P = 0.14) and the treatment intensification rates were 11.9% and 26% (P < 0.0001) for exenatide and glargine, respectively. Among exenatide-treated patients switched therapies, compared to 10.0% of glargine-treated patients (P = 0.0001). Glargine-treated patients were 33% more likely to modify treatment than exenatide-treated patients (Hazard Ratio (HR): 1.33, P < 0.0001). Glargine-treated patients were 72% more likely to intensify their treatment (HR = 1.72, P < 0.0001), 25% more likely to discontinue (HR = 1.25, P < 0.0001), and 29% less likely to switch to new therapy (HR = 0.71, P < 0.0001) compared to exenatide. CONCLUSIONS: This analysis showed that exenatide-treated patients were less likely to modify their treatment suggesting potential longer durability with exenatide therapy. Furthermore, exenatide-treated patients were less likely to discontinue or intensify but more likely to switch their treatment than glargine-treated patients.

Management of acromegaly in clinical practice conditions in Spain

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OBJECTIVES: The goal of treating acromegaly is directed at removing the tumor, preventing tumor re-growth and reducing long-term morbidity and mortality. For this purpose, different health resources are necessary. This study evaluates the disease resources and costs in Spain. METHODS: An epidemiological, prospective, naturalistic, multicentric study (30 endocrinologists) involving acromegalic patients with micro (≤10 mm) or macro (>10 mm) adenomas was performed. Patients were categorized as Surgical Group (SG) (surgery) in the 6 months before inclusion or during follow-up period and somatostatin analogue (SA) treatment for <8 months during the pre-surgery period) and Medical Treatment Group (MTG) (patients receiving SA treatment for 26 months, with/without surgery following SA treatment). Resource data were collected from standard visits during a 2-years period. RESULTS: The study included 74 patients (56 SG and 18 MTG). Most patients were women (62%). The mean age of the annual direct acromegaly cost per patient is 11,054 MTG. The cost of illness was higher in patients with young patients (<40 years). Surgical procedures in acromegaly (involving hospitaliza-