from the budget of both payers would raise by $79.5 thousand PLN (130.3 thousand €) in 2009 and 1.2 mln PLN (261 thousand €) in 2010. Depending on parameter changes, the budget would change by ± 17% and ±19% for NHS and both payers perspective, respectively. CONCLUSIONS: The reimbursement of vildagliptin will cause the raise of NHS expenses by 0.37% in 2009 and 0.70% in 2010 of the budget spent for oral drugs reimbursed in diabetes mellitus. For both payers' perspective, the reimbursement of vildagliptin will cause the raise expenses by 0.27% in 2009 and 0.53% in 2010 of the budget.

DBPB1 COST OF AN EPISODE OF DIABETIC FOOT ULCER IN SPAIN
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OBJECTIVES: To estimate the health care direct costs of an episode of a severe superficial or deep uncomplicated foot ulcer of neuropathic origin in patients with diabetes in Spain and identify the key factors that influence total costs. METHODS: A retrospective observational study of patients with an episode of foot ulcer during the period from January 2007 through December 2008 in 10 Spanish centres was performed. Data about sociodemographic characteristics, duration of the episode and health care-related resources were considered. The following resources were collected from hospital records: inpatient hospitalisations, surgeries, outpatient visits (specialized and primary care physician), diagnostic procedures, laboratory tests, ulcer-related cures, antibiotics and orthotic devices. Unitary cost (€, year 2009 values) data were taken from a Spanish Database of Health Costs and the Catalogue of Medicinal Products. RESULTS: Ninety-two patients (29.1% with one or more previous ulcers with a foot ulcer episode were identified. The majority of cases were males (76.9%). Patients' mean age was 65.20 ± 10.90 years and 50.0% of these were retired. Average duration of an ulcer episode was 131 ± 123 days. Most prevalent comorbidities were arterial hypertension (62.0% of cases), diabetic retinopathy (41.3%), renal impairment (30.4%), dyslipidemias (25.0%) and myocardial infarction (19.6%). Contami-
ting infections during the episode were reported in 33.7% of patients. The average cost per patient and ulcer episode was €17,262 (95% confidence interval CI), €11,315 (95% CI), 5th, 50th, 75th, and 90th percentiles, respectively. Similar trends were found in overweight patients compared with those of normal-weight, but the attributable costs were not significantly different except at the 75th percentile point. CONCLUSIONS: The attributable to being overweight and obese in patients were substantial and increased significantly in the upper tail of the treatment cost distribution. The important finding that the magnitude of attributable costs increased across the distribution of treatment costs would not have been possible without the quantile regression method.

DBPB6 GLYCEMIC CONTROL IN THE INPATIENT SETTING: INSULIN ASPART COMPARED TO HUMAN BOLUS INSULIN
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OBJECTIVES: Poor glycemic control is associated with increased morbidity and mortality among hospitalized patients. Insulin aspart may be more effective in achiev-
ing glycemic control than human insulin. This study compares glycemic control, length of stay (LOS), hospital mortality, and charges for hospitalized patients receiving insulin aspart or human bolus insulin. METHODS: This study is a retrospective analysis of the Health Facts® database (Cerner Corporation, Kansas City, MO). Health Facts® is a unique database built from hospital comprehensive clinical records including pharmacy, laboratory, emergency room admission, and billing information from hospitals throughout the United States, all time-stamped and sequenced. The sample included 36,591 medical patients with discharge dates from January 1, 2004 through December 31, 2007. Patients were segmented into those who exclusively received insulin aspart (n = 4605, 12.5%) or human (n = 32,386, 87.6%) bolus insulin. Outcomes of interest included blood glucose (BG) control (overall mean BG < 140 mg/ dl), length of stay (LOS), in-patient mortality, and hospital charges (in $2007). Results were compared with t-tests or chi-square tests. RESULTS: Insulin aspart patients demonstrated better blood glucose control (34.22% vs. 30.78% with mean BG < 140 mg/dl, p < 0.001) even though they experienced increased illness as dem-
onstrated by higher Charlson comorbidity scores (2.0 (1.7) vs. 1.9 (1.8), p < 0.001) and had more heart, kidney, and lung diseases diagnosed during their stay. Insulin aspart was also associated with shorter LOS (5.5 (5.4) vs. 6.3 (6.8) p < 0.001), lower mortality (3.8% vs. 8.7%, p < 0.001) and fewer total charges ($25,074 (28,775) vs. $35,472 (41,704), p < 0.001). CONCLUSIONS: Insulin aspart patients appeared to have better glycemic control, shorter LOS, lower mortality and reduced hospital charges than patients on human bolus insulin. Multivariate adjustments are needed to confirm these findings but the unadjusted results suggest insulin aspart is associated with better outcomes than human bolus insulin.